Idaho Behavioral Health Plan (IBHP) Provider Handbook Supplement Appendix C - Program Services

Effective Dec. 2, 2026

Note: Refer to the rate schedule posted on www.MagellanofIdaho.com, under *For Providers* / *Getting Paid* for additional payment details (e.g., billing modifiers).

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Individual Psychotherapy

Description

A trained therapist works with individuals to explore and address emotional, mental, and behavioral challenges. It provides a safe space to discuss concerns, understand feelings, and develop coping strategies to improve overall well-being.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the Idaho Department of Health and Welfare (IDHW). Funding is limited and may only be used until funding has run out.

Services

Psychotherapy is the practice of a trained professional clinician applying clinical techniques that originate from the principles of psychology in order to help members adjust to situations in their lives, manage or change how they think, manage or change how they feel, alter certain behaviors, or bring about change in other areas of their lives. Interventions are designed to build on and/or develop members' strengths, address identified needs, and improve and/or stabilize functioning of the member. Psychotherapy may be delivered in a home or community-based setting.

Progress notes should include, at a minimum:

- Date of service
- Start time
- End time
- CPT code
- Provider delivering the service
- Participants present
- Focus of the session
- Type of intervention used in the session and the member's response
- Progress or lack of progress
- Mental Status Exam (MSE) for masters level clinicians and above (required in initial assessments, progress notes, discharge notes)
- Current strengths and limitations (point in time for that session that is helping or hindering their ability to meet their goals or objectives)
- Identified risk factors and plan
- Referrals to ancillary services (if identified/needed)

- Risk identified (suicidal ideation/homicidal ideation/grave disability/relapse) and notification primary clinician (if applicable)
- Evidence of family participation or education (if indicated)
- Date of the next session.
- Provider signature and date.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed clinicians as defined per licensure by the Division of Occupational and Professional Licenses (DOPL) and IDAPA; and/or practicing under a supervisory protocol.

Authorization

No authorization required.

Payment Methodology

Code	Description	Unit
90832	Psychotherapy, 30 minutes with patient and/or family member	Unit = 30 minutes
90833	Psychotherapy, 30 minutes with patient and/or family member with an evaluation and management service	Unit = 30 minutes
90834	Psychotherapy, 45 minutes with patient and/or family member	Unit = 45 minutes
90836	Psychotherapy, 45 minutes with patient and/or family member with an evaluation and management service	Unit = 45 minutes
90837	Psychotherapy, 60 minutes with patient and/or family member	Unit = 60 minutes
90838	Psychotherapy, 60 minutes with patient and/or family member with an evaluation and management service	Unit = 60 minutes
90863	Pharmacologic Management performed with Psychotherapy	Unit = per session
90839	Psychotherapy for Crisis; initial 60 minutes	Unit = 60 minutes
90840	Psychotherapy for Crisis; additional 30 minutes	Unit = 30 minutes

Family Psychotherapy

Description

Family psychotherapy is a form of psychotherapy that focuses on the improvement of interfamilial relationships and behavioral patterns of the family unit as a whole, as well as among individual members and groupings, or subsystems, within the family.

Interventions are designed to build on and/or develop the member and member's family's strengths, address identified needs, and improve and/or stabilize functioning of the member and the member's family.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Family psychotherapy uses a variety of activities adapted to the family's individual needs and requirements to promote family growth, understanding, and communication. The therapist chooses a therapeutic approach and treatments that best support the family's goals to promote positive transformation. Psychotherapy may be delivered in a home or community-based setting.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed behavioral health clinicians as defined per licensure by the DOPL and IDAPA; and/or practicing under a supervisory protocol.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
90846	Family Psychotherapy, without patient present	Unit = 50 minutes
90847	Family Psychotherapy, with patient present	Unit = 50 minutes

Group Psychotherapy

Description

In group therapy, three or more people with similar emotional challenges talk and support each other. They do this under the guidance of a trained professional. This professional helps guide the conversation and ensures a safe environment.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Group psychotherapy is a treatment approach in which three or more members with similar emotional challenges and/or functional impairments interact with each other on both an emotional and a cognitive level in the presence of a clinician who serves as a catalyst, facilitator, or interpreter.

Group psychotherapy approaches vary, but in general, groups aim to provide an environment in which challenges and concerns can be shared in an atmosphere of mutual respect and understanding.

Group psychotherapy seeks to enhance self-respect, deepen self-understanding, and improve interpersonal relationships.
Note: Group therapy is most effective with at least three members. If there are occasions where only two members are present it is allowable to bill for group therapy for two members as this aligns with CMS minimum standards.

Group Note Requirements

- Date of Service
- Start and Stop Time
- CPT Code
- Who is doing the service
- Who is present for the session / # of members in group
- Focus of the group session / topic of the day
- How did the member engage in the group session
- Document the progress or lack of progress for that member regarding that groups session and how it ties back to one of the members treatment plan goals/objectives.
- Current strengths and limitations identified in that group
- Note any risk factors and plan if they are identified
- Evidence of family participation / family education (if applicable depending on type of

group)
- Date of the next group
- Signed and dated by the group facilitator

Group Log Requirements

Each group should have a group log that includes following information:

- Date of the group
- Start and Stop time of the group
- Name and Type of Group
- Topic / Focus of Group
- Facilitator Name and Credentials
- CPT Code
- Printed Members Names
- Signature of Members who participated
- Facilitator Signature and Date

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed clinicians as defined per licensure by the DOPL and IDAPA; and/or practicing under a supervisory protocol.
- Group therapy is limited to no more than 12 participants.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit	Duration/Setting
90853	Group Psychotherapy, other than multiple-family group	Unit = per session	No more than 12 participants, facilitated by a trained therapist simultaneously providing therapy to these multiple patients

Multiple-Family Group Psychotherapy

Description

This therapy brings together patients and their families who face similar challenges. In a group setting with a trained professional, they discuss and work on their emotional needs/challenges. The goal is to help each person and their family grow, handle their emotions better, and improve their daily life skills.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Multiple-Family Group Psychotherapy treatment allows beneficiaries and their families with similar issues to meet in-person in a group with a clinician. The group's focus is to assist the beneficiary and their family members in resolving emotional difficulties, encourage personal development and ways to improve and manage their functioning skills.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed clinicians as defined per licensure by the DOPL and IDAPA; and/or practicing under a supervisory protocol.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
90849	Multiple-family group psychotherapy	Unit = per session

Family Psychoeducation

Description

Family Psychoeducation (FPE) is an approach for partnering with families and members with Serious and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED). Family Psychoeducation gives youth and families information about mental illnesses, helps them build social supports, and enhances problem-solving, communication, and coping skills. Since Family Psychoeducation is a unique approach to mental health intervention, specialized sessions (e.g., joining sessions and an educational workshop) should be completed before beginning ongoing sessions and providers should be sure they are using an Evidence-Based Practice. Providers may follow whichever Evidence-Based Practice (EBP)for Family Psychoeducation that fits the needs of the youth, including EBPs where the youth is not present with the family.

Family psychoeducation services may be provided to a single family or multi-family group (two to five families). Specialized sessions (joining sessions and an educational workshop) shall be completed before beginning ongoing sessions, and ongoing Family Psychoeducation sessions typically occur every two weeks.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Family Psychoeducation (FPE) is an approach for partnering with families and members with Serious and Persistent Mental Illness (SPMI) and Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED).

Provider Requirements

Services may be provided by an independently licensed clinician or an individual with a master's degree who is able to provide psychotherapy. When a second facilitator is warranted, this may be a paraprofessional provider with a minimum of a bachelor's-level education operating in a group agency under a supervisory protocol.

Multifamily Group Psychoeducation (two to five families)
Multifamily psychoeducation warrants two facilitators; at least one of these will be an independently licensed clinician or a master's-level provider qualified to deliver psychotherapy in a group agency under supervision. The second facilitator may be a bachelor's-level paraprofessional operating in a group agency under supervision.
OR

Single Family Psychoeducation
Single-family psychoeducation requires a master's-level, independently licensed clinician (Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Clinical Professional Counselor) or a master's-level provider qualified to deliver psychotherapy in a group agency under supervision. In cases where providers are working with a single family having many participants or complex issues, the family could benefit from the involvement of a second facilitator.

Authorization
No authorization is required.

Payment Methodology

Code	Description	Unit	Duration/Setting
H2027	Family Psychoeducation, including Multiple-Family Group Psychoeducation	Unit = 15 minutes	Can be provided in a multiple family group (two to five families) or in a single-family format

Early Serious Mental Illness (ESMI)

Description

The Early Serious Mental Illness (ESMI) program is a recovery-oriented, multidisciplinary approach for adolescents and young adults with an early serious mental illness also known as first-episode psychosis (FEP). SAMHSA defines ESMI as a condition that affects an individual, regardless of their age, that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-5. ESMI is designed to provide early intervention services for youth and young adults who are experiencing psychosis and other symptoms and to avoid a higher level of care such as partial hospitalization, residential care or hospitalization as well as to support those members who are stepping down from a higher level of care. ESMI is a coordinated specialty care program that is informed by research studies funded by the federal government which demonstrated good outcomes for people with first-episode psychosis.

Member Eligibility

- Medicaid benefit for youth and young adults.
- Benefits may also be available for other eligible IBHP members without Medicaid for youth ages 15-30 years old. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

ESMI promotes shared decision making and uses a team of specialists who work with the individual to create a personal treatment plan to foster autonomy and resiliency for each person at their specific level. Services include:

- Assessment services, including annual assessments
- Treatment plans
- Psychoeducation
- Peer Support Services
- Case Coordination with weekly team meetings as an integral part of the program
- Crisis Intervention
- Individual therapy
- Group Therapy
- Medication management services
- Discharge Planning
- Outreach & Recruitment Coordinator (ORC)*
- Supported Education and Employment Specialist (SEES)*

*For members enrolled in Medicaid, services provided by the ORC and SEES are covered by Other State Funding. These services are not covered by Medicaid.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed clinicians as defined per licensure by the DOPL and IDAPA; and/or practicing under an Idaho supervisory protocol.
- Provider team members must be trained in the principles and delivery of the OnTrackNY **CSC model link**: **OnTrackNY.**
- Each member of the ESMI team will meet the requirements established in this document for the specific service they are delivering.

ESMI teams include:

- Team Leader - Licensed master's-level behavioral health clinician.
- Outreach & Recruitment Coordinator - Licensed master's-level behavioral health clinician.
- Primary Clinician - Licensed master's-level behavioral health clinician.
- Supported Education & Employment Specialist – bachelor's level.
- Psychiatric Care Provider - Psychiatrist, Psychiatric Nurse Practitioner, or Physician's Assistant.
- Nurse - Registered Nurse.
- Peer Support Specialist - Certified Peer Support Specialist.

Authorization

Adult Skills-Building/CBRS requires a prior authorization

Payment Methodology

Providers will follow Magellan's IBHP fee schedule. Providers should render all services in accordance with the parameters and guidelines of each individual service outlined in Appendix C.

Code	Description	Unit
H2023	Supported Education and Employment Specialist (SEES)	Unit = per 15 minutes

Note: As of 12/1/25 no additional members may start SEES, those who are already receiving the service may continue until completed.

Training

The Division of Behavioral Health, Center of Excellence ESMI Competency Center provides initial and ongoing model fidelity training and technical assistance following the OnTrackNY model for providers: DBH ESMI Competency Center.

Fidelity Monitoring
The ESMI Competency Center conducts an annual assessment of fidelity to the OnTrackNY model.

Medication Management

Description
Medication Management includes a clinical assessment of the member to determine the need for psychotropic medications and monitoring of the medications once they are prescribed. The prescription of medication and follow-up reviews are included as part of the member's individualized treatment plan. Medication Management is also used to evaluate the effectiveness and side effects of the medication through medical personnel monitoring of medications that a member takes to confirm that they are complying with a medication regimen, while also ensuring the member is avoiding potentially dangerous drug interactions and other complications.

Member Eligibility
- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services
Services include clinical assessment, psychotherapy, therapeutic injections, and ongoing medication management and monitoring for effectiveness.

Provider Requirements
Services may be provided by one of the following professionals operating within the scope of their practice:
- Licensed Psychiatrists, Psychologists with prescriptive authority, and prescribing APRNs (including Psychiatric Nurse Practitioners and/or Psychiatric Physician Assistants).

Authorization
No authorization is required.

Payment Methodology

Code	Description	Unit
90792	Psychiatric Diagnostic Evaluation with Medical Services	Unit = per session
90833	Psychotherapy, 30 minutes with patient and/or family member, with an evaluation and management service	Unit = 30 minutes

90836	Psychotherapy, 45 minutes with patient and/or family member with an evaluation and management service	Unit = 45 minutes
90838	Extended Visits Psychotherapy, 60 minutes with patient and/or family member	Unit = 60 minutes
99202	Office Outpatient New Patient, 15 minutes	Unit = 15 minutes
99203	Office Outpatient New Patient, 30 minutes	Unit = 30 minutes
99204	Office Outpatient New Patient, 45 minutes	Unit = 45 minutes
99205	Office Outpatient New Patient, 60 minutes	Unit = 60 minutes
99211	Office Outpatient Established Patient, 5 minutes	Unit = 5 minutes
99212	Office Outpatient Established Patient, 10 minutes	Unit = 10 minutes
99213	Office Outpatient Established Patient, 20 minutes	Unit = 20 minutes
99214	Office Outpatient Established Patient, 30 minutes	Unit = 30 minutes
99215	Office Outpatient Established Patient, 40 minutes	Unit = 40 minutes

Therapeutic Injection

Description

Drugs or medications administered (or given) either under the skin or directly into the muscle for behavioral health treatment. For certain chronic long-term conditions, injections can lead to better results and consistent use. In some situations, injections are the best way to give these medications.

In some cases, therapeutic injections create better outcomes and compliance with chronic medication administration. In other cases, therapeutic injections are the preferred method for the application of medications.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services
Therapeutic injection given subcutaneously or intramuscularly means that a drug is given by injection under the skin or in the muscle.

Provider Requirements
Services may be provided by one of the following professionals operating within the scope of their practice:

- Psychiatrists or Psychologists with prescriptive authority and prescribing APRNs (including Psychiatric Nurse Practitioners and/or Psychiatric Physician Assistants).

Authorization
No authorization is required.

Payment Methodology

Code	Description
96372	Therapeutic injection; subcutaneous or intramuscular

Electroconvulsive Therapy (ECT)
At this time, ECT will not be reimbursed through Magellan and should be billed through Gainwell.

For more information, and contact information, please visit www.idmedicaid.com.

Transcranial Magnetic Stimulation (TMS)

Description
Transcranial magnetic stimulation (TMS) may be considered for treatment of major depressive disorder for adults who, by accepted medical standards, can be expected to improve significantly through this noninvasive procedure. TMS uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression.

The treating psychiatric provider must demonstrate that the patient's symptoms are treatment-resistant to both a course of medication management and a course of psychotherapy. Resistance to treatment is defined in this guideline as a failure to achieve a 50% reduction in depressive symptoms after adequate trials of antidepressant therapy and evidence-based psychotherapy.

Member Eligibility
- Medicaid benefit.
- State funded benefits does not cover TMS treatment.

Services

TMS requires multiple treatments, usually three to five times per week over several weeks.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Psychiatrists and prescribing APRNs (including Psychiatric Nurse Practitioners).

Authorization

Authorization is required.

Payment Methodology

Code	Description	Unit
90867	Therapeutic Repetitive Transcranial Magnetic Stimulation (TMS) Treatment; Initial, including Cortical Mapping, Motor Threshold Determination, Delivery and Management	Unit = Per Session
90868	Therapeutic Repetitive Transcranial Magnetic Stimulation (TMS) Treatment; Subsequent Delivery and Management, per session	Unit = Per Session
90869	Therapeutic Repetitive Transcranial Magnetic Stimulation (TMS) Treatment; Subsequent Motor Threshold Re-Determination with Delivery and Management	Unit = Per Session

Psychological Testing

Description

These evaluation services are a formal set of tests that providers use to understand how a person thinks, feels, and behaves. These tests also help determine a person's strengths, challenges, personality, and how they handle situations.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Psychological Test Evaluation Services are a set of formal procedures utilizing reliable and validated tests designed to measure areas of intellectual, cognitive, emotional, and behavioral functioning, in addition to identifying psychopathology, personality style, interpersonal processes, and adaptive skills.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed psychologist or psychology extender as defined per licensure by the DOPL and IDAPA; and practicing under a supervisory protocol.
    - The provider's professional training and licensure must include any of the following:
        - A doctoral-level psychologist who is licensed to practice independently and demonstrates sufficient training and experience.
        - A psychometrist or psychometrician who administers and scores psychological tests under the supervision of a licensed, doctoral-level psychologist, and whose services are billed by the supervising 56psychologist.
        - The supervising psychologist must have in-person contact with the participant at intake and during the feedback session.
        - The supervising psychologist is also responsible for final test interpretation, report writing, and final signature of approval.
        - A master’s-degreed behavioral health professional whose licensure specifically allows for provision of psychological testing services.

- The master's-degreed provider has professional expertise in the types of tests/assessments being administered.
- The master's-degreed provider conducts test administration, scoring and interpretation in accordance with licensing standards and the professional and ethical standards of psychological testing.

Authorization

No authorization is required until the threshold of 14 hours is met.

Payment Methodology

Code	Description	Threshold
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	14 hours of psychological testing for all codes combined per member, per calendar year
96131	Each additional hour (List separately in addition to code for primary procedure)	
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes	
96137	Each additional 30 minutes (List separately in addition to code for primary procedure)	
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	
96139	Each additional 30 minutes (List separately in addition to code for primary procedure)	
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only	

Neuropsychological Testing

Description

These evaluation services use a formal set of tests specifically designed to detect brain damage, injuries, or other issues, and to identify any related challenges in how the brain functions.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Neuropsychological Test Evaluation Services are a set of formal procedures utilizing reliable and valid tests specifically focused on identifying the presence of brain damage, injury, or dysfunction, and any associated functional deficits.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed psychologists, APRN, or psychology extenders as defined per licensure by the DOPL and IDAPA; and/or practicing under a supervisory protocol.
    - The provider's professional training and licensure must include any of the following:
        - A doctoral-level psychologist who is licensed to practice independently and demonstrates sufficient training and experience.
        - A psychometrist or psychometrician who administers and scores neuropsychological tests under the supervision of a licensed, doctoral-level psychologist, and whose services are billed by the supervising psychologist.
        - The supervising psychologist must have in-person contact with the participant at intake and during the feedback session.
        - The supervising psychologist is also responsible for final test interpretation, report writing, and final signature of approval.

Authorization

No authorization is required until the threshold of 14 hours is met.

Payment Methodology

Code	Description	Threshold
96116	Neurobehavioral status exam by professional; first hour	14 hours of neuropsychological testing for all codes combined per member, per calendar year
96121	Neurobehavioral status exam by professional; each additional hour	
96132*	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	
96133	Each additional hour (List separately in addition to code for primary procedure)	
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes	
96137	Each additional 30 minutes (List separately in addition to code for primary procedure)	
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	
96139	Each additional 30 minutes (List separately in addition to code for primary procedure)	
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only	

*96132 can be billed via telehealth.

Assertive Community Treatment (ACT)

Description

Assertive Community Treatment (ACT) is an intensive, evidence-based treatment program that provides a full array of community-based services as an alternative to higher levels of care or criminal justice system involvement for adults with serious and persistent mental illnesses who have the most intense service needs. ACT is a client-centered, recovery-oriented mental health service delivery model that utilizes a multidisciplinary ACT team to provide 24-hour outreach and support in the community to facilitate community living, psychosocial rehabilitation, and recovery for persons who have not benefited from traditional outpatient programs. ACT teams help members who have extensive needs live safely and autonomously in the community. To achieve this goal, providers must implement the model with fidelity.

Member Eligibility

- Medicaid benefit for adults 18 years old and older (
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the Idaho Department of Health and Welfare. Funding is limited and may only be used until funding has run out.

Services

Individuals receive ACT services from a mobile, transdisciplinary team in community settings. These services are available to the individual 24 hours per day, seven days per week. Individuals will have an average of 2 hours or more of in-person contact and 3 or more contacts weekly. Services include individualized treatment planning, crisis intervention, peer services, community-based rehabilitation services, medication management, case management, individual and group therapy, co-occurring treatment, and coordination of other community support services. The person-centered service plan must be reviewed, and revised as appropriate, every 90 calendar days.

ACT Services include:

- Assessment
- Assertive Engagement
- Person-centered Planning
- Case Management
- Crisis Intervention
- Crisis Response
- Community Integration
- Medication Management
- Family Psychoeducation

- Integrated Dual Disorder Treatment
- Individual, Group, and/or Family Psychotherapy
- Non-medical Transportation (NMT)
- Peer Support Services
- Family Peer Support Services
- Self-management and Skill Training
- Psychosocial Rehabilitative Services
- Vocational and/or Educational Support Services

Service Exclusions

Individuals under the age of 18 are not able to receive ACT services. Individuals with a primary diagnosis of substance use disorder, intellectual disability, or brain injury are also not the intended target group for ACT services.

ACT services are designed to meet all of an individual's treatment needs. Therefore, some services are considered duplicative when receiving ACT services such as Intensive Care Coordination (ICC), Skills-Building/Community-Based Rehabilitation Services, Peer Support Services, Mental Health Partial Hospitalization Program Services, Mental Health Intensive Outpatient Treatment, and Mental Health Outpatient Services (including individual, family, or group therapy, or psychiatry. On occasion and for approved clinically appropriate reasons, specialty outpatient services can be concurrently approved on a case by case basis and with prior approval from a Magellan Care Manager.

If an individual is receiving certain services or is residing in certain placements for longer than 30 days while involved with ACT service, the individual also becomes unable to continue with ACT services. Receiving treatment in long term treatment locations such as State Hospital or long-term residential facilities will disqualify individuals from continuing to receive ACT services, and they will need to be discharged. Other types of ongoing placement and/or treatment that disqualify a member for continue ACT services requiring discharge would be incarceration or long-term medical placements, such as skilled nursing facilities.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed professional staff and unlicensed staff under the supervision of licensed staff.
- All ACT services providers are required to complete State Medicaid Agency identified training prior to rendering services and meet the requirements for the specific service they are delivering. Fully functioning ACT teams include the following team members:
    - Clinical supervisor – Team lead
    - Psychiatrist/prescriber – Psychiatric care provider
    - Registered nurse
    - Master's-level clinicians

- Substance use disorder specialist
- Peer specialist/recovery coach
- Bachelor's-level and paraprofessional behavioral health workers
- Supported employment specialist
- Administrative assistant – Program Assistant

Authorization

ACT Encounter Billing Requirements

Providers must submit encounter claims for all services delivered as part of the ACT service bundle in addition to billing the ACT per diem.

- Each individual service provided within the ACT service bundle must be submitted as an encounter claim.
- All ACT encounter claims must include the Q2 modifier in the first modifier position.
- ACT encounter claims must be billed at $0.01 and are submitted for reporting and encounter-tracking purposes only. Encounter claims are not separately reimbursable.
- Providers must continue to bill H0040 with modifier Q2 for the ACT daily rate. The ACT per diem is the only reimbursable component of the ACT service bundle.
- Both the ACT per diem claim and any applicable encounter claims must be submitted for the applicable date of service. Claims may be submitted on the same claim form or on separate claim forms.
- Services not included within the ACT service bundle must be billed in accordance with applicable billing requirements.
- Billing the ACT daily rate while a member is incarcerated is not permitted.

Notice of Admission (NOA) is required. The initial request for services can be a request for a 30 day time period. After the initial 30 day review period expires, Magellan will review up to six months (180 days) and then as needed through ongoing concurrent reviews.

Payment Methodology

Code	Description	Unit
H0040	Assertive community treatment program, per diem	Unit = 1 day

Comprehensive Diagnostic Assessment (CDA)

Description

The initial evaluation for treatment or comprehensive diagnostic assessment (CDA) completed at initial intake includes a current mental status examination, as well as a description of the member's readiness and motivation to engage in treatment, participate in the development of the treatment plan and adhere to the treatment plan.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Magellan does not require a specific instrument for the diagnostic assessment. However, the tool used should include the following elements:

- Presenting Problem and conditions identified to include the onset, duration, and frequency of symptoms the member is currently experiencing along with how current symptoms are impacting the members ability to function.
- Biopsychosocial history that provides information on previous medical, behavioral health conditions and substance use issues, interventions including medications, outcomes, (including family history) and lists of current and previous providers.
- Complete DSM-V diagnosis.
- Mental status exam A complete mental status exam is in the record, documenting the member's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.
- Risk assessment for any current and historical suicidal ideation, homicidal ideation, or grave disability. Documentation must include dates, method, and lethality and any behaviors that could be considered a danger to self or others.
- Substance use screening for anyone over the age of 10. Per Idaho Code § 39-306(3)(e) if a substance use concern is identified, the provider must include the six ASAM dimensions in the CDA. The ASAM assessment and placement determination must be completed by a provider trained in the ASAM criteria multidimensional assessment process and level of care placement decision making.
- History of abuse as both a victim and as a perpetrator.
- History of trauma
- Depression screening either within the assessment or if you use an alternative screening, document within the assessment that you reviewed the screening and what the score was and if anything significant was identified that may need to be a focus of treatment.
- Developmental assessment- prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.
- Has the member had a physical exam within the last 12 months and, if not are you referring them to their PCP?
- Does the member have a PCP AND are you coordinating care with that PCP?

- Education
- History of member AND family legal history
- Is the member currently accessing community resources? If so where, for how long and what is beneficial for them?
- Legal issues
- Social Support
- Assessment of spiritual and culture variables impacting treatment.
- Clinical formulation and treatment recommendations

The *Combined Assessment* that Magellan has created includes all the domains listed above and allows those assessing a member with SUD to follow ASAM criteria. This assessment is available through the Availity Essentials *Assessment* tile in the Magellan Healthcare of Idaho Payer Space. It includes all the required data elements that providers must collect for federal reporting. It also will be sent directly to Magellan's internal system, which will support medical necessity for authorized services.
Providers who choose not to use the full Magellan *Combined Assessment* tool must submit federally required reporting data if they are serving members without Medicaid. The *Combined Assessment* tool allows providers to enter data only into those required sections instead of utilizing the entire tool.

The following services may be initiated prior to the completion of the CDA:

Code	**Services Allowed Prior to CDA**	**CDA Required**
90839 & 90840	Crisis Psychotherapy	NO CDA required
H2011	Crisis Intervention	NO CDA required
96116, 96121, 96130, 96131, 96132, 96133, 96136-96139, 96146	Psychological Testing/Neuropsychological Testing	NO CDA required
T1017	Community Based Case Management	16 units and then CDA is required
96156 – 96159, 96164-96168	Health & Behavior Assessment & Intervention	NO CDA required
H0038 HR	Family Support	16 units and then CDA is required
H0038 HF*	Recovery Coaching	16 units and then CDA is required*

H0038 HB*	Adult Peer Support	16 units and then CDA is required (Only available for ESMI participants)
H0038 HA*	Youth Support	16 units and then CDA is required*

*16 units of Recovery Coaching, Adult Peer Support, and Youth Support are allowed prior to a CDA as long as the member is also receiving Crisis Psychotherapy, Crisis Intervention, and/or Case Management prior to their CDA.

Magellan will provide guidance and education to providers on best practices for the completion of the CDA, including when services could begin using an alternative assessment.
A provider can utilize another provider's CDA if it was completed in the last six months. There is still a requirement for a provider to complete an independent clinical assessment/interview to verify that the information provided is accurate. If the previous CDA does not meet the requirements of the provider, the clinician needs to update it. Clinicians can bill 90791 for the CDA or they can bill for a psychotherapy session (billing 90834, 90837, etc.) whichever code applies to the length of session, with an addendum. An addendum is a way to add any additional relevant clinical information to the CDA. Providers will utilize the CDA and a functional assessment tool to guide individualized treatment planning.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed behavioral health clinicians as defined per licensure by the DOPL and/or practicing under Magellan's supervisory protocol.

Per Idaho Code § 39-306(3)(e) when a substance use concern is identified, the six ASAM dimensions must be included in the member's Comprehensive Diagnostic Assessment (CDA). The GAIN administered by a GAIN-certified provider can meet this requirement. Other assessment tools may also meet this requirement and can be administered by those certified/licensed to administer the specific tool. The ASAM assessment and dimensional placement determination must be completed by an individual trained in the ASAM Criteria® multidimensional assessment process along with level of care placement decision-making. This training must be documented in the individual's HR file through certificates, transcripts, or CEU. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable. If the assessing provider is not qualified to complete the ASAM portion of the CDA, a referral must be made to an ASAM qualified professional for completion.

Authorization

No authorization is required. Reimbursable every six months, per member, per year, per provider.

Payment Methodology

Code	Description	Unit
90791	Comprehensive Diagnostic Assessment; initial assessment or reassessment once every six months	Unit = per session

Treatment Planning

The treatment plan should be based on the member's presenting condition and is used to document realistic and measurable treatment goals as well as the evidence-based treatments that will be used to achieve the goals of treatment. Effective treatment planning should also include significant variables such as the member's functional deficits, strengths, and weaknesses, as well as age and level of development, the history of treatment, whether the proposed services are covered in the IBHP and are available in the community. Providers should include the member in the treatment planning as the treatment plan must be geared towards the individual member's needs and include treatment goals in the member's own words.

Services cannot be provided until a treatment plan has been completed. Documentation must confirm that the member or legal guardian has participated in and agreed to the treatment plan, which should include signatures as best practice, although they are not required except for Person Centered Service Plans and Community Based Rehabilitation Services/Skills-building plans. The treatment plan must be consistent with the diagnosis, member strengths and functional needs, and include objective and measurable short and long-term goals with time frames for goal attainment. The plan must also include an initial discharge plan.

Treatment Plan Should Include the Following:

- Treatment plan should address the symptoms, behaviors and impairments as identified in the assessment and should be consistent with the diagnosis.
- If under 19 years old, was the CANS used to develop the treatment plan?
- Tx Plan should have short term and long term goals in the members own words
- There should be measurable objectives
- The treatment plan should include a safety plan when risks are identified
- Intervention is what the professional staff should being doing and include who (therapist, CBRS worker, peer support specialist, etc.) is doing the intervention.
- Estimated time frames should be included in the treatment plan to account for long and short term goals/objectives.
- Interventions are appropriate for the member based on needs and strengths
- When appropriate, family member involvement should be included within the treatment plan.
- Include discharge planning within the treatment plan.

- Should be simple and easy for the member/family to follow
- Should be signed by the staff and the member.

Treatment plan updates occur when goals are achieved, or new goals are identified. Treatment plan reviews should be completed every ninety (90) calendar days and should reflect changes in the strengths and needs indicated from functional assessment tool updates.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed behavioral health clinicians as defined per licensure by the DOPL and/or practicing under Magellan's supervisory protocol.

Per Idaho Code § 39-306(3)(e) when a substance use concern is identified, the six ASAM dimensions must be included in the member's Comprehensive Diagnostic Assessment (CDA). The GAIN administered by a GAIN-certified provider can meet this requirement. Other assessment tools may also meet this requirement and can be administered by those certified/licensed to administer the specific tool. The ASAM assessment and dimensional placement determination must be completed by an individual trained in the ASAM Criteria® multidimensional assessment process along with level of care placement decision-making. This training must be documented in the individual's HR file through certificates, transcripts, or CEU. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable. If the assessing provider is not qualified to complete the ASAM portion of the CDA, a referral must be made to an ASAM qualified professional for completion.

Functional Assessment

Description

A Functional Assessment is a multi-purpose strengths-based assessment tool that can be used in-person or via telehealth to evaluate a member's functional status level and need for assistance with everyday activities. The results of the assessment support decision making, including recommendations for an array of services based on the severity and complexity of the member's strengths and needs; treatment planning with the member and family; and monitoring of outcomes of services. The assessments should be member-centered, culturally informed, and responsive to each member's psychosocial, developmental and treatment needs.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

The Functional Assessment is completed at intake as a result of the Comprehensive Diagnostic Assessment (CDA) findings and updated as a result of significant changes in the member, reviews of progress during person-centered treatment planning, formal re-assessment, and transitioning out of or into a formal program or service.

- Youth:
    - The Child and Adolescent Needs and Strengths (CANS) is the IDHW-required functional assessment tool developed for youth services. All youth under 18 must have a CANS. Refer to the Idaho Child and Adolescent Needs and Strengths (CANS) 3.0 section of this appendix.
    - Additional assessments may be appropriate based on clinical discretion if the CANS is used initially and is updated every 90 days.
- Adults: IDHW does not mandate a specific functional assessment tool for adults. Examples include the Adult Needs and Strengths Assessment (ANSA) and the Level of Care Utilization System (LOCUS). **Magellan has the ANSA built into Availity Essentials along with the CANS for providers** should they choose to use it.

The provider will utilize the CDA and functional assessment tool to guide individualized treatment planning.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- A provider who is certified/licensed to administer the specific assessment tool.
- Provider requirements for the administration of the CANS can be found in the Idaho CANS 3.0 section of this appendix.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
H1011*	Function Assessment tool, including but not limited to, Infants and Toddler Assessment	Unit = 15 minutes

*This code is not billable for SUD other state funding

Individualized Skills-Building Treatment Plan

Description

This is a teamwork method where a trained clinician, a skills-builder, the member, and their family come together to create a personalized Skills-Building/Community-Based Rehabilitation Services (CBRS) treatment plan. The approach focuses on the member's strengths and helps them meet goals.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

The **skills-building plan using the teaming approach** is a collaborative process in which the independently licensed or master's-level clinician (under a supervisory protocol), the Skills-Building paraprofessional, the member, and the member's family or authorized representative work together to develop an individualized Skills-Building/CBRS treatment plan. The process is **person-centered, strengths-based, collaborative, individualized, and outcome-focused**.

Skills-Building/CBRS services must be guided by a service-specific, individualized treatment plan that reflects the member's unique needs and strengths identified through a comprehensive diagnostic and functional assessment. Treatment planning for this service is completed using the **teaming approach** to ensure that:

- The skills-building paraprofessional receives appropriate clinical supervision when developing the treatment plan.
- The supervising clinician maintains a clear clinical understanding of the case being overseen.
- The treatment plan effectively addresses the member's identified goals and promotes measurable progress toward recovery and independence.
- The treatment plan is approved by the clinician and confirmed with their signature and title. AND;
- The Skills-Building/CBRS treatment plan must be developed prior to the provision of services and prior to the submission of the service request form. AND;
- The treatment plan shall contain the following:
    - Observable, measurable objectives aimed at assisting the Member in achieving his/her goals related to the specific functional need.
    - The specific evidence-based intervention(s)/modality for each skill/knowledge or resource objective related to the specific functional need.
    - The provider responsible for providing the intervention, and the amount, frequency, and expected duration of service.

- The skills-building treatment plan must include the member/member's family and or the member's authorized representative signature on the document indicating his/her agreement with treatment plan goals and objectives and his/her participation in its development.
- The skills-building treatment plan must be reviewed using the teaming meeting approach for progress towards goals no less than every 90 days or whenever clinically indicated.

The plan is designed to teach members skills that may include:

- Coping skills
- Psychiatric symptom management
- Communication skills
- Basic living skills
- Social skills
- Problem serving
- Anger management
- Crisis support
- Medication management

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Independently licensed or master's-level clinicians under supervisory protocol, and providers qualified to provide Skills-Building/CBRS (see Skills-Building/CBRS provider qualifications).

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
H0032	Individualized Skills-Building Treatment Plan - Billed by clinician and paraprofessional for teaming with patient present	Unit = 15 minutes

Skills-Building/Community-Based Rehabilitative Services (CBRS)

Description

Skills-Building/Community-Based Rehabilitative Services (CBRS) is a home- or community-based service that utilizes psychiatric rehabilitation interventions focusing on behavioral, social, communication, rehabilitation, and/or basic living skills training. The primary goal of Skills-Building/CBRS is to improve functional capabilities, reduce the risk of psychiatric hospitalization and readmission, and support stability and improved quality of life in the community living environment by helping to reduce mental health and/or behavioral symptoms as an adjunctive to evidence-based treatment appropriate to the member's needs and diagnoses.

Skills-Building/CBRS is indicated as part of an individualized treatment plan for adults (18 years old or older) with Serious Mental Illness (SMI) or youth (17 years old or younger) with Serious Emotional Disturbance (SED) when the level of need exceeds other available evidence-based treatment and/or community-based resources, or when service augmentation is needed to yield desired treatment outcomes.

The intent of Skills-Building/CBRS is to address the member's specific needs and strengths to the point where the member may be safely, efficiently, and effectively treated in the least restrictive service level. Skills-Building/CBRS addresses specific functional needs and is not intended for general support service. Skills-Building/CBRS is not intended as a standalone service. Many members with SMI or SED will not sufficiently improve using Skills-Building/CBRS alone. Therefore, the member **should** either be referred to or already working with a licensed clinician to address mental health symptoms and impairments while the Skills-Building/CBRS provider is assisting with the development of skills that support and improve the members' mental health and/or behavioral symptoms.

Skills-Building/CBRS utilizes qualified practitioners (paraprofessional) supervised by independently licensed clinicians abiding by best practices in psychiatric rehabilitation to help members achieve the intended purpose. Skills-Building/CBRS vary in intensity, frequency, and duration to support members' ability to manage functional difficulties and to realize recovery and resiliency goals.

Skills-Building/CBRS is intended to be delivered in-person to support skill development and functional improvement in the member's natural environment. In-person service delivery is the standard expectation. Any use of telehealth must be justified in the clinical record, clearly documenting the clinical rationale and how telehealth delivery supports the member's treatment goals without compromising service effectiveness. This should be regularly reviewed as part of the treatment planning process.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Adults: Skills-Building/CBRS is intended to treat adults recovering from a Serious Mental Illness (SMI) or a Serious and Persistent Mental Illness (SPMI) who have been assessed to have at least two (2) significant functional needs indicated on the functional assessment tool that are related to the identified SMI/SPMI. OR

Youth: Skills-Building/CBRS is intended to treat a youth member identified as having an SED and has been assessed to have at least one (1) significant functional need related to the identified SED.

AND

Skills-Building/CBRS services are necessary for the member to obtain, apply, and/or when skills require a defined period of reinforcement, of the developmentally age-appropriate skills.

Services

An independently licensed or master's-level clinician under supervisory protocol, and providers qualified to provide Skills-Building/CBRS, work with the member in the home or community to develop an Individualized Skills-Building Treatment Plan using the teaming approach with the member and family. The process is person-centered, strengths-based, collaborative, individualized, and outcome-based. The plan is based on the member's individual needs and strengths identified from a comprehensive diagnostic and functional assessment and is updated every 90 days while Skills-Building is being utilized.

For additional information on the teaming approach please see the section above **Individualized Skills-Building Treatment Plan.**

Admission Criteria

Skills- Building/CBRS must meet medical necessity criteria based on the criteria including the presence of a serious mental illness based upon medical records, including a comprehensive diagnostic assessment, psychiatric evaluation, or other diagnostic assessment which includes one of the following:

- Serious Emotional Disturbance (Youth) as defined by Idaho Code § 16-2403, or
- Serious Mental Illness (Adult) as defined by Idaho Code § 39-3122, or
- Serious and Persistent Mental Illness as defined by Idaho Code § 39-3122

And, because of the mental illness, the person has a moderate to severe functional impairment that interferes with or limits performance in at least 1 (one) area for youth or at least 2 (two) areas for adult as indicated in a functional assessment.

Clinical Documentation

- A CDA dated within the last 12 (twelve) months signed by the licensed clinician treating the member and/or psychiatric evaluation signed by a licensed clinician
- Functional assessment (CANS, ANSA, or other applicable functional assessment)
- Treatment records, progress notes, testing results, or other clinical documentation to support the medical necessity of the requested service.

Continued Stay Criteria

Continued Stay for Skills-Building/CBRS must meet medical necessity based on the criteria and the individualized treatment plan should be updated frequently enough to reflect changes in the member's condition, functional needs, goals, progress, preferences, change in skill related goals and or at the request of the member/member's representative/family. The period between reviews shall not exceed ninety (90) calendar days.

- Individualized Skills-Building Treatment Plan developed using a teaming approach signed by the member's licensed treating clinician, the skills-building practitioner, the member and the member's natural supports that were involved in the treatment plan development.
- Treatment plan updates should reflect findings of functional assessment tool updates.
- Continued care requests should describe the identified Skills-Building/CBRS interventions and goals; document the member's attendance and adherence to treatment recommendations, and expectations for progress in the targeted skill.

Clinical Documentation

- Individualized Skills-Building Treatment Plan
- Treatment records, progress notes, testing results, or other clinical documentation to support the medical necessity of the requested service,

Discharge Criteria

For discharge from service, the admission criteria are no longer met, the member's condition no longer requires Skills-Building/CBRS, and or the member's condition has changed to the extent that the condition now meets admission criteria for another level of care.

Skills-Building is not

- Provision of transportation, respite, case management, or any other general support or treatment service.
- Daycare or a substitute for supervision.
  Provided without involvement, communication, and coordination with the family and/or legal guardian.

Provider Requirements

Skills-Building/CBRS specialists within the IBHP network must hold a minimum of a bachelor's-level degree and be practicing under the supervisory protocol.

Authorization
Prior authorization is required:

For members aged 18 and older: for all services.

For members aged 17 and younger: after 308 units have been utilized in a calendar year.

Payment Methodology

Code	Description	Unit
H2017	Skills-Building/CBRS	Unit = 15 minutes

Skills Training and Development (STAD)

Description
Skills Training and Development (STAD) is treatment for children and youth whose functioning is sufficiently disrupted to the extent that it interferes with their daily life as identified by a comprehensive diagnostic assessment (CDA) and a functional assessment tool (CANS is required for youth under 18). It takes place in a structured group environment within a mental health clinic or appropriate group setting that is developmentally and age appropriate.

Member Eligibility
- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services
Includes independent and group activities that focus on enhancing and/or developing social, communication, behavior, coping, and basic living skills. Activities may include each adult or child doing the same or similar tasks in the group or individuals doing independent tasks and bringing them back to the group. Group size depends on the purpose of the group. While in a group environment, STAD is outcome-based, strengths-based, culturally responsive, and responsive to each adult or child's individual psychosocial, developmental, and treatment needs.

Provider Requirements
Services may be provided by one of the following professionals operating within the scope of their practice:
- Independently licensed clinicians or above.
- Master's-level clinicians working under Magellan's approved supervisory protocol.

- Bachelor's-level paraprofessionals with a degree in a health and human services field who have completed required Magellan-approved STAD training.

STAD treatment plans must be updated frequently enough to reflect changes to the youth's condition, needs, and preference or at the request of the youth/family. Time between reviews must not exceed 90 calendar days.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
H2014	Skills Training and Development	Unit = 15 minutes

Case Management

Description

Case Management (CM), provided by a community-based provider, is available to members with a behavioral health, Substance Use Disorder (SUD) or co-occurring diagnosis who need help navigating the system or coordinating care. Case management refers to outcome-focused, strength-based activities that assist members and their families by locating, accessing, coordinating and monitoring mental health, physical health, social services, educational, and other services and supports. Case management includes both informal and formal assessment of service needs and service planning. It includes assessing, reassessing, monitoring, facilitating, linking, and advocating for needed services for members and their families. For youth enrolled in YES, Case Managers use a CFT approach as described in the YES Principles of Care and Practice Model and use Multi-Disciplinary Teams (MDTs) for adults with SMI or SPMI.
Case management includes in-person activities or collateral contacts that directly benefit the Member and the member's family. Case Managers maintain reasonable caseloads, consistent with accepted industry standards for children's and adult mental health systems of care based on intensity of their client's acuity, needs, and strengths.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - SUD Case Management for eligible IBHP members without Medicaid is available under billing code H0006 and should not be billed under billing code T1017; see SUD Case Management.

- Case Management may be provided up to 180 days prior to discharge for youth transitioning out of an inpatient or residential facility.

Services

Services are community-based and may be provided via telehealth. Case Management responsibilities include but are not limited to:

- Formally and informally assessing member's needs, through working with the member, completing needed documentation, gathering information from other sources (as necessary) to form a complete assessment of the member.
- Working with the member to develop a Case Management plan that includes member's strengths and needs as identified in the assessment of the member or identified through a formal person-centered service plan (PCSP) (e.g. the PCSP or Wraparound plan if the member is receiving ICC or Wraparound); the Case Management plan must specify goals and actions that must address the medical, social, education, and other services/supports needed by the member. Making sure ensure all members shall have a voice and choice in where, when, and from whom they receive medically necessary covered benefits.
- Participating in multi-disciplinary team meetings including Child and Family Teams (CFTs) and adult Multi-Disciplinary Teams (MDTs).
- Working with the Intensive Care Coordinators or Wraparound Coordinators, as applicable, and collaborating to ensure that the same services and supports are not being delivered by the Intensive Care Coordinator, Wraparound Coordinator or Case Manager.
- Completing a person-centered service plan through a CFT facilitated by the case manager, when a member is not receiving ICC or Wraparound but requires a person-centered service plan.
- Working with the member through their transitions in the continuum of care, including, but not limited to, working with discharge coordinators from inpatient stays, Crisis Centers, EDs, and residential placements to assist with meeting the members' needs in the community.
- Advocating for assisting members and by educating, locating, accessing, linking, coordinating, advocating for, and monitoring services and supports that assist the member in meeting their needs.
- Monitoring appropriateness of care and adjusting as needed.
- Being knowledgeable and informed about the different Medicaid programs and across system processes.

The Case Manager will be reimbursed for care coordination activities under the following conditions (42 CFR 440.169):

- Collecting and compiling information to support assessment activities.
- Referral and coordination to arrange for services and related activities.
- Following up on coordinating care to ensure services are provided and member's needs are adequately addressed.

Magellan ensures that Case Management services are delivered in a conflict-free manner in accordance with 42 CFR 441.18 and federal guidance to the State around conflict-free case management.

Case Management services cannot be duplicative of any services or activities that the member is already getting from any hospital or residential discharge coordinators. Case Managers should work collaboratively with the hospital or discharge coordinator to ensure that treatment goals are not duplicative.

Case Management services can be provided to members receiving Intensive Care Coordination through Magellan Intensive Care Coordinators or Wraparound Coordinators. Case Managers should work collaboratively with the Intensive Care Coordinator or Wraparound Coordinator to ensure that treatment goals are not duplicative.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Paraprofessional with at least a bachelor's degree in a health and human field practicing under supervisory protocol.
- **Health and Human Services Field** means a degree in a discipline focused on the promotion of health, behavioral health, human development, social functioning, community well-being, or the delivery of health and social services. Examples include Social Work, Psychology, Counseling, Human Services, Nursing, Public Health, Sociology, Child Development, Marriage and Family Therapy, Addiction Studies, Behavioral Health, and other closely related fields.
    - o
- Licensed Clinicians

Authorization

Prior authorization is required once utilization exceeds 240 units.

Payment Methodology

Code	Description	Unit
T1017	Case Management for Behavioral Health, including mental health and SUD	Unit = 15 minutes

SSI/SSDI Outreach, Access, and Recovery (SOAR) Case Management

Description

SSD/SSDI, Outreach, Access and Recovery (SOAR) Case Management provides Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) program application assistance to individuals, both youth and adults, who are experiencing homelessness or are at risk of homelessness and who have a severe and persistent mental illness, co-occurring SUD, and/or other medical issues.

Member Eligibility

- Medicaid benefit

Services

Please refer to the Case Management section in this appendix.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:
Case Managers who have the SOAR certificate of completion through SAMHSA or the Idaho Department of Health and Welfare.

Minimum of a bachelor's-level degree in a health or human services field and be practicing under Magellan's supervisory protocol.

All questions regarding SOAR Case Manager qualifications must be directed to the current SOAR State Lead at SOARInquiries@dhw.Idaho.gov. You can also visit the Idaho SOAR Website.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
T1017	Case Management for Behavioral Health, including mental health and SUD.	Unit = 15 minutes

Adult Peer Support Services

Description

Adult Peer Support Services are non-clinical services provided by an Idaho-certified peer support specialist (CPSS) that support members aged 18 and older who are living with a mental health or co-occurring mental health and substance use condition. Adult Peer Support Services may be initiated when there is a reasonable likelihood that such services will support the

member in working toward self-directed recovery/wellness, building hope, empowerment, resilience, and identifying natural supports in the community of their choice. A Certified Peer Support Specialist supports members in identifying wellness goals and steps to work toward them, relates to members using their lived experience, helps members navigate barriers and obstacles in their recovery journey, and supports members in building natural supports in the community.

Services are delivered in a range of environments that are chosen by the member including the member's home, community, and/or agency settings. Adult Peer Support Services may be delivered in-person or via telehealth and can be offered individually and/or in group settings.

Adult peer support services must align with the values of peer support including:

- **Peer support is voluntary:** members choose whether to participate in peer support services and participation is never required
- **Peer support is equally shared power:** peer support specialists work to balance power by collaborating, sharing ideas and opinions, and discussing options.
- **Peer support is strengths-focused:** peer support specialists focus on what's strong, not what's wrong to encourage members to identify and use their strengths.
- **Peer support is transparent:** peer support specialists clearly communicate their role, boundaries, and limitations, and invite members to share their own boundaries.
- **Peer support is person-driven:** peer support specialists promote self-determination and encourage members to lead their own wellness journey

Member Eligibility

- Medicaid benefit for members 18 years of age or older.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the Idaho Department of Health and Welfare. Funding is limited and may only be used until funding has run out.
- A licensed professional through the completion of a CDA has determined that peer support will assist in the member's social, interpersonal, familial, and/or personal wellness.
- The member is not at imminent risk to self, others, or property.
- The member has demonstrated a need for support in self-directed recovery/wellness, building resilience, and living successfully in their community.

Services

The CPSS will describe peer support to the member so there is shared understanding about the role of a certified peer support specialist and ensure the member voluntarily confirms the service is a good fit.

Peer support services are limited to the following:

- **Recovery and wellness support, which includes**

    - Building rapport and establishing a peer-to-peer relationship rather than a hierarchical relationship
    - Applying principles of cultural awareness, competency, and humility
    - Supporting the member with setting wellness goals and determining steps they would like to take to work toward their goals
    - Assisting the member in identifying and building on their strengths and resiliencies
    - Strategically sharing lived experience to relate to the member, using active listening, empathy, validation, and healthy boundaries
    - Assisting the member in identifying natural support
    - Supporting the member in connecting with other providers and/or resources when the member needs support that is outside the peer support role experiences

- **Mentoring which includes**
    - Role modeling healthy behaviors, boundaries, and communication skills
    - Supporting the member in determining activities they do or would like to try for wellness
    - Supporting the member in making self-directed choices
    - Supporting the member in identifying and establishing healthy relationships and boundaries
    - Supporting the member in practicing effective communication, conflict resolution, and problem solving

- **Advocacy which includes**
    - Encouraging the member to advocate for themselves
    - Advocating within systems to promote person-centered recovery/wellness support services
    - Helping the member understand their rights and responsibilities
    - Promoting the member's choice and self-determination
    - Discussing holistic approaches and multiple pathways to recovery/wellness based on what the member determines works for them
    - Using person-centered language with members and coworkers

- **Ethical responsibility**
    - Demonstrating alignment with the responsibilities and limitations of the peer support role
    - Maintaining privacy, confidentiality, and accurate documentation
    - Using supervision to address and resolve issues
    - Disclosing to supervisor personal relationships or limitations that may impact ability to perform peer support job duties

Peer Support Services do not include the following:

- Peer Support services are not a replacement for case management. Peer support services do not include functions typically performed by case managers such as care coordination or service linkage.
- Peer support services are not a replacement for Skills-Building/CBRS. Peer support services do not include functions typically performed by Skills-Building/CBRS such as teaching skills.
- Peer Support services are not a replacement for clinical services. Peer support services do not include clinical or diagnostic functions such as processing trauma, therapeutic counseling, medication management, or medication monitoring.
- Peer support does not include routine transportation of members. Time spent in transit with a member may be reimbursable only when it is directly connected to a documented recovery goal and when transportation justification is clearly reflected in the member's service record. Transportation should be limited, infrequent, and non-recurring, and does not include routine activities such as regularly transporting a member to the grocery store. All available natural supports for transportation must be explored, exhausted, and documented in the member's service record before a peer support specialist provides transportation.
- Peer support does not include ongoing accompaniment of members at support group meetings. The CPSS can support a member in attending a support group meeting for the first time. The CPSS should assist the member in brainstorming about what will help them sustain their support group meeting attendance when the CPSS is not accompanying them.

Goals and Documentation

- The CPSS will support the member in defining what is important to them related to their recovery, resiliency, and wellness.
- Within 30 days of first engagement with the member, the CPSS will support the member in defining a minimum of one recovery/wellness goal(s) and how the CPSS will support the member in working toward their goal(s).
- The member's recovery/wellness goal(s) should be self-directed, strengths-based, and chosen by the member. The member's goal(s) should not be chosen by the treatment team.
- Goal documentation should follow best practices, for example SMART goals, PACT goals, or other goal setting formats.
- The CPSS will collaborate with the member to specify the CPSS's role in supporting the member with their goal(s) and the frequency with which peer support services will be delivered.
- Activities that a CPSS and member do together should be in alignment with and support of the specific goals the member has chosen.
- The CPSS should revisit the member's goals with them on a regular basis to discuss which goals the member is still working toward, and which goals the member would like to revise.

- Documentation should demonstrate a strengths-based, recovery and resiliency focus and the peer support specialist's individualized support and benefit to the member. Documentation should also describe the activities that a CPSS and member do together in alignment with and support of the specific goals the member has chosen.
- Adult Peer Support Services should adhere to the Magellan supervisory protocol.

Groups

- Adult Peer Support services can be billed at the group rate for a minimum of one IBHP member.
- The number of Peer Support group facilitators should be appropriate for the size of the group. When two or more providers facilitate a Peer Support group, only one provider can submit a claim for a member. Two or more providers facilitating the same group cannot bill for the same members within the group.
- Peer support groups are non-clinical. It is best practice for certified peer support specialists to facilitate peer support groups.
- Magellan encourages best practices in group facilitation for peer support providers rendering peer support in a group setting. The peer support supervisor, as defined by the Magellan supervisory protocol, should ensure that peer support group facilitators are equipped with the knowledge and skills to effectively lead groups. The supervisor should also determine whether initial or ongoing guidance on group facilitation is needed and determine how they will assist and supervise the peer support provider's development in providing group services. Find additional resources on the peer services page on MagellanofIdaho.com.
- Peer Support groups should incorporate trauma-informed principles. Group facilitators should strive to create a person-centered, recovery-oriented, culturally sensitive, and+ inclusive environment in which to conduct groups.
- Peer Support groups may support members in:
    - Discussing their experiences living with mental health challenges and learning from one another.
    - Developing a social support network and encouraging social interaction to develop confidence and assertiveness.
    - Reducing isolation and increasing hopefulness by hearing personal recovery stories and interacting with others who have similar life experiences.
    - Learning about themselves, discussing the direction they would like their lives to go, and determining steps for working toward their goals.
    - Receiving feedback from other peers instead of just professionals.

Provider Requirements

Providers of Adult Peer Support services must:

- Be 18 years of age or older.
- Have a high school diploma or equivalent.
- Be an individual with their own personal lived experience in recovery from a mental health condition.

- Hold a current Idaho Peer Support Specialist Certification issued by BPA Health. A peer support training certificate of completion alone is NOT adequate to provide services.
- Provide services within an agency in the IBHP network.

Fidelity to Best Practices

- The member voluntarily chooses to participate in peer support services.
- Peer support services are non-clinical, and they are distinct from case management, Skills-Building/CBRS, and therapy.
- Peer Support services are inherently individualized, flexible, and based on the strengths and needs of the member.
- Magellan endorses the National Practice Guidelines for Peer Supporters as a framework for providing ethical and effective Peer Support services. The guidelines can be found at magellanofidaho.com/idaho-peer-services.

Authorization

No initial prior authorization is required. For Adult Peer Support Services, 416 units can be provided per member, per calendar year. Additional services must then be prior authorized via Magellan's prior authorization process. 16 units of Adult Peer Support Services may be initiated prior to the completion of the Comprehensive Diagnostic Assessment (CDA) as long as the member is also receiving Crisis Psychotherapy, Crisis Intervention, and/or Case Management prior to their CDA.

Payment Methodology

Code	Service	Unit	Threshold
H0038	Adult Peer Support One-on-One	Unit = 15 minutes	416 units per member, per calendar year, including individual and groups.
H0038	Adult Peer Support Groups	Unit = 15 minutes	

Adult Peer Support services can be billed at the group rate for a minimum of one IBHP member and up to 12 members. Please visit magellanofidaho.com/w/rate-schedules to see applicable modifiers in the rate schedule.

Family Peer Support Services

Description

Family Peer Support Services are non-clinical services provided by an Idaho-certified family support partner (CFSP) that support parents and caregivers who are caring for a child, youth, or young adult member 21 years of age and younger who has a diagnosis of SED, mental health condition, or co-occurring conditions. Family Support Services may be initiated when there is a reasonable likelihood that such services will support the parent/caregiver in building hope, empowerment, and resilience, advocating for their needs, and developing a support system.

Services are delivered in a range of environments that are chosen by the member including the member's home, community, and/or agency settings. Adult Peer Support Services may be delivered in-person or via telehealth and can be offered individually and/or in group settings.

Family Support services must align with the values of peer support including:

- **Family support is voluntary:** family members choose whether to participate in family support services and participation is never required
- **Family support is equally shared power:** family support specialists work to balance power by collaborating, sharing ideas and opinions, and discussing options.
- **Family support is strengths-focused:** family support specialists focus on what's strong, not what's wrong to encourage family members to identify and use their strengths.
- **Family support is transparent:** family support specialists clearly communicate their role, boundaries, and limitations, and invite members to share their own boundaries.
- **Family support is person-driven:** family support specialists promote self-determination and encourage members to lead their own wellness journey

A Certified Family Support Partner supports parents/caregivers who are caring for a youth member who is experiencing mental health or co-occurring challenges, relates using their lived experience, helps parents/caregivers navigate barriers and obstacles in their family's situation, and supports parents/caregivers in building natural supports in the community. Family Support services include but are not limited to:

- Supporting the parent/caregiver in defining the focus that is important to them related to their family's situation.
- Supporting the parent/caregiver in choosing self-directed goals and how the family support partner can support the parent/caregiver.
- Supporting the parent/caregiver in engaging community resources based on the parent/caregiver's needs and goals.
- Collaboration with other family members, services, and treatment providers.

Member Eligibility

- Medicaid benefit for youth under 18 years of age/young adults 21 years of age or younger
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
- A licensed professional through the completion of a CDA has determined that peer support will assist in the member's social, interpersonal, familial, and/or personal wellness.

- The parent/caregiver has demonstrated a need for support in building hope, empowerment, and resilience, advocating for their needs, and developing a support system.

Services

The CFSP will describe peer support to the family member so there is shared understanding about the role of a CFSP and ensure the family member voluntarily confirms the service is a good fit.

Family peer support services are limited to the following:

- **Recovery and wellness support, which includes**
  - Building rapport and establishing a peer-to-peer relationship rather than a hierarchical relationship
  - Applying principles of cultural awareness, competency, and humility
  - Supporting the family member with setting wellness goals and determining steps they would like to take to work toward their goals
  - Assisting the family member in identifying and building on their strengths and resiliencies
  - Strategically sharing lived experience to relate to the family member, using active listening, empathy, validation, and healthy boundaries
  - Assisting the family member in identifying natural support
  - Supporting the family member in connecting with other providers and/or resources when the family member needs support that is outside the peer support role

- **Mentoring which includes**
  - Role modeling healthy behaviors, boundaries and communication skills
  - Supporting the family member in determining activities they do or would like to try for wellness
  - Supporting the family member in making self-directed choices
  - Supporting the family member in identifying and establishing healthy relationships and boundaries
  - Supporting the family member in practicing effective communication, conflict resolution, and problem solving

- **Advocacy which includes**
  - Encouraging the family member to advocate for themselves and their child, youth, or young adult.
  - Advocating within systems to promote person-centered recovery/wellness support services
  - Helping the family member understand their rights and responsibilities
  - Promoting the family member's choice and self-determination

- Discussing holistic approaches and multiple pathways to recovery/wellness based on what the family member determines works for them
- Using person-centered language with family members and coworkers

- **Ethical responsibility**
  - Demonstrating alignment with the responsibilities and limitations of the family support specialist role
  - Maintaining privacy, confidentiality, and accurate documentation
  - Using supervision to address and resolve issues
  - Disclosing to supervisor personal relationships or limitations that may impact ability to perform family support specialist job duties

Family Support Services do not include the following:

- Family Support services are not a replacement for case management. Peer support services do not include functions typically performed by case managers such as care coordination or service linkage.
- Family support services are not a replacement for Skills-Building/CBRS. Peer support services do not include functions typically performed by Skills-Building/CBRS such as teaching skills.
- Family support services are not a replacement for clinical services. Peer support services do not include clinical or diagnostic functions such as processing trauma, therapeutic counseling, medication management, or medication monitoring.
- Family support does not include routine transportation of members. Time spent in transit with a member may be reimbursable only when it is directly connected to a documented recovery goal and when transportation justification is clearly reflected in the member's service record. Transportation should be limited, infrequent, and non-recurring, and does not include routine activities such as regularly transporting a member to the grocery store. All available natural supports for transportation must be explored, exhausted, and documented in the member's service record before a family support specialist provides transportation.
- Family support does not include ongoing accompaniment of family members at support group meetings. The CFSP can support a family member in attending a support group meeting for the first time. The CFSP should assist the member in brainstorming about what will help them sustain their support group meeting attendance when the CFSP is not accompanying them.

Goals and Documentation

- The CFSP will support the parent/caregiver in defining what is important to them related to their family's recovery, resiliency, and wellness.
- Within 30 days of first engagement with the parent/caregiver, the CFSP will support the parent/caregiver in defining a minimum of one individualized family support goal(s) and how the CFSP will support the parent/caregiver.

- The parent/caregiver's individualized family support goal(s) should be self-directed, strengths-based, and chosen by the parent/caregiver. The CFSP will collaborate with the parent/caregiver to specify the CFSP's role in supporting the parent/caregiver and the frequency by which family support services will be delivered.
- Documentation should demonstrate a strengths-based, recovery and resiliency focus and the CFSP's individualized support and benefit to the parent caregiver.
- With the consent of the parent/caregiver, the CFSP collaborates with other family members, service and treatment providers, other programs, and natural supports to assist the parent/caregiver's self-directed goals.
- Family Support Services are coordinated with other mental health professionals and adjunct social service agencies that are engaged with the parent/caregiver, when appropriate.
- Family Support Services should adhere to the Magellan supervisory protocol.

Groups

- Family Peer Support Services can be billed at the group rate for a minimum of one IBHP member.
- The number of family support group facilitators should be appropriate for the size of the group. When two or more providers facilitate a family support group, only one provider can submit a claim for a member. Two or more providers facilitating the same group cannot bill for the same members within the group.
- Family support groups are non-clinical groups for parents/caregivers of youth members. It is best practice for certified family support partners to facilitate family support groups.
- Magellan encourages best practices in group facilitation for family support providers rendering family support in a group setting. The family support supervisor, as defined by the Magellan supervisory protocol, should ensure that family support group facilitators are equipped with the knowledge and skills to effectively lead groups. The supervisor should also determine whether initial or ongoing guidance on group facilitation is needed and determine how they will assist and supervise the family support provider's development in providing group services. Find additional resources on the family services page on MagellanofIdaho.com.
- Family support groups should incorporate trauma-informed principles. Group facilitators should strive to create a person-centered, recovery-oriented, culturally sensitive, and inclusive environment in which to conduct groups.
- Family support groups may support family members in:
    - Discussing their experiences support a child, youth or young adult with mental health challenges and learning from one another.
    - Developing a social support network and encouraging social interaction to develop confidence and assertiveness.
    - Reducing isolation and increasing hopefulness by hearing personal resiliency stories and interacting with others who have similar life experiences.
    - Learning about themselves, discussing the direction they would like their lives to go, and determining steps for working toward their goals.

- Receiving feedback from other peers instead of just professionals.

Provider Requirements

Providers of Family Support Services must:

- Be 18 years of age or older.
- Have a high school diploma or equivalent.
- Be an individual with their own personal lived experience caring for a child who has a mental health or co-occurring condition.
- Hold a current Idaho Family Support Partner Certification.
- Provide services within an agency in the Idaho Behavioral Health Plan network.
- A certified family support partner who has a background check waiver/variance is not eligible to provide Family Peer Support.

Fidelity to Best Practices

- The family/caregiver voluntarily chooses to participate in family support services.
- Family support services are non-clinical, and they are distinct from case management and Skills-Building/CBRS.
- Family support services are inherently individualized, flexible, and based on the strengths and needs of the family/caregiver.
- Magellan endorses the National Practice Guidelines for Peer Supporters as a framework for providing ethical and effective Peer Support services. The guidelines can be found at magellanofidaho.com/idaho-peer-services.

Authorization

No authorization is required. For Family Support Services, 416 units can be provided per member, per calendar year. Additional services must be prior authorized via Magellan's prior authorization process.

Payment Methodology

Code	Description	Unit	Threshold
H0038	Family Peer Support One-on-One	Unit = 15 minutes	416 units per member, per calendar year Including individual and groups
H0038	Family Peer Support Groups	Unit = 15 minutes	

Family Peer Support Services can be billed at the group rate for a minimum of one IBHP member and up to 12 members.

Youth Peer Support Services

Description

Youth Peer Support Services are non-clinical services provided by a Youth Peer Support Specialist (YPSS). A YPSS is an Idaho-certified peer support specialist (CPSS) who has completed additional training in Youth Peer Support through Magellan. These services support members aged 12-17 who have a diagnosis of SED, a mental health condition, or co-occurring conditions. Youth Support Services may be initiated when there is a reasonable likelihood that such services will support the youth member in working toward self-directed recovery, building hope, empowerment, and resilience, and identifying natural supports in the community of their choice.

A Certified Peer Support Specialist with Youth Support Training supports youth members who are experiencing mental health or co-occurring challenges, relates to youth using their own lived experience, helps youth navigate barriers and obstacles in their recovery journey, and supports youth in building natural supports in the community. Services are delivered in a range of environments that are chosen by the member including the member's home, community, and/or agency settings. Youth Peer Support Services may be delivered in-person or via telehealth and can be offered individually and/or in group settings.

Youth peer support services must align with the values of peer support including:

- Peer support is voluntary: members choose whether to participate in peer support services and participation is never required
- Peer support is equally shared power: peer support specialists work to balance power by collaborating, sharing ideas and opinions, and discussing options.
- Peer support is strengths-focused: peer support specialists focus on what's strong, not what's wrong, to encourage members to identify and use their strengths.
- Peer support is transparent: peer support specialists clearly communicate their role, boundaries, and limitations, and invite members to share their own boundaries.
- Peer support is person-driven: peer support specialists promote self-determination and encourage members to lead their own wellness journey
- Collaboration with family members, service and treatment providers, other programs, and natural supports to assist the member's self-directed recovery/wellness (with the consent of the member).

Member Eligibility

- Medicaid benefit for members between the ages of 12-17.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

- A licensed professional has determined that youth peer support will assist in the member's social, interpersonal, familial, and/or personal wellness.
- The member is not at imminent risk to self, others, or property.
- The member has demonstrated a need for support in self-directed recovery/wellness, building resilience, and living successfully in their community.

Services

The YPSS will describe youth peer support to the member so there is shared understanding about the role of a certified peer support specialist and ensure the youth voluntarily confirms the service is a good fit.

Peer support services are limited to the following:

- **Recovery and wellness support, which includes**
  - Building rapport and establishing a peer-to-peer relationship rather than a hierarchical relationship
  - Applying principles of cultural awareness, competency, and humility
  - Supporting the member with setting wellness goals and determining steps they would like to take to work toward their goals
  - Assisting the member in identifying and building on their strengths and resiliencies
  - Strategically sharing lived experience to relate to the member, using active listening, empathy, validation, and healthy boundaries
  - Assisting the member in identifying natural support
  - Supporting the member in connecting with other providers and/or resources when the member needs support that is outside the peer support role

- **Mentoring which includes**
  - Role modeling healthy behaviors, boundaries, and communication skills
  - Supporting the member in determining activities they do or would like to try for wellness
  - Supporting the member in making self-directed choices
  - Supporting the member in identifying and establishing healthy relationships and boundaries
  - Supporting the member in practicing effective communication, conflict resolution, and problem solving

- **Advocacy which includes**
  - Encouraging the member to advocate for themselves
  - Advocating within systems to promote person-centered recovery/wellness support services
  - Helping the member understand their rights and responsibilities
  - Promoting the member's choice and self-determination

- Discussing holistic approaches and multiple pathways to recovery/wellness based on what the member determines works for them
- Using person-centered language with members and coworkers

- **Ethical responsibility**
  - Demonstrating alignment with the responsibilities and limitations of the peer support role
  - Maintaining privacy, confidentiality, and accurate documentation
  - Using supervision to address and resolve issues
  - Disclosing to supervisor personal relationships or limitations that may impact ability to perform peer support job duties

Peer Support Services do not include the following:

- Peer Support services are not a replacement for case management. Peer support services do not include functions typically performed by case managers such as care coordination or service linkage.
- Peer support services are not a replacement for Skills-Building/CBRS. Peer support services do not include functions typically performed by Skills-Building/CBRS such as teaching skills.
- Peer support services are not a replacement for respite. Peer support services include functions typically performed by respite such as providing short term childcare to enable family members to rest and recuperate.
- Peer Support services are not a replacement for clinical services. Peer support services do not include clinical or diagnostic functions such as processing trauma, therapeutic counseling, medication management, or medication monitoring.
- Peer support does not include routine transportation of members. Time spent in transit with a member may be reimbursable only when it is directly connected to a documented recovery goal and when transportation justification is clearly reflected in the member's service record. Transportation should be limited, infrequent, and non-recurring, and does not include routine activities such as regularly transporting a member to the grocery store. All available natural supports for transportation must be explored, exhausted, and documented in the member's service record before a peer support specialist provides transportation.
- Peer support does not include ongoing accompaniment of members at support group meetings. The CPSS can support a member in attending a support group meeting for the first time. The CPSS should assist the member in brainstorming about what will help them sustain their support group meeting attendance when the CPSS is not accompanying them.

Goals and Documentation

- The CPSS will support the member in defining what is important to them related to their recovery, resiliency, and wellness.

- Within 30 days of first engagement with the member, the CPSS will support the member in defining a minimum of one recovery/wellness goal(s) and how the CPSS will support the member in working toward their goal(s).
- The member's recovery/wellness goal(s) should be self-directed, strengths-based, and chosen by the member. The member's goal(s) should not be chosen by the treatment team or caregiver.
- Goal documentation should follow best practices, for example SMART goals, PACT goals, or other goal setting formats.
- The CPSS will collaborate with the member to specify the CPSS's role in supporting the member with their goal(s) and the frequency with which peer support services will be delivered.
- Activities that a CPSS and member do together should be in alignment with and support of the specific goals the member has chosen.
- The CPSS should revisit the member's goals with them on a regular basis to discuss which goals the member is still working toward, and which goals the member would like to revise.
- Documentation should demonstrate a strengths-based, recovery and resiliency focus and the peer support specialist's individualized support and benefit to the member. Documentation should also describe the activities that a CPSS and member do together in alignment with and support of the specific goals the member has chosen.
- Youth Peer Support Services are coordinated with other mental health professionals and adjunct social service agencies that are engaged with the member, when appropriate.
- With the consent of the member, the YSP collaborates with family members, service and treatment providers, other programs, and natural supports to assist the member's self-directed recovery/wellness.
- Youth Peer Support Services should adhere to the Magellan supervisory protocol.

Groups

- Youth Peer Support Services can be billed at the group rate for a minimum of one IBHP member.
- The minimum ratio is one facilitator to six participants. Groups exceeding six participants require two facilitators or must be conducted as separate groups.
- When two or more providers facilitate a peer support group, only one provider can submit a claim for a member. Two or more providers facilitating the same group cannot bill for the same members within the group.
- Youth peer support groups are non-clinical. It is best practice for groups to be facilitated by certified peer support specialists who have completed Youth Peer Support Training.
- Magellan encourages best practices in group facilitation for youth peer support providers rendering youth peer support in a group setting. The peer support supervisor, as defined by the Magellan supervisory protocol, should ensure that youth peer support group facilitators are equipped with the knowledge and skills to effectively lead groups. The supervisor should also determine whether initial or ongoing guidance on group facilitation is needed and determine how they will assist and supervise the youth peer

support provider's development in providing group services. Find additional resources on the peer services page on MagellanofIdaho.com.

- Youth peer support groups should incorporate trauma-informed principles. Group facilitators should strive to create a person-centered, recovery-oriented, culturally sensitive, and inclusive environment in which to conduct groups.
- Youth peer support groups may support youth members in:
  - Discussing their experiences living with mental health challenges and learning from one another.
  - Developing a social support network and encouraging social interaction to develop confidence and assertiveness.
  - Reducing isolation and increasing hopefulness by hearing personal recovery stories and interacting with others who have similar life experiences.
  - Learning about themselves, discussing the direction they would like their lives to go, and determining steps for working toward their goals.
  - Receiving feedback from other peers instead of just professionals.

Provider Requirements

Providers of Youth Peer Support Services must:

- Be 18 years of age or older.
  - While it is not required, it is recommended that providers of youth peer support services be between the ages of 18-35. This recommendation is based on the importance of youth peer support providers connecting on a peer-to-peer level and being relatable to the youth they support.
- Have a high school diploma or equivalent.
- Be an individual with their own personal lived experience with a mental health or co-occurring condition in their youth.
- Hold a current Idaho Peer Support Specialist Certification issued by BPA Health. A peer support training certificate of completion alone is NOT adequate to provide services.
- If Idaho Peer Support Specialist Certification lapses or expires. Providers may not render YPSS or PSS services until certification is active.
- Complete Idaho Youth Support Training and receive the Youth Support Endorsement.
- Provide services within an agency in the Idaho Behavioral Health Plan network.
- A certified peer support specialist who has a background check waiver/variance is not eligible to attend Youth Peer Support Training and cannot provide youth peer support services.

Fidelity to Best Practices

- The youth member voluntarily chooses to participate in youth support services.
- Youth support services are always provided with the youth present.
- Youth support services are non-clinical, and they are distinct from case management, Skills-Building/CBRS, and therapy.
- Youth support services are inherently individualized, flexible, and based on the strengths and needs of the member.

- Magellan Healthcare endorses the National Practice Guidelines for Peer Supporters published by the National Association of Peer Supporters (N.A.P.S.) as a framework for providing ethical and effective youth peer support services. The guidelines can be found at magellanofidaho.com/idaho-peer-services.

Authorization

No initial prior authorization is required. For Youth Peer Support Services, 416 units can be provided per member, per calendar year. Additional services must be prior authorized via Magellan's prior authorization process. 16 units of Youth Peer Support Services may be initiated prior to the completion of the Comprehensive Diagnostic Assessment (CDA) as long as the member is also receiving Crisis Psychotherapy, Crisis Intervention, and/or Case Management prior to their CDA.

Payment Methodology

Code	Description	Unit	Authorization
H0038	Youth Peer Support One-on-One	Unit = 15 minutes	416 units per member, per calendar year Including individual and groups
H0038	Youth Peer Support Group	Unit = 15 minutes	

Youth Peer Support Services can be billed at the group rate for a minimum of one IBHP member. and up to 12 members. Please visit magellanofidaho.com/w/rate-schedules to see applicable modifiers in the rate schedule.

Respite

Description

Respite services are short-term, temporary direct care and supervision services for youth with serious emotional disturbance (SED) intended to relieve a stressful situation, de-escalate a potential crisis situation, or provide a therapeutic outlet for a youth's emotional problems. The goal is to prevent disruption of the youth's placement by providing rest and relief to caregivers and youth while helping the youth to function as independently as possible. Respite services are generally limited to a few hours, overnight, a weekend, or other relatively short period of time. Services can be furnished on a regular basis. Respite services can be furnished in the youth's home, another home, a therapeutic foster home, or other community location.

Member Eligibility

- Medicaid benefit for youth enrolled in Medicaid's 1915(i) for SED, also known as the Medicaid YES Program.
    - Respite may be accessed immediately upon enrollment in the program but must be included on the youth's Person-Centered Service Plan (PCSP) for ongoing services.

    - PCSPs must be completed annually for YES youth members.
- State funded benefits do not cover Respite services.

Services

Respite services are generally limited to a few hours, overnight, a weekend, or other relatively short period of time (up to 72 hours in a home setting or 10 hours in an agency). Services can be furnished on a regular basis. Respite services can be furnished at an agency, in the youth's home, another home, a therapeutic foster home, or other community location. It may be provided individually (with a staff-to-client ratio of 1:1) or in a group (with a maximum staff-to-client ratio of 1:4).

Other Medicaid services cannot be provided at the same time as respite services. Respite cannot be provided on a continuous, long-term basis as a daily service to enable an unpaid parent/guardian(s) to work. Restraints are not allowed other than physical restraints in the case of an emergency to prevent injury to the youth or others; physical restraints may only be used by staff with documented training in the use of restraints and they must be documented in the youth's record.

Respite services cannot be delivered via telehealth.

Provider Requirements

- Individual Respite is provided by a credentialed agency in the member's home, another family's home, foster family home, a community-based setting and/or at the agency facility.
- Group Respite may only be provided at the credentialed agency facility, a community-based setting, or in the home for families with multiple children who have a diagnosis of SED.
- Providers of respite services must:
    - Be employed by a credentialed IBHP network provider.
    - Be at least 18 years of age.
    - Be at least a high school graduate or have a GED.
    - Have a CPR certification.
    - Have completed the required Respite Training provided by Magellan.
    - Be no less than 36 months older than the member to which they are rendering services.
- Agencies providing respite are required to complete an 1915(i) HCBS Attestation annually.

Authorization

No authorization is required.

- Limited to 300 hours per calendar year.

- Services cannot exceed 72 hours of consecutive care (when delivered in a home or therapeutic foster care setting) or 10 hours of consecutive care (when delivered in a community location).

Payment Methodology

Code	Description	Unit
S5150	Respite Care	Unit = 15 minutes

Payment cannot be made for room and board.

Respite may be available to youth who are not in the Medicaid YES Program through the vouchered respite program. Find information about the vouchered respite program at: Idaho Respite Care | BPA Health.

Intensive Outpatient Program – Mental Health

Description

Intensive Outpatient Programs - Mental Health (IOP-MH) are structured programs available to adults and adolescents who are recovering from mental health (MH) conditions including eating disorders and are experiencing moderate behavioral health symptoms that can be addressed and managed in a level of care that is less intensive than partial hospitalization but that require a higher level of care. IOP can also be provided for members experiencing an eating disorder through specifically credentialed and contracted Eating Disorder IOP providers.

IOP is provided in a manner that is strengths- and outcome-based, culturally responsive, and responsive to each member's individual psychosocial, developmental, and treatment needs. All services are outcome-based and are individualized to the youth's or adult's treatment needs and preferences within the program guidelines. The program may function as a step-down program from psychiatric hospitalization, partial hospitalization, or residential treatment. It may also be used to prevent or minimize the need for a more intensive level of treatment.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

IOP-MH is appropriate for individuals who live in the community without the restrictions of a 24-hour supervised treatment setting during non-program hours. Services for youth are offered separately from services for adults. Services are provided in-person and may include telehealth. IOP-MH occurs at minimum three days per week, maintaining at least 9 hours of service for adults and at least 6 hours of service for adolescents. Common treatment duration is six to eight weeks.

During IOP, a psychiatric evaluation needs to be completed at least monthly. These evaluations can be performed by a physician, a Nurse Practitioner (NP), or a Physician's Assistant (PA) with the proper experience and training for whom this service is in their scope of practice. After the initial evaluation, the following ones can be brief updates. Medications are optional but evaluations are required. The psychiatric evaluations can be done internally or externally. If done externally, then the outside practitioners would need to communicate with the IOP staff and provide their documentation. The diagnoses and treatment plans of the various providers must be unified. Care coordination is a critical component of IOP treatment.

Service Delivery Guidelines

- IOP services must include a minimum of 9 to 19 hours per week of structured, therapeutic programming.
- Each IOP program day must include a minimum of three (3) hours of services.
- At least six (6) hours per week must consist of core clinical services, including individual therapy*, group therapy, and family therapy.
- The remaining weekly hours may include supportive and adjunctive services such as psychoeducation, psychiatric or medication evaluation, case management, skills development, clinical assessment and treatment plan updates, and recovery-focused activities.
- If the required minimum three (3) hours of services are not delivered for a given day, the provider may not bill for IOP services for that day.

*Individual therapy is required for all members in IOP Services.

Programs must offer the majority of services as clinically focused interventions delivered by licensed professionals, including group therapy sessions.

Evidence based practice usage:

- Providers must complete formal training in the evidence based practice (EBP) model prior to independently facilitating the group.
- Documentation of training and certification (when applicable) must be maintained and made available upon request.
- Providers must demonstrate ongoing competency through supervision and continued learning consistent with the model's requirements.
    - *Example:* If a model such as cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), seeking safety, moral reconation therapy (MRT), or motivational interviewing requires formal training or certification, only trained staff may facilitate the group.
    - Paraprofessional staff may support EBP groups only under the supervision of a qualified licensed or trained clinician.
    - Paraprofessionals cannot independently deliver EBP interventions that require clinical judgment, training, or licensure.
    - Supervising clinicians are responsible for ensuring adherence to model fidelity.
    - If a group is not using an approved EBP curriculum, it must be identified as psychoeducation/supportive services, not an EBP.
        - *Example:* Running a group called "CBT group" without a CBT curriculum or without trained staff is not permitted.

Required IOP components:

- Assessment and treatment planning
- The following services are provided in the amounts, frequencies, and intensities as appropriate to the members' treatment needs:

- Individual therapy, family therapy, group therapy, and/or psychoeducation
- Skills-building activities
- 24-hour crisis services
- Psychiatric evaluation (can also be billed outside of the bundled rate for external providers)
- Medication management (can also be billed outside of the bundled rate for external providers)
- Substance use screening and monitoring, and drug testing (as appropriate)
- During admission, a psychiatrist must be available to consult with the program during and after normal program hours
- Care coordination/transition management/discharge planning
- For eating disorders:
    - Health assessment and monitoring
    - Dietary and nutrition services.

Note: Any external services e.g. psychiatric evaluation or medication management must be coordinated with the IOP program and integrated with the treatment plan.

When a member is participating in IOP, only the following services can be received outside of the program:

- Separate case management
- Child and family teams (CFT)
- Wraparound Intensive Services (WInS), intensive care coordination, targeted care coordination (through Dec. 31, 2024)
- Respite
- Youth support
- Family support
- Recovery coaching
- Medication management for external providers only
- Psychological/neuropsychological testing.

IOP services do not include overnight housing and cannot be located within a safe and sober house.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Doctoral-level providers and licensed prescribing practitioners.
- Licensed behavioral health clinicians.
- Master's-level behavioral health clinicians under Magellan's approved supervision policy.
- Bachelor's-level and/or paraprofessionals working under Magellan's approved supervision policy.

Other professionals that may provide a necessary component of the program must provide appropriate services within the scope of their practice. They may or may not be reimbursable by the IBHP, depending on whether the services are outside of the scope of the IBHP.

Guidelines:

- An initial CDA must be completed by a master's-level provider or higher within one program day of admission.
- An initial treatment plan should be developed within three program days of admission and reviewed/updated at least once every 30 program days.
- Goals must be developed and signed off on by a licensed provider within three program days of admission.
- Discharge criteria and planning for aftercare must begin upon admission and be included in the treatment plan.
- Groups size is limited to no more than 12 participants.

If a youth is no longer meeting the minimum 6 hours per week of treatment but does not meet medical necessity to transition to outpatient therapy yet, a transitional step-down may be considered for one to two weeks prior to the planned discharge. Following discharge, treatment records shall be completed within 30 calendar days.

Additionally, the youth receives a physical exam within the first week of treatment to address their whole health and psychiatric evaluations at least once a month.

Authorization

17 and under: No authorization is required
18+: Prior authorization after threshold of 50 units

Payment Methodology

Code	**Description**	**Unit**
S9480 or Rev code 0905 with S9480	IOP-Intensive Outpatient Program Psychiatric Services	Unit = per diem
S9480 or Rev code 0905 with S9480	IOP-Intensive Outpatient Program Eating Disorder Program	Unit = per diem

Partial Hospitalization Program – Mental Health

Description

Partial Hospitalization Programs (PHP) are structured, intensive, and time limited services provided by a hospital, free-standing facility, or provider group utilizing evidence-based medical and clinical practices that are provided under the direction of a medical director.

Partial Hospitalization (PHP) programs can be used to treat mental health conditions, including eating disorders, substance use disorders, or co-occurring conditions. Partial hospitalization is a facility-based, structured bundle of services for members whose symptoms result in severe personal distress and/or significant psychosocial and environmental issues and whose symptoms can be addressed and managed in a level of care that is less intensive than psychiatric hospitalization but requires a higher level of care than routine outpatient or other intensive services. All services are individualized to the member's treatment needs and preferences within the program guidelines. Services must be delivered in a manner that is strengths-based and with cultural responsiveness**, under the supervision of a licensed physician**, MD/DO with the proper experience and training for whom this service is in their scope of practice.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Partial hospitalization provides not only behavioral health treatment but also the opportunity to practice new skills. Services for youth are offered separately from services for adults. Oversight of the program must be by a licensed physician, but day-to-day activity can be done by another provider. Services are delivered a minimum of 20 hours per week and no less than four days/week. Common treatment duration is four to six weeks.

During PHP, a psychiatric evaluation needs to be completed at least monthly. These evaluations can be performed by a physician, a Nurse Practitioner (NP), or a Physician's Assistant (PA) with the proper experience and training for whom this service is in their scope of practice. After the initial evaluation, the following ones can be brief updates. Medications are optional but evaluations are required. The psychiatric evaluations can be done internally or externally. If done externally, then the outside practitioners would need to communicate with the PHP staff and provide their documentation. The diagnoses and treatment plans of the various providers must be unified. Care coordination is a critical component of PHP treatment.

Evidence of collaboration and coordination of care with external providers must be maintained and be available upon request.

Service Delivery Guidelines

- PHP services must include a minimum of 20 hours per week of structured, therapeutic programming.
- Each PHP program day must include a minimum of five (5) hours of service.
- Over the course of the week, at least twelve (12) of the required weekly hours must consist of core clinical services such as individual therapy, group therapy, and family therapy.
- The remaining minimum of eight (8) weekly hours may include supportive and adjunctive services such as psychoeducation, psychiatric or medication evaluation, case management, skills development, clinical assessment and treatment plan updates, and recovery-focused activities.
- If the required minimum five (5) hours of services are not delivered for a given day, the provider may not bill for PHP services for that day.

EBP usage:

- Providers must complete formal training in the EBP model prior to independently facilitating the group.
- Documentation of training and certification (when applicable) must be maintained and made available upon request.
- Providers must demonstrate ongoing competency through supervision and continued learning consistent with the model's requirements.
    - *Example:* If a model such as CBT, DBT, seeking safety, moral reconation therapy (MRT), or motivational interviewing requires formal training or certification, only trained staff may facilitate the group.
- Paraprofessional staff may support EBP groups only under the supervision of a qualified licensed or trained clinician.
- Paraprofessionals cannot independently deliver EBP interventions that require clinical judgment, training, or licensure.
- Supervising clinicians are responsible for ensuring adherence to model fidelity.
- If a group is not using an approved EBP curriculum, it must be identified as psychoeducation/supportive services, not an EBP.
    - *Example:* Running a group called "CBT group" without a CBT curriculum or without trained staff is not permitted.

Required PHP components:

- Comprehensive Diagnostic Assessment and treatment planning
- The following services are provided in the amounts, frequencies, and intensities as appropriate to the member's treatment needs:
    - Individual therapy*, family therapy, group therapy, and/or psychoeducation
- Skill-building activities

- 24-hour crisis services
- Psychiatric evaluation (can also be billed outside of the bundled rate for external providers)
- Medication management (can also be billed outside of the bundled rate for external providers)
- Substance use screening and monitoring, and drug testing (as appropriate)
- A registered nurse (RN) or higher must be available 24 hours as part of the program
- A physical exam: If stepping up or entering a PHP program, a new exam is to be done within three days (or one program day if SUD or ED). If stepping down within seven days of discharge, a previous exam done by a behavioral health provider (inpatient or residential level of care) is accepted.
- Care coordination/transition management/discharge planning
- For eating disorders:
    - Health assessment and monitoring
    - Dietary and nutrition services.

*Individual therapy is required for all members in PHP Services

Note: Any external services e.g. psychiatric evaluation or medication management must be coordinated with the IOP program and integrated with the treatment plan.

When a member is participating in PHP, only the following services can be received outside of the program:

- Separate case management
- Child and Family Teams (CFT)
- Wraparound Intensive Services (WInS), intensive care coordination, targeted care coordination (through Dec. 31, 2024)
- Respite
- Youth support
- Family support
- Recovery coaching
- Medication management for external providers only
- Psychological/neuropsychological testing.

PHP services do not include overnight housing and cannot be delivered via telehealth*.

PHP services cannot be co-located in safe and sober housing.

***Physical exam requirements may be completed via telehealth if a RN or higher-level medical practitioner is physically present with member to assist in physical exam being conducted by medical practitioners via telehealth.**

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Doctoral-level providers and licensed prescribing practitioners
- Licensed behavioral health clinicians
- Master's-level behavioral health clinicians under Magellan's approved supervision policy
- Bachelor's-level and/or paraprofessionals working under Magellan's approved supervision policy.

Other professionals that may provide a necessary component of the program must provide appropriate services within the scope of their practice. They may or may not be reimbursable by the IBHP, depending on whether the services are outside of the scope of the IBHP.

Guidelines

- An initial CDA completed by a master's-level clinician or higher completed within one program day of admission.
- A crisis plan is developed with the youth by program day three, and
- the initial treatment plan is developed within five program days of admission.
- Goals must also be completed and signed by a licensed provider within five program days of admission.
- Treatment plans are reviewed and updated at least once every 14 days.
- After discharge, treatment records are completed within 30 calendar days.
- Groups size is limited to no more than 12 participants. Weekly psychiatric reviews are done by either an MD/DO or medical director's designee (NP, PA, or prescribing psychologist).
- In addition, a youth needs a new physical exam within three program days (one program day if they have a SUD or eating disorder diagnosis) of admission when stepping up in level of care.
- A new physical exam must be completed within seven days of discharge when stepping down a level of care, or a previous exam may be accepted if stepping down from inpatient or residential treatment levels of care.

Authorization

Authorization is required.

Payment Methodology

Code	Description	Unit
H0035 or rev code 0913 w/ H0035	Partial Hospitalization Program, all-inclusive payment of 5 or more hours (full day)	Unit = per diem
H0035 or rev code 0913 w/ H0035	Partial Hospitalization Program - Eating Disorder, all-inclusive payment of 5 or more hours (full day)	Unit = per diem

Adolescent Residential Treatment Center

Description

A behavioral health Residential Treatment Center (RTC) for youth is a non-hospital facility that provides comprehensive, multi-faceted treatment in a residential setting for participants who have multiple significant behavioral health symptoms and needs that impair their ability to safely function in the home, school, and/or community setting. The treatment facility provides therapeutic services that are appropriate for participants whose psychiatric, behavioral, SUD, or cognitive problems are so severe that they cannot be treated in a lower level of care. Services are provided on-site by physician or non-physician practitioners, or master's-level licensed clinical behavioral health professionals.

RTCs provide rehabilitative services including individual, group, and family therapy, recreational, and educational experiences. Services are generally lower in intensity and frequency than services provided in a Psychiatric Residential Treatment Facility (PRTF).

Member Eligibility

- Medicaid benefit for youth through the end of the month of their 18th birthday or through the end of the month of their 21st birthday via the Early and Periodic Screening, Diagnostic, and Testing (EPSDT) benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid up to age 18. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD & CMH funding; funding is limited and may only be used until funding has run out.

Services

Covered services and interventions may include the following:

- Behaviorally focused skills-building
- Case consultation
- Crisis intervention (available 24 hours)
- Diagnostic assessments
- Focused therapeutic interventions
- Psychoeducation
- Psychotherapy (individual, family, group, multiple-family group)
- Service coordination or clinical case management
- Social and interpersonal skills
- Treatment planning
- Telehealth may be used for family involvement only

Adolescent residential treatment centers are required to provide family therapy, as relevant and feasible, as well as other therapeutic and supportive interventions involving the youth and their family or caregivers. These services should be aimed at strengthening family functioning, addressing factors that contributed to the youth's admission, and preparing the youth and family for a successful transition back into the home. Family involvement and reintegration planning should occur throughout the course of treatment and be incorporated into discharge planning to support continuity of care and long-term stability.

When a substance use concern is identified, the six ASAM dimensions must be included in the member's Comprehensive Diagnostic Assessment (CDA). Other assessment tools may also meet this requirement and can be administered by those certified/licensed to administer the specific tool. The ASAM assessment and dimensional placement determination must be completed by an individual trained in the ASAM Criteria® multidimensional assessment process along with level of care placement decision-making. This training must be documented in the individual's HR file through certificates, transcripts, or CEU. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable. If the assessing provider is not qualified to complete the ASAM portion of the CDA, a referral must be made to an ASAM qualified professional.

Intensive Care Coordination is provided by Magellan when a member is placed in residential care. The Child and Family Team (CFT) members will include the residential care provider. The Individualized Treatment Plan will address the transition out of residential care and family involvement while the member is in the residential care facility.

Provider Requirements

Behavioral health residential treatment facilities must meet the following requirements:

- Have a National Provider Identifier (NPI).
- Meet State Medicaid Agency identified certification.
- Be a licensed children's residential facility in accordance with IDAPA regulation requirements 16.04.18.
- For SUD RTC's, be nationally accredited by the commission on accreditation of rehabilitation facilities and have an ASAM level of care certification per Idaho Code 39306B.
- Meet all licensing and certification requirements for the states in which they are located.
- RTCs must adhere to the requirements for the use of restraint or seclusion when providing inpatient psychiatric services for individuals under 21 outlined in 42 CFR Part 483 Subpart G.
- Abide by Idaho Code 1815-10 (providing shelter to runaway children, 17 years of age or younger).
    - Licensed children's residential care facilities, registered children's institutions, and behavioral health youth crisis centers providing emergency runaway services are not guilty of a violation of this section if:

- The facility attempts to contact and is unable to locate the child's parent or legal guardian or the child refuses to disclose the contact information of the child's parent or legal guardian; and
- The facility has notified the county sheriff or police of the child's whereabouts pursuant to local laws and licensure requirements.

Services are provided by qualified medical and clinical professionals and paraprofessionals within their scope of practice. An appropriately credentialed nurse must be responsible for any medication administration. Any medication changes must be made under the guidance of an appropriately licensed physician or non-physician practitioner.

Authorization

- Prior authorization is required.
- Concurrent reviews will be completed.
- Any youth placed in a residential facility in another state must have an Interstate Compact completed upon admission to the facility.

Medical necessity for services is determined by review of current clinical information, including:

- Current clinical information including a treatment plan
- Comprehensive Diagnostic Assessment (CDA) updated within the last 365 days
- Child and Adolescent Needs and Strength (CANS) functional assessment tool updated within the last 90 days
- Psychiatric assessment
- Psychological testing, if available
- Documentation of a qualifying diagnosis and corresponding functional impairment (serious emotional disturbance or SED).
    - Examples of qualifying diagnoses, when diagnosed as a major mental health disorders that are currently causing debilitating symptoms, are: anxiety disorders, depressive disorders, bipolar disorders, and psychotic disorders
    - Less debilitating diagnoses are not solely sufficient for a qualifying diagnosis. Examples include: adjustment disorder, dysthymic disorder, and cyclothymic disorder.
- Evidence that available local resources and treatment in less restrictive levels of care have failed to address one or more of the following situations:
    - Danger to self, danger to others, and/or serious dysfunction in daily living.

- Evidence that behaviors or conditions require comprehensive treatment in residential setting and there is risk of admission into an acute psychiatric hospital without RTC services.
- Written recommendation from the treating outpatient provider that includes at minimum:
    - The need/reason for this level of care

- The reason(s) lower level of care is not appropriate or has not yet produced the desired result
- The provider's anticipated post-discharge plan

Approval of Residential Treatment Center (RTC) services does not guarantee acceptance and/or admission to an RTC. After approval for RTC level of care, the Magellan care coordination team will help the member and their family locate an RTC that is able to admit the youth. If an RTC placement is not found within 90 days, the approval will be re-reviewed to ensure medical necessity continues to be met. If updated records are not received for the re-review within 10 business days of Magellan's request, a denial will be issued and a new Prior Authorization request will need to be submitted.

A tentative discharge plan and master treatment plan must be submitted at the time of admission. Once admitted to an RTC, Continued Stay Reviews are typically conducted no less frequently than every 30 days. An updated discharge plan and master treatment plan should be submitted with updated clinical with each Continued Stay Review.

Payment Methodology

Code	Description	Unit
1000	Residential treatment - Psychiatric General	Unit = Per Diem

Medicaid does not cover room and board services including custodial care, vocational, or education costs.

Psychiatric Residential Treatment Facility (PRTF)

Description

A Psychiatric Residential Treatment Facility (PRTF) is a facility other than a hospital that provides psychiatric services to youth in an inpatient setting. Psychiatric Residential Treatment Facilities are licensed centers that offer 24-hour comprehensive services in a highly structured setting in a standalone facility under the direction of a physician. PRTF care is provided in a manner that is strengths- and outcome-based, culturally responsive, and responsive to each youth's individual psychosocial, developmental, and treatment needs. On a continuum of care, psychiatric residential treatment is the most restrictive and intense treatment available. Some youth need treatment apart from their usual environment due to the complexity of their clinical needs and/or they need a highly structured and therapeutic setting.

Member Eligibility

- Medicaid benefit for youth through the end of the month of their 21st birthday.

- Benefits may also be available for other eligible IBHP members without Medicaid up to age 18. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

The components of care include, but are not limited to:

- 24-hour supervision in a high intensity therapeutic environment.
- Active Treatment
  - When school is in session, 10 hours of active treatment each week, excluding milieu management.
  - When school is not in session, 25 hours of active treatment each week, excluding milieu management.
- Family therapy in-person or via telehealth at least 1 time per week that includes the adults in the living situation the youth immediately came from, unless contraindicated. If the youth will be going to a different living setting after discharge, the adults in the new living setting shall participate, unless contraindicated.
- Psychiatric assessment, diagnosis, intervention, and pharmacological treatment and management provided by or under the direction of a Licensed Psychiatrist.
- Discharge planning that includes collaboration by the qualified mental health professional, the youth, parent/guardian(s), community-based providers, and the case manager and/or staff from DHW and/or its designee (contractor) and identifies and arranges required community supports the youth will need upon discharge.
- Providers are obligated to ensure the youth's physical needs are met.

Intensive Care Coordination is provided by Magellan when a member is placed in residential care and the Child and Family Team (CFT) members will include the residential care provider. The Individualized Treatment Plan will address the transition out of residential care and family involvement while the member is in the residential care facility.

Provider Requirements

Facility requirements:

- PRTFs must be a stand-alone psychiatric facility that is not a hospital and accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State Medicaid Agency.
- In-state facilities must be licensed by the Bureau of Facility Standards and certified by CMS as a Psychiatric Residential Treatment Facility.
- The IDHW application packet includes the information and documents that must be submitted and approved by the Bureau of Facility Standards prior to initial PRTF certification: IDHW PRTF Application.
- Out-of-state facilities must be licensed in the host state and certified by CMS as a Psychiatric Residential Treatment Facility.

- PRTFs must adhere to the requirements for the use of restraint or seclusion when providing inpatient psychiatric services for individuals under 21 outlined in 42 CFR Part 483 Subpart G.
- PRTFs must meet the requirements in 42 CFR Part 441 Subpart D.
- Abide by Idaho Code 1815-10 (providing shelter to runaway children, 17 years of age or younger).
    - Licensed children's residential care facilities, registered children's institutions, and behavioral health youth crisis centers providing emergency runaway services are not guilty of a violation of this section if:
        - The facility attempts to contact and is unable to locate the child's parent or legal guardian or the child refuses to disclose the contact information of the child's parent or legal guardian; and
        - The facility has notified the county sheriff or police of the child's whereabouts pursuant to local laws and licensure requirements.

Provider qualifications:
An interdisciplinary team develops and delivers the plan of care. The team must include, at a minimum, either:

- A Board-eligible or Board-certified psychiatrist;
- A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state.

The team must also include a master's-level social worker or counselor, and one of the following:

- A registered nurse with specialized training or one year of experience in treating mentally ill individuals.
- An occupational therapist who is licensed and who has specialized training or one year of experience in treating mentally ill individuals.
- A psychologist who has a master's degree in clinical psychology or who has been certified by the state.

Authorization

- Prior authorization is required.
- Concurrent reviews are required.
- Any youth placed in a residential facility in another state must have an Interstate Compact completed upon admission to the facility.

Prior authorization requests should include current clinical information such as:

- Current clinical information including a treatment plan, medications, etc.
- Comprehensive Diagnostic Assessment (CDA) updated within the last 365 days

- Child and Adolescent Needs and Strength (CANS) functional assessment tool updated within the last 90 days
- Psychiatric assessment
- Psychological testing, if available
- Documentation of a qualifying diagnosis and corresponding functional impairment (serious emotional disturbance or SED).
    - Examples of qualifying diagnoses, when diagnosed as a major mental health disorder that are currently causing debilitating symptoms, are: anxiety disorders, depressive disorders, bipolar disorders, and psychotic disorders.
    - Less debilitating diagnoses are not solely sufficient for a qualifying diagnosis. Examples include adjustment disorder, dysthymic disorder, and cyclothymic disorder.
- Evidence that available local resources and treatment in less restrictive levels of care have failed to address one or more of the following situations:
    - Danger to self, danger to others, and/or serious dysfunction in daily living.
- Evidence that behaviors or conditions require continuous monitoring and intensive treatment, including 24/7 medical supervision, and there is risk of admission into an acute psychiatric hospital without PRTF services.
- Written recommendation from the treating outpatient provider that includes at minimum:
    - The need/reason for this level of care
    - The reason(s) lower level of care is not appropriate or has not yet produced the desired result
    - The provider's anticipated post-discharge plan

Approval of PRTF services does not guarantee acceptance and/or admission to a PRTF. After approval for PRTF level of care, the Magellan care coordination team will help the member and their family locate an PRTF that is able to admit the youth. If a PRTF placement is not found within 90 days, the approval will be re-reviewed to ensure medical necessity continues to be met. If updated records are not received for the re-review within 10 business days of Magellan's request, a denial will be issued and a new Prior Authorization request will need to be submitted.
A tentative discharge plan and master treatment plan must be submitted at the time of admission. Once admitted to a PRTF, Continued Stay Reviews are typically conducted no less frequently than every 30 days. An updated discharge plan and master treatment plan should be submitted with updated clinical with each Continued Stay Review.

Home passes: PRTFs are allowed to bill their contracted rate for the days youth are on medically necessary home passes.

Payment Methodology

Code	Description	Unit
1001	Residential Treatment – Psychiatric	Unit = Per Diem

Homes for Adult Residential Treatment (HART)

Description

HART homes provide a structured and therapeutic mental health treatment facility for individuals 18 years of age or older who meet medical necessity criteria for Serious and Persistent Mental Illness (SPMI) and do not need hospitalization at either the acute or sub-acute level of care, but who require mental health treatment and supervision on an ongoing (24 hour-per-day) basis. The HART model provides additional supports and services to eligible recipients to maintain safe and stable housing that supports their recovery. The model includes delivery of non-residential integrated behavioral health treatment and peer support services in the HART home, which allows for additional staff to be on hand to assist clients as well as licensed professional staff to monitor and maintain progress in managing the residents' SPMI symptoms.

Member Eligibility

- Medicaid benefit.
    - Magellan is responsible for reimbursement of outpatient behavioral health services delivered in the HART.
    - State Plan Personal Care Services, Aged and Disabled waiver services, and milieu management are reimbursed through the Bureau of Long Term Care (BLTC).*
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

*State Plan Personal Care Services, Aged and Disabled waiver services, and milieu management are not covered through the IBHP, but are instead covered through the Bureau of Long-Term Care (BLTC). HART milieu management is only authorized for qualifying residents of a credentialed HART provider. HART milieu management includes provision of daily activities, including directing the activities of direct care staff, managing client interactions, and coordinating with clinical staff. HART providers must have a Milieu Manager on duty at all times who demonstrates knowledge and experience in providing services and supports to adults who have SPMI and experience challenges with community living due to complex behavioral and personal care needs.

Services

The model offers an enhanced combination of behavioral health services, personal care services, and nursing services that are not generally provided in other licensed residential care settings. Magellan covers a full array of outpatient behavioral health services billed within the HART including:

- Adult peer support*
- Case management
- Comprehensive diagnostic assessment (CDA)
- Crisis response

- Crisis intervention
- Group psychotherapy
- Individual psychotherapy
- Individualized skills-building and treatment plan
- Skills-Building/CBRS
- Skills training and development
- Treatment planning

*Adult mental health peer support is not covered by Medicaid or other state funding.

HART 1:1 Supervision up to 24 hours per day is provided to members of higher acuity who need more intensive monitoring within the HART model. This service requires a prior authorization and is reimbursed through other state funding rather than Medicaid. One-on-one supervision must be non-Medicaid funded, as funding allows, for all IDHW approved individuals-both Medicaid and non-Medicaid eligible- as outlined in the Cost/Billing procedure of the contract.

Provider Requirements

Provision of a HART's behavioral health services are from a designated Idaho Behavioral Health Plan (IBHP)-approved network provider. Providers must meet the requirements established in this document for the specific service they are delivering (see below). The facility must be licensed through the IDHW (IDHW)'s Licensing and Certification program as a licensed residential assisted living facility (RALF) in Idaho.

The approved behavioral health agency that is either affiliated with the HART or is providing HART services directly is responsible for providing all the behavioral health services and must have the credentialed qualified staff to provide those services.

- Board Certified or Board Eligible Psychiatrist; OR
- Magellan approved Behavioral Health Provider (NP or PA that meet attestation requirements with demonstrated experience working with SPMI population); AND
- Available medical and nursing consultation as needed; AND
- Social worker, Skills-Building/CBRS, peer support, and case management.
- All provider types who provide care in ambulatory settings are eligible.

Magellan incorporates the IDHW's HART model standards into its quality management plan and provider reporting requirements to support monitoring and continuous quality improvement of the HART program.

Authorization

Prior authorization is required for adult skills-Building/CBRS.

Magellan will apply the following Utilization Management (UM) methodology:

- The member has a validated primary diagnosis of an SPMI (Intellectual Disability/Developmental Disability and/or SUD cannot be the principal diagnosis);

- HART is medically necessary and is the least restrictive level of care needed to meet mental health needs of the member;
- The member meets appropriate levels of stability (a risk to self/others but not at imminent risk, has ability to engage in activities of daily living (ADLs), not aggressive/violent, medically stable, etc.); and
- Continued stay criteria must be met if stay exceeds initial PA and discharge criteria must be met when consumer is ready for discharge from the HART facility. An initial PA request would be set at 30 days and concurrent review would be set at 120 days for clients being considered for continued stay.

At time of admission

- A comprehensive individual assessment including a CDA, nursing assessment for any medical needs, psycho-social evaluation, and other evaluations as appropriate used to develop an individualized strengths-based treatment plan is to be completed within two weeks if one has not been completed within the last 180 days. A clear and detailed program of care with progressively lower levels of structure should be developed as a discharge plan.
- Level of skilled intervention is consistent with individual risk.
- Active discharge planning is initiated upon admission to program.
- Psychosocial services for an individual include an assessment and planned education, vocational support, individual and/or group therapy services, as clinically indicated.
- Family system is receiving evaluation and intervention to the extent possible.

For continuation of services

- Initial discharge plan has been formulated and is in the process of implementation.
- Active treatment is focused upon implementing the program of care developed from the comprehensive assessment.
- Level of skilled intervention is consistent with current individual risk factors.
- Treatment plan has been modified to reflect individual's progress and/or new information that has become available during the residential treatment.
- Routine assessments and treatment progress updates are completed. Although member is making progress toward goals in the expected treatment process, further progress must occur before transition to a lesser level of care is clinically safe and appropriate.
- Individual and family, to the extent possible, are involved in treatment and discharge planning.

Payment Methodology

Providers will follow Magellan's IBHP fee schedule, see codes below. Providers should render all services in accordance with the parameters and guidelines of each individual service outlined in Appendix C.

Code	Description	Unit
T1017	Case Management, Behavioral Health w/ or w/o Care Coordination Activities	Unit = 15 minutes
H2011	Crisis Intervention	Unit = 15 minutes
H0030	Crisis Response (Telephonic)	Unit = per call
90853	Group Psychotherapy	Unit = per session
90832	Psychotherapy with patient	Unit = 30 minutes
90833	Psychotherapy with patient, with E&M service	Unit = 30 minutes
90834	Psychotherapy with patient	Unit = 45 minutes
90836	Psychotherapy with patient, with E&M service	Unit = 45 minutes
90837	Psychotherapy with patient	Unit = 60 minutes
90838	Psychotherapy with patient, with E&M service	Unit = 60 minutes
H0032	Individualized Skills-Building Treatment Plan - Billed by clinician and paraprofessional for teaming with patient present	Unit = 15 minutes
H2017	Skills-Building/CBRS	Unit = 15 minutes
H2014	Skills Training and Development	Unit = 15 minutes

Inpatient Hospitalization

Description

Magellan covers medically necessary inpatient psychiatric services and co-occurring Substance Use Disorder (SUD) treatment for members who have a diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) with substantial impairment in thought, mood, perception, or behavior. Both severity of illness and intensity of services criteria must be met for admission. Inpatient services include medically necessary involuntary treatment inpatient hospitalizations pursuant to Title 66, Chapter 3, Idaho Code, including treatment for individuals awaiting placement in another level of care or awaiting notification from the Designated Examiner (DE) that a hold has been lifted.

Member Eligibility

- Medicaid benefit for:
  - Youth under 21 for hospitals, psychiatric hospitals, and hospital based IMDs.
  - Adults ages 21 through 64 enrolled in Medicaid for hospitals, psychiatric hospitals, hospital based IMDs, and non-hospital IMDs for up to 59 consecutive days.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
  - Youth under the age of 18 who meet the criteria for YES and who meet Federal Poverty Guidelines per the Federal HHS requirements at: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines#:~:text=The%20poverty%20guidelines%20are%20sometimes,administrative)%20where%20precision%20is%20important.
  - Involuntary treatment inpatient hospitalization (after commitment) pursuant to Title 66, Chapter 3, Idaho Code, if the committed individual's treatment is determined to be medically necessary.
  - Stays in Institutions for Mental Disease (IMDs) for members ages 21 through 64 enrolled in Medicaid that exceed 59 consecutive days.
  - Note: State funded benefits do not reimburse for inpatient SUD services (ASAM 4.0 and 3.7), but can reimburse for ASAM 3.7 in a residential setting.

Services

Inpatient hospital services include semi-private accommodations, unless private accommodations are medically necessary and ordered by a physician, or if semi-private accommodations are unavailable in the facility.

Inpatient treatment is guided by an Individual Plan of Care developed by a multidisciplinary team.

- Individual Plan of Care: The individual plan of care is developed upon admission. The objective of the plan is to improve the members' condition to the extent that acute psychiatric care is no longer necessary. It must be implemented within 72 hours of admission and reviewed at least every three days. The individual plan of care must contain:
  - A diagnostic evaluation that includes examination of the medical, behavioral, and developmental aspects of the participant's situation and reflects the medical necessity for Inpatient care;
  - Treatment objectives related to conditions that necessitated the admission;
  - An integrated program of therapies, treatments (including medications), activities (including special procedures to assure the health and safety of the participant), and experiences designed to meet the objectives;
  - A discharge plan designed to achieve the participant's discharge at the earliest possible time that includes plans for coordination of community services to ensure continuity of care with the participant's family.

- Interdisciplinary Team: The individual plan of care must be developed by an interdisciplinary team capable of assessing the participant's immediate and long-term therapeutic needs, developmental priorities and personal strengths and liabilities, assessing the potential resources of the participant's family, setting the treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives. The team must include at a minimum:
  - One of the following:
    - A board-certified psychiatrist;
    - A licensed psychologist and a physician licensed to practice medicine or osteopathy;
    - A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental disease and a licensed clinical professional counselor;
  - One of the following:
    - A licensed, clinical or master's social worker;
    - A registered nurse with specialized training or one year's experience in treating individuals with behavioral health needs;
    - A licensed occupational therapist who has had specialized training or one year of experience in treating individuals with behavioral health needs;
  - The participant and their parents, legal guardians, or others into whose care they will be released after discharge.

SUD Services:
Please refer to the Inpatient SUD section of this appendix.

Magellan assigns regionally based utilization management (UM) care managers and Transition of Care Coordinators to inpatient facilities, providing designated support and discharge planning for all members who are admitted.

Provider Requirements

Facility Types

Inpatient behavioral health services are provided by the following provider types in accordance with IDAPA 16.03.09.700-706 and the requirements of the IBHP Contract including:

- Acute Care Hospitals with a psychiatric unit
- Psychiatric Hospitals
- Institutions for Mental Diseases (IMDs)
- In accordance with 42 CFR § 438.3(e)(2)(i) through (iii), Magellan may provide services in alternative inpatient settings that are licensed or approved by the IDHW, in lieu of services in an inpatient hospital.

Certification/Accreditation

- Hospitals:
    - Acute care hospitals and psychiatric hospitals must be Medicare-certified and licensed in Idaho or the state where services are performed.
    - Inpatient hospital psychiatric services must be provided under the direction of a physician in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the state of Idaho or the state in which they provide services. To provide services beyond emergency medical screening and stabilization treatment, the hospital must have a separate psychiatric unit with staff qualified to provide psychiatric services. General hospitals licensed to provide services in their state, but are not JCAHO certified, may not bill for psychiatric services beyond emergency screening and stabilization.
- IMDs: A hospital, nursing facility or other institution of 17 or more beds that is primarily engaged in diagnosing and treating mental diseases is considered an IMD. A specific licensure is not necessary to meet the definition of an IMD. This includes medical attention, nursing care, and related services.
- SUD Services: Facilities that provide ASAM 3.7 or 4.0 levels of care, including IMDs, must have a certification from the Commission on Accreditation of Rehabilitation Facilities (CARF). Staff must meet the ASAM standards for the level of service provided.

Authorization

- Notice of Admission (NOA) is required. With the NOA process, Magellan applies the same pre-screening process to determine the scope of benefits covered and the member's eligibility status, with a review of facility information to justify a continued stay.
- Magellan may reimburse inpatient behavioral health services for members awaiting placement in another level of care or awaiting an involuntary hold to be lifted.

- If the member has an approved initial stay for inpatient behavioral health services, providers may request a continued stay authorization for certification of acute level of care during the following situations:
    - While the hospital is awaiting notification from the Designated Examiner (DE) that the involuntary hold has been lifted and the participant may be discharged; or
    - While the participant is awaiting admission to a State Hospital.
- If a member is awaiting transfer to an alternative level of care, such as a PRTF or a Skilled Nursing Facility (SNF), and the acute level of care is deemed no longer medically necessary, Magellan will not continue to certify an acute level of care. Magellan may authorize Administratively Necessary Days (ANDs) for a Medicaid member if the provider follows all policies and procedures for reimbursement of that service and complies with requirements in IDAPA 16.03.09.403.

Payment Methodology

- A variety of payment methodologies will be employed when reimbursing providers of inpatient services, including but not limited to, per diem and All Patients Refined Diagnosis Related Groups (APR DRG).
- Medicaid:
    - Youth under 21 years of age enrolled in Medicaid: If the facility is a hospital, psychiatric hospital, or hospital based IMD and the member is under the age of 21, Medicaid reimbursement is allowable.
    - Adults ages 21-64 enrolled in Medicaid: If the facility is an IMD, Medicaid reimbursement is only allowable for stays up to 59 consecutive days with discharge on the 60th day. Stays exceeding 59 consecutive days may be reimbursable through other State funded benefits.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out. The limitations regarding length of stay do not apply.

A facility with certification from the Commission on Accreditation of Rehabilitation Facilities (CARF) to deliver 3.7 or 4.0 levels of care shall bill with Revenue code 0193 for room and board when the stay is received by a participant with a primary diagnosis of SUD.

Crisis Psychotherapy

Description

This therapy is offered when someone is experiencing an acute crisis but is not in immediate danger of hurting themselves or others. The main aim is to quickly assess the situation and help the person find stability in a short time.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Provided when a member is experiencing an acute crisis, is not at imminent risk of harm to self or others, and psychotherapy for crisis is appropriate for providing rapid and time-limited assessment and stabilization.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed clinicians as defined per licensure by the DOPL and IDAPA; and/or practicing under a supervisory protocol.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
90839	Psychotherapy for crisis; first 60 minutes	Unit = 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (List separately in addition to code for primary service)	Unit = 30 minutes

Crisis Response

Description

Crisis Response services are available 24/7 and provide telephonic intervention for members experiencing a behavioral health crisis. Crisis Response provides assessment and crisis stabilization through counseling, support, active listening, or other telephonic interventions to alleviate the crisis and offer referrals to services and community providers.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Provided when a member is experiencing an acute crisis and is not at imminent risk of harm to self or others. Crisis response is appropriate for providing rapid and time-limited assessment and stabilization to determine the most appropriate response to a crisis situation.

Within the 24 hours following a behavioral health crisis, crisis service providers will follow up telephonically with the youth and their family to assess stability and crisis follow-up needs.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed clinicians as defined per licensure by the DOPL and IDAPA; and/or practicing under a supervisory protocol.
- Bachelor's-level paraprofessional working under DHW's approved supervision policy and also trained and certified in Verbal Crisis Intervention by the Crisis Prevention Institute (CPI) *or* Psych Hub training paraprofessionals crisis training learning path.

Authorization

No authorization is required.

Payment Methodology

Code	**Description**	**Unit**
H0030	Crisis Response Telephonic	Unit = per call

Crisis Intervention

Description

Crisis Intervention services are available 24/7 and provide in-person intervention for members experiencing a mental health crisis. Crisis Intervention is provided in the location where the crisis is occurring. Crisis Intervention addresses the immediate safety and well-being of the member, family, and community. Crisis Intervention assesses, intervenes, and coordinates with the member's current behavioral health provider and/or provides referrals to behavioral health and/or emergency services.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Provided in-person when a member is experiencing an acute crisis, is not at imminent risk of harm to self or others, and crisis intervention is appropriate for providing rapid and time-limited assessment and stabilization. Crisis Intervention safely identifies and assesses immediate strengths and needs to ensure that appropriate services are provided to de-escalate the current crisis and prevent future crises. Services shall be provided consistent with an existing crisis plan using formal and informal supports, in partnership with the family.

Provider Requirements

Services may be provided by up to two of the following professionals operating within the scope of their practice and may bill simultaneously for providing Crisis Intervention:

- Licensed clinicians as defined per licensure by the DOPL and IDAPA; and/or practicing under a supervisory protocol.
- Bachelor's-level paraprofessionals working under DHW's approved supervision policy and also trained and certified in Verbal Crisis Intervention by the Crisis Prevention Institute (CPI) *or* Psych Hub training Paraprofessionals crisis training learning path. Within the 24 hours following a behavioral health crisis, crisis service providers will follow up telephonically with the member/member's family to assess member stability and crisis follow-up needs.

Crisis services are intended to stabilize the member during a behavioral health crisis. Crisis service providers practice only within their scope of practice and make referrals, as appropriate, based on the acuity of the crisis.

Crisis services are not supervision of a member after the member is transferred to the appropriate level of care.

Providers of crisis services create and/or update the crisis/safety plan with the member and member's family.

Authorization
No authorization is required.

Payment Methodology

Code	Description	Unit
H2011	Crisis Intervention	Unit = 15 minutes

Idaho Crisis System

Description
Idaho's Crisis System provides 24/7 "no-wrong door" access to community-based mental health, suicidal and substance use crisis services for all Idahoans anywhere, anytime, regardless of payer status, age or underlying need. The goal is resolution of the immediate crisis and to connect individuals to ongoing timely services to prevent future crises. Integrated crisis services reduce avoidable hospitalizations and emergency room visits and reduce the need for law enforcement involvement and diversion from the criminal justice system when appropriate. Idaho's crisis system is designed to consider unique resources and challenges of each region and special populations including rural and remote, individuals with intellectual and developmental disabilities, and Spanish speaking and Tribal members.

Idaho's integrated crisis system includes three core elements as defined in the SAHMSA *National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit:*

1. Crisis Call Center: The Idaho Suicide and Crisis Line (ISCH) is Idaho's statewide crisis call center and centralized hub for the coordination of the crisis system services.
2. Regional Crisis Mobile Response: Community Bridges, Inc. (CBI) and Benchmark Human Services (Benchmark) provide and maintain Mobile Response Teams (MRTs) to meet the projected crisis needs in each of the IDHW's seven regions.
3. Crisis Centers: Idaho's seven Adult and four Youth Crisis Centers provide voluntary, walk-in crisis receiving and stabilization services.

These core elements are connected by "Air Traffic Control" (ATC) technology that, as the crisis system expands, will provide a seamless interface with broader community-based services e.g., outpatient services, bed registries, and the public health system.

Crisis Call Center – 988
Magellan contracts with the Idaho Crisis and Suicide Hotline (ICSH) to provide 24 hours per day, seven days per week, 365 days per year real-time access to a live person via telephone, chat or

text for all Idahoans experiencing a crisis ("anyone, anywhere, anytime"), regardless of payer status, age or underlying need. ICSH is a member of the 988 Suicide & Crisis Lifeline and is responding to 988 contacts for Idaho as part of a national network of crisis call centers. ISCH is the central hub providing air traffic control (ATC) coordination of crisis care in real time, helping to resolve the immediate crisis and connecting the caller to community-based crisis services including dispatches to regional Mobile Response Teams (MRTs) or connecting individuals though a warm handoff to Crisis Centers, the emergency room or 911 based on assessed need. For those individuals who do not need a higher level of care and the crisis is resolved, ISCH connects them to ongoing community-based care and develops a safety plan to prevent future crises.

ISCH provides post-crisis follow-up calls within 24-48 hours based on the client's acuity to determine if the client is stable and if the services to which they were referred were provided in a timely manner and are meeting their needs.

ISCH is staffed with clinical staff and peers with lived experience.

Mobile Response Team (MRT)

Description

Mobile response services provide voluntary in-person community-based crisis intervention to individuals wherever they are with the goals of de-escalation and resolution of the immediate crisis as an alternative to unnecessary hospitalizations and incarcerations. Mobile Response Teams (MRTs) are deployed real-time, 24 hours a day, seven days a week, 365 days per year* to provide recovery focused, brief intervention crisis services for all Idahoans in a timely manner, promoting the least restrictive level of care for individuals in crisis. Mobile response services identify current stressors and focus on identifying natural supports and strengths to alleviate the current crisis and promote referral(s) to services to meet ongoing behavioral health needs of participants and to prevent future crises.

MRTs are dispatched by calling 988 - the Idaho Crisis and Suicide Helpline (ICSH).

***MRTs are available 24/7/365.**

Member Eligibility

- Mobile response services are available to all Idahoans regardless of insurance eligibility and/or their ability to pay for services.
- MRTs are dispatched by the Idaho Crisis and Suicide Helpline (ICSH).

Services

MRTs assess, intervene, de-escalate, and produce a stabilization/crisis plan coordinating with current services, and provide linkages and referral for follow-up care to participants and families experiencing a behavioral health crisis. Crisis interventions are intended to address the

immediate safety and well-being of the participant and family due to the participant's escalating behaviors that may be creating disruption to the participant's functioning and stability. Crisis interventions are short-term and time-limited as identified by the participant, family, or crisis services provider.

Mobile response practitioners conduct an initial assessment upon arrival. Initial assessment includes evidence-based best practice instruments approved by the IDHW to assess for:

- Mental health status
- Danger to self/danger to others/grave disability due to mental illness as defined in state code Section 66-317
- Substance use disorder.

Mobile response practitioners provide the following as clinically appropriate and within their respective scope of practice:

- De-escalation
- Assessing for participant's safety
- Assessing for participant's presenting needs
- Non-violent crisis interventions
- Recovery focused interventions
- Resolution focused mental health interventions
- Trauma informed care
- Safety planning
- Referral to necessary level of care
- Administer Naloxone as appropriate

Disposition: The result of a mobile crisis intervention is a stabilized participant who remains in the community, a stabilized child participant whose family elects to receive some unplanned respite, or a participant who gets linked with a higher level of care or response. If a higher level of care is needed, mobile response practitioners connect participants to facility-based care as needed through warm handoffs and coordinating transportation when and only if situations warrant transition to other locations.

MRT clinical consultation and supervision:

- Teams must have 24/7 access to consultations/staffing by a licensed clinician.
- MRTs may utilize IDHW-approved telehealth options for clinical consultation if necessary.
- Teams must have 24/7 access to on-call supervisors. Teams may utilize IDHW-approved telehealth options for supervision.

Provider Requirements

Mobile response practitioners must meet practitioner qualifications in accordance with DBH standards.

Mobile response practitioners must complete IDHW-recommended trainings for mobile response practitioners. Additionally, mobile crisis practitioners must have access to a crisis trained licensed master's-level clinician during service delivery. Mobile response clinicians are licensed through the Idaho DOPL; and/or practicing under an Idaho supervisory protocol. Unlicensed staff providing this service must be supervised by a master's-level clinical supervisor.

The master's-level clinician can be one of the following:

- Licensed Professional Counselor (LPC)
- Licensed Clinical Professional Counselor (LCPC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Masters Social Worker (LMSW)
- Licensed Clinical Social Worker (LCSW).

MRT practitioners establish agency-to-agency collaboration through establishing working relationships and initiating Memorandums of Understanding (MOUs) when needed for the exchange of PHI.

Authorization

No authorization is required.

Payment Methodology

MRT Visit Episode: One episode of an MRT visit is defined as the community-based in-person crisis intervention, with connection and or referral to services to final disposition and one post crisis follow up call. Any dispatch for MRT services after final disposition is a new MRT episode.

Fidelity Monitoring

Magellan monitors and reports on the performance of the MRTs.

Adult Crisis Centers

Description

Adult crisis centers provide voluntary intervention, stabilization, and support to those experiencing a behavioral health crisis. Operations are 24 hours a day, seven days a week, 365 days a year to provide services to those experiencing a behavioral health crisis for no more than 23 hours and 59 minutes per single episode of care. Services will be provided on an outpatient basis, which is not equivalent to an emergency room (ER) level of care.

A behavioral health crisis is a situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress due to psychiatric symptoms associated with mental illness or substance use disorder(s).

Member Eligibility
All adult Idahoans 18 years old and older regardless of insurance status or ability to pay.

Services
Voluntary intervention, stabilization, and support including assessment and referral to higher levels of care if needed. Interventions provided may include acute stabilization of psychiatric symptoms, assessment of mental health and substance use disorders, motivational enhancement to help individuals who are struggling to commit to change, safe sobering up, active treatment to assist those who would benefit from learning and practicing skills to manage behavioral health symptoms, relapse prevention support, and recovery support to identify and build strengths, safety planning, peer support, education, referral to community resources, and other treatment planning.

A variety of available Magellan team members assist with coordination of care based on the individual's needs, including Intensive Care Coordinators, Care Coordinators, and Transition of Care Specialists.

Provider Requirements
Crisis Centers are accredited by the Joint commission or CARF or credentialed by Magellan. Provider must meet the Idaho Medicaid Crisis Center Minimum Requirements.

Authorization
No authorization is required.

Payment Methodology

Code	Description	Unit
S9485	Crisis Center-rate is all-inclusive of professional fees	Unit = per diem, up to 23 hours and 59 minutes
H2011	Crisis Intervention	Unit = 15 minutes

Place of service should be billed as 20.
If diagnosis is not known, diagnosis code should be billed as Z65.8.
Agencies may not bill other services while a member is in the crisis center.

Youth Crisis Centers

Description
Youth crisis centers (YCC) provide voluntary intervention, stabilization, and support to those experiencing a behavioral health crisis. Operations are 24 hours a day, seven days a week, 365 days a year to provide services to those experiencing a behavioral health crisis for no more than

23 hours and 59 minutes per single episode of care. Services will be provided on an outpatient basis, which is not equivalent to an emergency room (ER) level of care.

A behavioral health crisis is a situation in which an individual is exhibiting extreme emotional disturbance or behavioral distress due to psychiatric symptoms associated with mental illness or substance use disorder(s).

Member Eligibility

Youth up to 18 years old regardless of insurance status or ability to pay.

Services

Voluntary intervention, stabilization and support including assessment and referral to higher levels of medical care if needed. Interventions provided may include acute stabilization of psychiatric symptoms, assessment of mental health and substance use disorders, motivational enhancement to help individuals who are struggling to commit to change, safe sobering up, active treatment to assist those who would benefit from learning and practicing skills to manage behavioral health symptoms, relapse prevention support, and recovery support to identify and build strengths, safety planning, peer support, education, referral to community resources, and other treatment planning.

A variety of available Magellan team members assist with coordination of care based on the individual's needs including Intensive Care Coordinators, Care Coordinators and Transition of Care Specialists.

Provider Requirements

Crisis centers are accredited by the Joint commission or CARF or credentialed by Magellan. Provider must meet the Idaho Medicaid Crisis Center Minimum Requirements.

Youth crisis centers must abide by Idaho Code 1815-10 (providing shelter to runaway children, 17 years of age or younger).

- Licensed children's residential care facilities, registered children's institutions, and behavioral health youth crisis centers providing emergency runaway services are not guilty of a violation of this section if:
  - The facility attempts to contact and is unable to locate the child's parent or legal guardian or the child refuses to disclose the contact information of the child's parent or legal guardian; and
  - The facility has notified the county sheriff or police of the child's whereabouts pursuant to local laws and licensure requirements.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
S9485	Crisis Center-rate is all-inclusive of professional fees	Unit = per diem, up to 23 hours and 59 minutes
H2011	Crisis Intervention	Unit = 15 minutes

Place of service should be billed as 20.
If diagnosis is not known, diagnosis code should be billed as Z65.8.
Agencies may not bill other services while a member is in the crisis center.

Child and Adolescent Needs and Strengths (CANS) 3.0

Description

The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose functional assessment tool developed for youth services to support decision making, including service recommendations based on the severity and complexity of the youth's strengths and needs; treatment planning; to facilitate quality improvement initiatives; and to allow for the monitoring of outcomes of services. The CANS looks at multiple areas in a youth's life in domains of: Strengths, Life Functioning, Traumatic/Adverse Childhood Experiences, Behavioral and Emotional Needs, Risk Behaviors, Caregiver Resources and Needs, and Transition to Adulthood for youth age 16+. The initial CANS is completed as a result of a Comprehensive Diagnostic Assessment with updates and transitions completed as a result of significant changes in the youth and family, reviews of progress during person-centered treatment planning, formal re-assessment, and transitioning out of or into a formal program or service.

Member Eligibility

- Medicaid benefit for youth under the age of 18 or through the end of the month of their 21st birthday via the Early and Periodic Screening, Diagnostic, and Testing (EPSDT) benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid up to age 18. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

The CANS completion involves youth, families, parent/guardian(s), and relevant natural and formal supports. Youth and their families are regarded as the experts on their experience and the CANS motivates them to recognize their own strengths, needs and resources. Through active engagement in the CANS, youth and families are empowered to make choices and give their opinions about the care they receive.

- The CANS is designed to follow the course of the youth and family from system access to goal attainment and transition.
- The CANS is used to communicate the shared vision throughout the system.
- The CANS is required prior to a youth receiving any outpatient behavioral health services except those services that do not address a functional need (e.g., Health Behavior Assessment and Interventions, Neuro/Psychological Testing, Medication Management, and Crisis Services).

- All treatment plans that address a functional need (i.e., Psychotherapy) must be based on the CANS.
- The results of the **CANS, entered into P-CIS**, guides the person-centered service plan development and additional specific treatment plans.
- Any documentation in the CANS can be accessed through the member portal, including the narrative. Ensure all narratives are clinically appropriate as they could be viewed by parents, guardians, and other professionals. CANS narratives are not psychotherapy notes.
- A CANS must be updated at least every 90 days or more frequently as necessary based on the youth's needs, the request of the family, or whenever there is a change in condition.

Provider Requirements

Individuals who complete CANS assessments must maintain current CANS certification. CANS assessments may be completed by the following professionals operating within the scope of their practice:

- CANS-certified independently licensed clinicians.
- CANS-certified master's-level clinicians working under DHW's approved supervision policy.
- CANS-certified paraprofessional with a bachelor's degree in a human services field and who is regularly and meaningfully involved in the youth's care and providing other services to the youth.

Training and Certification Requirements

Individuals must complete required training and certification before conducting CANS assessments.

The CANS certification process includes:

- Completion of an approved eight-hour CANS training, including review of Idaho CANS Mental Health 3.0 training content.
- Passing the CANS certification exam.
- Obtaining access to P-CIS, the assessment system used to document CANS assessments.
- Maintaining annual certification.

Providers seeking recertification may use training materials as a refresher. If certification has lapsed for less than 12 months, providers may recertify by completing the certification exam without repeating the full eight-hour training.

Training Opportunities and Fidelity Monitoring

The Division of Behavioral Health's Transformational Collaborative Outcomes Management (TCOM) Competency Center supports clinicians through certification training, technical assistance, coaching, mentoring, and fidelity monitoring.

Training opportunities include:

- Idaho TCOM virtual training sessions.
- Idaho TCOM in-person training sessions.
- Agency-sponsored training coordinated with the Idaho TCOM Institute.
- Self-paced online training through TCOMTraining.com using the Idaho General Bundle. Fees may apply. Self-paced training may not include Idaho-specific guidance related to YES services and implementation of CANS within Idaho's behavioral health system.

The TCOM Competency Center also:

- Provides certification training for the CANS and Crisis Assessment Tool (CAT).
- Organizes and facilitates collaboratives that promote community partnership, shared responsibility, and system improvement.
- Provides coaching, mentoring, technical assistance, certification support, fidelity monitoring, and analysis of standards and guidelines.

For further information, visit the TCOM Competency Center.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
H0031	CANS Assessment for adolescent under the age of 18	Unit = 15 minutes

Early Child Assessment Age 0-5

Description

This is an assessment a clinician performs for children under age 6 to see if a child has an early mental health concern.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services
The DC: 0-5 provides a mechanism similar to the Diagnostic and Statistical Manual of Mental Disorders (DSM), 5 but is specifically designed for children under age 6. DC: 0-5 is a multiaxial diagnostic framework.

Provider Requirements
Services may be provided by one of the following professionals operating within the scope of their practice:
Master's-level clinicians (and higher), who are qualified to diagnose as part of their clinical licensure, and who have a current Infant Mental Health Specialist or Early Childhood Mental Health Specialist Endorsement (IMH-E® or ECMH-E®) from the Idaho Association for Infant and Early Childhood Mental Health Association (also known as Aim Early Idaho, https://www.aimearlyidaho.org) or who have completed all the requirements for the aforementioned endorsements, submitted their Endorsement Application to Aim Early Idaho for review/approval, and are awaiting results.

Authorization
No authorization is required.

Payment Methodology

Code	Description	Unit
H1011	DC: 0-5 Functional Assessment Tool	Unit = 15 minute

Intensive Home and Community Based Services (IHCBS)

Description
Intensive Home and Community Based Services (IHCBS) are intensive services provided in the youth's home or in the community. Services are individualized, strengths-based, family-centered, and culturally competent. All services focus on the youth's emotional/ behavioral needs. Services may include behavior management, therapy, crisis intervention, and parent education and training. Intensive services should be provided to, among others, youth at risk of out-of-home placement, including a residential program or psychiatric hospital, youth transitioning from an out-of-home placement back to their families or other community setting, and youth with significant behavioral health needs.

Member Eligibility

- Medicaid benefit for youth through the end of the month of their 18th birthday or through the end of the month of their 21st birthday via the Early and Periodic Screening, Diagnostic, and Testing (EPSDT) benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid up to age 18. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

All treatment, care, and support services must be provided in a context that is individualized, family-centered, strengths- and outcome-based, culturally responsive, and responsive to each youth's psychosocial, developmental, and treatment care needs. Delivery of services may include, but are not limited to, the following modalities:

Functional Family Therapy (FFT)
FFT is a prevention/intervention program for youth who have demonstrated a range of maladaptive, acting out behaviors and related syndromes. The youth served are between the ages of 11 and 18 and have ongoing trouble regulating their emotions/behavior as a result of trauma. FFT interventions seek to reduce delinquency and other adverse behaviors of the youth. For additional information on FFT, visit www.fftllc.com.

Multidimensional Family Therapy (MDFT)
MDFT is an integrated, comprehensive, family-centered treatment for youth between the ages of 6 and 17. MDFT simultaneously addresses substance use, delinquency, antisocial and aggressive behaviors, mental health symptoms, and school problems. For additional information on MDFT, visit https://www.mdft.org/.

Multisystemic Therapy (MST)
MST is an intensive family- and community-based treatment that addresses and seeks to reduce multiple causes of serious behavioral health needs of youth ages 12-17 when less intensive treatment has been ineffective or is inappropriate. This includes youth who:

- Are frequently involved in the justice system or justice-involved due to violence;
- Are at risk of out-of-home placement or transitioning from an out-of-home setting;
- Have ongoing multiple system involvement due to high-risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems;
- Have externalizing behavior symptomology resulting in a DSM diagnosis such as Conduct Disorder, Oppositional Defiant Disorder (ODD), or Behavior Disorder Not Otherwise Specified (NOS).

For additional information visit https://www.mstservices.com/.

Therapeutic Behavioral Services (TBS)
TBS is a collaborative, one-to-one behavior modification and cognitive-behavioral therapy intervention for youth ages 5-18 with serious emotional disturbances. TBS engages the

parent/guardian(s) in helping the youth to identify the underlying needs of maladaptive behaviors and teaches them to successfully meet their needs using more suitable replacements or alternative behaviors.

Family Program (FP)
FP serves children and youth from ages 4 to 18 who are at risk of out-of-home placement, severe behavioral challenges, and those returning from residential placement. FP is an intensive in-home program that specializes in parent skills-building, teaching co-regulation skills and promoting healthy relational skills that address behavior challenges in the home in order to help parents create safety in the home while addressing aggressive behaviors, family problems and emotional issues. For additional information visit https://www.healthyfoundations.co/in-home-program.html.

Other Modalities
Providers may request "other modalities" for IHCBS to allow for additional Evidence-Based Practices (EBPs) that are IHCBS programs. Providers interested in offering additional EBPs through their agency must provide justification of how the program serves the needs of high-risk members and helps prevent out-of-home placement or hospitalization.

Provider Requirements

Provider qualifications vary according to the specific IHCBS modality requirements including training, credentialing and/or certifications.

- FFT: Provider agencies are required to have an FFT site certification from FFT, LLC and follow the guidelines as set by FFT, LLC.
- TBS: Providers are required to go through TBS training prior to providing TBS.
- MST: Provider agencies are required to have an MST certification from MST Incorporated.
- MDFT: Providers are required to have a MDFT certification from MDFT International and follow the guidelines as set by MDFT International.
- FP: Providers are required to work for a Family Program certified site from Healthy Foundations and must follow the guidelines as set by Healthy Foundations - renewed annually to be a FP Agency. Providers are required to complete FP training and supervision to hold a Healthy Foundations Family Program certification.

Authorization

Authorization is required.

Payment Methodology

Code	Description	Unit
H0036	Intensive Home and Community Based Service - FFT, MDFT, Family Program, and other evidenced-based practice modalities	Unit = 15 minutes
H0036	Intensive Home and Community Based Service - Therapeutic Behavioral Services (TBS)	Unit = 15 minutes

H2033	Intensive Home and Community Based Service - Multisystemic Therapy; rendered by provider(s) with MST certification from MST Incorporated	Unit = 15 minutes

Children's Day Treatment

Description

Day treatment is a structured program available to youth exhibiting severe needs that may be addressed and managed in a level of care that is less intensive than inpatient psychiatric hospitalization, partial hospitalization, or residential treatment, but requires a higher level of care than intensive or routine outpatient services. These services typically include a therapeutic milieu that may include skills-building, medication management, and group, individual and family therapy, provided by an interdisciplinary team. Day treatment providers will ensure consistent coordination and communication with other agencies working with the youth, including coordination with the schools. Day treatment programs are offered four to five days per week and may include after-hours and weekends. Services must be delivered for a minimum of 3 hours per day and maximum of 5 hours per day. All day treatment services are provided in a manner that is strengths-based, culturally responsive, and responsive to each youth's individual psychosocial, and developmental needs. Common treatment duration is six to eight weeks.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

- Assessment and treatment planning
- At least two of the following:
    - Individual therapy, family therapy, group therapy, and/or psychoeducation
- Skill-building activities
- 24-hour crisis services
- Care coordination/transition management/discharge planning

When a youth is participating in Day Treatment, only the following services may be received outside of the program:

- Separate case management /CFT
- Respite
- Youth support or family support
- Recovery coaching
- Psychological/neuropsychological testing

- Psychiatric evaluation
- Medication management

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Doctoral-level providers and licensed prescribing practitioners.
- Master's-level, licensed behavioral health clinicians or a master's-level behavioral health clinician working under Magellan's approved supervision policy.
- Bachelor's-level and/or paraprofessionals working under Magellan's approved supervision policy.

Other professionals that may provide a necessary component of the program must provide appropriate services within the scope of their practice. They may or may not be reimbursable by the IBHP, depending on if the services are outside of the scope of the IBHP.

Treatment plans are developed by a master's-level provider within 72 hours of initiating services and should be updated frequently enough to reflect changes in the youth's condition, needs and preferences, or at the request of the youth/family. Time between reviews must not exceed 30 calendar days. Following discharge, treatment records must be completed within 30 calendar days.

Day treatment services cannot be delivered via telehealth.

Authorization

Authorization is required.

Payment Methodology

Code	Description	Unit
H2012	Day Treatment-mental health, all-inclusive payment generally 3-5 hours per day 4-5 days per week	Unit = 15 minutes

Therapeutic After School and Summer Program (TASSP)

Description

Therapeutic After School and Summer Programs (TASSP) are structured programs that consist of a range of individualized therapeutic, recreational, and socialization activities for youth. These individual and group therapeutic experiences assist youth in developing social,

communication, behavioral, and basic living skills, as well as psychosocial and problem- solving skills. TASSP are a collaboration between provider agencies, community-based organizations, professionals, and/or other entities. Services are provided in a manner that is strengths-based, culturally responsive, and responsive to each youth's individual psychosocial, developmental, and treatment needs. TASSP services are strengths- and outcome-based, and the goal of the program is to enable each youth to improve their functioning in the home, school, and community by providing structured treatment services during afterschool, summer, or out of school time.

TASSP may be structured in various ways:

- A provider agency can incorporate activities into their existing clinical service array: the provider agency identifies other professionals that may provide components of their TASSP (e.g., a music professional, Science, Technology, Engineering, Mathematics (STEM) provider or educational tutor). These professionals will provide appropriate activities/services within their level of training, experience, and education. Activities/services delivered by professionals that are outside of the IBHP cannot be reimbursed by the IBHP contractor except in cases of non-contracted Indian Health Care Providers (IHCPs).
- A provider could partner with existing non-therapeutic after school and summer programs and provide clinical services within that program.

TASSP may include, but is not limited to, the following services:

- Individual, family, and/or group psychotherapy
- Family psychoeducation
- Skills-Building/CBRS
- Skills training and development

Member Eligibility

- Medicaid benefit for youth through the end of the month of their 18th birthday or through the end of the month of their 21st birthday via the Early and Periodic Screening, Diagnostic, and Testing (EPSDT) benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid up to age 18. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

TASSP billable services include:

- Individual, family and or group psychotherapy (mental health and substance use disorder)
- Skills Training and Development
- Skills-Building/CBRS
- Family Psychoeducation

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Independently licensed clinicians or above.
- Master's-level clinicians under Magellan's approved supervision policy.
- Bachelor's-level and/or paraprofessionals working under Magellan's approved supervision policy.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
90832	Psychotherapy with patient	Unit = 30 minutes
90833	Psychotherapy with patient, with E&M service	Unit = 30 minutes
90834	Psychotherapy with patient	Unit = 45 minutes
90836	Psychotherapy with patient, with E&M service	Unit = 45 minutes
90837	Psychotherapy with patient	Unit = 60 minutes
90838	Psychotherapy with patient, with E&M service	Unit = 60 minutes
90846	Family Psychotherapy without patient	Unit = 50 minutes
90847	Family Psychotherapy with patient	Unit = 50 minutes
90853	Group Psychotherapy	Unit = per session
H0001	Individual Assessment and Treatment Plan, Substance Use	Unit = 15 minutes
H0004	Individual Counseling, Substance Use	Unit = 15 minutes
H0005	Group Counseling, Substance Use	Unit = 15 minutes
H2014	Skills Training and Development	Unit = 15 minutes
H2017	Skills-Building/Community-Based Rehabilitative Services	Unit = 15 minutes
H2017	Skills-Building/Community-Based Rehabilitative Services - Group	Unit = 15 minutes
H2027	Family Psychoeducation	Unit = 15 minutes
H2027	Multiple Family Group Psychoeducation	Unit = 15 minutes

Parenting with Love and Limits®

Description

Parenting with Love and Limits® (PLL) is a family-focused evidenced-based intervention for adolescents with a serious emotional disturbance (SED) or substance use disorder (SUD) diagnosis. The benefit is designed to help families re-establish adult authority through setting consistent limits and reclaiming loving relationships. PLL® consists of both multi-family group therapy sessions and individual family therapy coaching sessions. The PLL® program is curriculum-based and allows members to meet with other families who have similar issues.

Member Eligibility

- Medicaid benefit for youth 10 years old through the end of the month of their 18th birthday or through the end of the month of their 21st birthday via the Early and Periodic Screening, Diagnostic, and Testing (EPSDT) benefit (pending approval of a State Plan Amendment from the Centers for Medicare & Medicaid Services).
- Benefits may also be available for other eligible IBHP members without Medicaid up to age 18. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Services are delivered in the home or provider office. Multifamily group therapy sessions are led by two facilitators, including one clinician and one co-facilitator. Group session topics building parent connections, techniques to avoid button-pushing, building behavior contracts and family plans, engaging youth in the change process, and steps for restoring nurturing relationships. Individual family therapy coaching sessions are intended to complement the group sessions and follow four phases of treatment. The first phase sets the terms of the therapy, as stressors in the family system and their root causes are identified. The second and third phases focus on identifying feedback loops, utilizing tools to change family interactional patterns, and practicing skills. The fourth and final phase focuses on evaluating and maintaining progress and preventing relapse. After initial work to stabilize the family system, clinicians also address trauma in the family system, as needed.

Program sessions include:

- Family therapy with or without participant present
    - Six or more family sessions
    - Sessions are 1 to 2 hours
- Multi-family therapy
    - No more than eight families
    - Six consecutive 2-hour group sessions held weekly.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed master's-level behavioral health clinicians as defined per licensure by the DOPL and IDAPA; and/or practicing under an Idaho supervisory protocol.
- The group co-facilitator can be a BA/BS level.
- Network providers who have agreements with the IDHW, Division of Behavioral Health (DBH), Parenting with Love and Limits (PLL) Competency Center to serve as PLL providers.
    - Contracted providers must follow the requirements for PLL as outlined in the DBH *Principles of Agreement to Maintain PLL Certification*. Link to DBH PLL Competency Center.
- Providers must be trained and licensed by the Savanah Family Institute (SFI) or by SFI's trained partners.

Authorization

No prior authorization is required until the 200-unit threshold is met.

Payment Methodology

Code	Description	Unit
H0046	Parenting with Love and Limits (PLL)	Unit = 15 minutes

Training

-
- PLL providers will agree to participate in trainings, fidelity reviews, case consultations and any other activities required by the IDHW to maintain status as PLL providers, at the frequency determined by the IDHW.

Fidelity Monitoring

The DBH PLL Competency Center conducts ongoing fidelity monitoring to the Savannah Family Institute PLL model.

Child and Family Team (CFT) and CFT Interdisciplinary Team Meetings

Description

Child and Family Teams are a care planning process that utilizes a teaming approach to create a coordinated care plan. Coordinated care plans can take many forms, but there are some plans that have specific criteria and requirements, such as the Person-Centered Services Plan (PCSP) and the Wraparound Plan of Care.

All youth involved in the Youth Empowerment Services (YES) system of care should have access to a CFT facilitated by community providers, a Magellan Intensive Care Coordinator, a Magellan Care Coordinator, or Wraparound Coordinator – a group of individuals the youth and family select to help and support them while the youth receives treatment. At a minimum, the team includes the youth, their family, and their primary mental health providers, but may also include friends, neighbors, coaches, instructors, religious leaders, and other community members. This team works together to:

- Recognize and encourage the youth and family's strengths.
- Identify the needs of the youth and family.
- Learn what the youth and family want to accomplish.
- Set realistic short- and long-term goals.
- Find solutions that build on the strengths of the youth and family and lead to necessary changes.

CFTs are formed during the care planning process and continue while the youth is in treatment. The size and involvement of team members is driven by the needs and desires of the youth and family, and, as those needs change, members may be added or removed from the team. Each CFT works through the six components of the Practice Model and uses the Principles of Care in all the phases of the Practice Model.

CFTs may operate differently based on the needs of the youth. Teams may be facilitated by the primary mental health provider, an Intensive Care Coordinator with Magellan, or a Wraparound Intensive Services (WInS) Coordinator. The frequency of team meetings and intensity of work depends on the needs of the youth and family.

All members of the CFT are responsible for attending and participating in meetings, collaborating with other team members, and listening to and respecting the opinions of others. Find more information about CFTs in the YES Practice Manual.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

CFT Interdisciplinary Team Meetings provide a forum in which the CFT can review the effectiveness of current services, assess the youth's progress towards objectives specified in the plan of care, and discuss treatment options and service adjustments for possible inclusion into the creation and revision of a coordinated care plan. Treatment options and service adjustments can be informed through the needs and strengths identified in the CANS. A clinician must be present to recommend and sign off on the coordinated care plan.

CFT meetings may occur when a member or member's family requests a meeting, the identified strengths and needs change, the existing services and supports are not effective, new resources are available, the progress towards a goal is not as expected, goals are met, and new goals are identified, and/or there is a decrease in safety or a risk of crisis.

Providers who actively participate in the development, implementation, and revision of the services prescribed in the plan(s) can be reimbursed for attending planning sessions and participating on the CFT.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Master's-level behavioral health clinicians or above.
- Bachelor's-level paraprofessionals and other qualified paraprofessionals directly involved in the member's care (regardless of certification/endorsement requirement).
- To facilitate development of a Person-Centered Services Plan (PCSP), a provider must meet the above criteria as well as complete the on-demand, web-based Person-Centered Services Plan Training that can be found on Magellan's provider training webpage.

Authorization

No authorization is required.

Payment Methodology*

Code	Description	Unit
T1017 w/ U3 modifier	Case Management for Behavioral Health specific to participating in the development of a Person-Centered Services Plan	Unit = 15 minutes

*This service should not be billed by the Wraparound Coordinator.

Wraparound Intensive Services (WInS)

Description

Wraparound Intensive Services (WInS) is Idaho's High-Fidelity Wraparound (HFW) service, an evidence-based form of Intensive Care Coordination (ICC) for youth and families with complex or intensive needs. WInS brings together the youth, family, providers, and other formal and informal supports to develop and carry out a coordinated plan of care. The process is strengths-based, culturally responsive, family-driven, and youth-guided and is facilitated by a High-Fidelity Wraparound-trained Wraparound Coordinator.

Through the Child and Family Team (CFT), participants identify and prioritize needs and strengths, use CANS information to inform planning, develop and monitor the plan of care and

outcomes, address crisis and safety planning, and prepare for transition from WInS. The CFT may include the youth, family or guardian(s), providers, and other natural or community supports identified by the family. The Wraparound Coordinator works collaboratively with the case manager and other team members to coordinate services, reduce duplication, and support a cohesive system of care that helps the youth and family move toward their identified goals.

There are four phases of WInS:

- Phase 1 - Engagement
- Phase 2 - Initial plan development
- Phase 3 - Plan implementation
- Phase 4 - Transition

Youth who are engaged in WInS cannot receive duplicative services, such as intensive care coordination.

WInS may be appropriate for youth with intensive needs.

Wraparound eligibility requires youth to have all the following:

1. An overall CANS assessment score with an overall level of care of Comprehensive or Intensive.
2. Behavioral health involvement and involvement in at least one additional child serving system:
    - Court involvement
    - Child Protection Services (CPS) involvement
    - Education needs (IEP, 504, or desire to improve child's educational performance)
    - Physical health needs
    - Developmentally disabled or intellectually disabled needs
3. Youth and family desire to participate in the Wraparound care planning process.
4. Youth and family can benefit from intensive care coordination and/or have not experienced improvements with current care coordination.

Additional indicators for Wraparound are as follows but not limited to:

1. Nearing risk of out-of-home placement.
2. A need for or transitioning from higher levels of behavioral health intervention such as intensive home and community-based services, intensive outpatient, partial hospitalization, hospitalization, or residential care.

Member Eligibility

Wraparound eligibility requires youth to have all the following:

1. A CANS Level of Care of Comprehensive or Intensive.

2. Behavioral health involvement and involvement in at least one additional child serving system:
    - Court involvement
    - Child Protection Services (CPS) involvement
    - Education needs (IEP, 504, or desire to improve child's educational performance)
    - Physical health needs
    - Developmentally disabled or intellectually disabled needs
3. Youth and family desire to participate in the Wraparound care planning process.

Additional indicators for Wraparound are as follows but not limited to:

- Nearing risk of out-of-home placement.
- A need for or transitioning from higher levels of behavioral health intervention such as intensive home and community-based services, intensive outpatient, partial hospitalization, hospitalization, or residential care.
- Medicaid benefit for youth through the end of the month of their 18th birthday or through the end of the month of their 21st birthday via the Early and Periodic Screening, Diagnostic, and Testing (EPSDT) benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid up to age 18. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Wraparound Coordinators provide conflict-free services and adhere to the following timelines:

- Engage youth and families in WInS within 3 days of referral.
- Develop initial Wraparound Plan of Care within 45 to 60 days of being engaged.
- Coordinate wraparound teams to meet every 30-45 days to review and modify the Plan of Care as needed.
- Coordinate transition from formal planning process over a 30–60-day timeframe.
- Follow up with youth and families three to six months after transition from the formal planning process.

Wraparound Coordination may be provided in the home, community, office, or school setting, or through telehealth, based on the youth and family's needs and preferences. Wraparound is a family-driven and youth-guided process that places the youth and family at the center of planning and decision-making. With support from the Wraparound Coordinator, the youth and family develop a Child and Family Team (CFT) that includes individuals important to achieving the family's vision and goals. Team members may include natural supports, community members, service providers, and other professionals involved with the youth and family.

The youth and family, with support from the CFT, identify their team vision and goals and develop individualized strategies, services, and supports to address prioritized needs and build

on strengths. The CFT works collaboratively to implement the plan, monitor progress and outcomes, and revise strategies as needed.

Discharge from Wraparound Intensive Services occurs when the team mission has been achieved, identified goals and outcomes have been met, or the youth and family choose to discontinue services.

Case management services may be provided concurrently with Wraparound Intensive Services. When both services are provided, the Wraparound Coordinator and case manager must collaborate to coordinate responsibilities, avoid duplication, and ensure services support the youth and family's identified goals.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Be a licensed behavioral health clinician or hold at least a bachelor's degree and practice under the supervision of a clinical supervisor.
- Complete required WInS certification training through the Idaho Wraparound Team and meet annual certification benchmarks established by the Idaho Wraparound Team to maintain certification.
- Complete all required Idaho TCOM Team CANS certification training requirements. Providers must maintain current CANS certification annually, in accordance with Idaho TCOM Team requirements, to remain eligible to provide services.
- Have experience working with children, youth, and families with significant mental and behavioral health issues.
- Have a maximum caseload of 10-12 families.
- Understand and follow the YES Principles of Care and Practice Model.

The Wraparound Coordinator must ensure that all Child and Family Team (CFT) members receive orientation to the principles and delivery of the WInS model at the beginning of their participation in the Wraparound process.

A provider exemption through The Centers for Medicare & Medicaid Services (CMS) is required when:

- A provider may offer both WInS and respite services at the same location.
- Different staff members at the agency can deliver either WInS or respite services, but the same staff member cannot provide both services.
- The WInS staff member may include respite services in the person-centered service plan (for the 1915i Medicaid YES Program) or another coordinated plan. However, staff writing plans should avoid making direct referrals to specific individuals within the agency. If an exemption is in place and due diligence confirms that the same agency is the only "willing and able" provider for respite services, a different staff member within the agency could deliver the respite care.

Providers must thoroughly document that they are the only available and willing provider in the area and that efforts to refer the client to other providers were made prior to offering both services.

Authorization
Notice of Admission is required.

Payment Methodology

Code	Description	Unit
H2022	Community-based wraparound services	Unit = Daily

Fidelity and Quality Monitoring
Magellan monitors and reports on the performance of the WInS providers through quality record reviews.

The Idaho Wraparound Team and IDHW support quality management of Wraparound practice through coaching, ongoing fidelity monitoring throughout the year, and annual quality service reviews that include record reviews and interviews with youth and families.

Flexible Funds

Description
For The Idaho Behavioral Health Plan (IBHP), Magellan will identify and utilize resources "to assist the child's family to care for the child in his home and community whenever possible." Services for children with an SED "shall be individually planned to meet the unique needs of each child and family" and may include family supportive services, wraparound, and crisis intervention services, among others[1].

Care teams may utilize flexible funds, also known as "Flex Funds," to provide additional supports to the youth and their family. Flexible Funds may be available to meet the unique needs not otherwise paid for in an individualized treatment plan. Examples of flex funds include, but are not limited to, family supports such as limited rental payments, utilities, automobile repair, and individual supports such as therapeutic behavioral incentives.

For more information about Flex Funds, please contact your Wraparound Coordinator, Magellan Intensive Care Coordination, or Magellan Customer Service at 1-855-202-0983. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

1. Idaho Code § 16-2402(3)
   Jeff D. v C.L. "Butch" Otter, No. 4:80-CV-04091-BLW Settlement Agreement; Appendix C Services and Supports

Wraparound coordinators may contact Magellan regarding flex funds at IBHPFlexFunds@MagellanHealth.com.

Behavior Modification and Consultation (BMC)

Description

At this time, BMC will not be reimbursed through Magellan. These services may be covered under Idaho Medicaid when medically necessary. Prior authorization should be obtained through Telligen and claims should be submitted to Gainwell.

For more information and contact information about prior authorizations, please visit https://idmedicaid.telligen.com, and for information and contact information about billing, please visit www.idmedicaid.com.

Health and Behavioral Assessment and Intervention (HBAI)

Description

The Health and Behavior Assessment and Intervention (HBAI) benefit provides reimbursement for integrated clinics that provide medical services to provide brief behavioral interventions for members with a primary medical diagnosis.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

HBAI services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the treatment of physical health problems. The assessment includes evaluation of the member's responses to disease as well as coping skills, motivation, and adherence to medical treatment. Refer to the American Psychological Association 2020 Health Behavior Assessment and Intervention Billing and Coding Guide for additional guidance on service delivery.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed behavioral health clinicians as defined per licensure by the DOPL and IDAPA.
- Providers need to be contracted with Magellan to provide this service.

Authorization

No authorization is required until the threshold of 60 units per member per calendar year is reached.

Payment Methodology

Code	Description	Unit
96156	H&B assessment or reassessment, untimed	Unit = per session
96158	H&B intervention, individual	Unit = initial 30 minutes

96159	H&B intervention, individual (add-on)	Unit = each additional 15 minutes
96164	H&B intervention, group	Unit = initial 30 minutes
96165	H&B intervention, group, (add-on)	Unit = each additional 15 minutes
96167	H&B intervention, family w/patient	Unit = initial 30 minutes
96168	H&B intervention, family w/patient (add on)	Unit = each additional 15 minutes

Language Interpretation Services

Description

If English is not a member's primary language, or they are hearing impaired, they can get free oral translation or American Sign Language services when they are speaking to Magellan or providers in any setting. To get language interpretation services, members can call Magellan at 1-855-202-0973 (TTY 711).

Magellan aligns with and follows the guidance in the Idaho Medicaid Provider Handbook and expects providers to adhere to these guidelines as well for Magellan members.

Members who are hearing impaired may also use Idaho Relay Services at TTY 711 or:

- Voice: 1-800-377-1363
- Speech-to-Speech: 1-888-791-3004
- Visually Assisted Speech-to-Speech (VA STS): 1-800-855-9400
- Spanish: 1-866-252-0684

Written materials can be translated to another language and provided in alternate formats such as audio, large print, or Braille. Members should call Magellan at 1-855-202-0973 (TTY 711) for help with written materials.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Federal law and Idaho Medicaid regulations require Medicaid providers to make reasonable modifications in their practices or clinics to ensure members who have a limited ability to read,

speak, write, or understand English have full access to Medicaid services. This limitation is referred to as Limited English Proficiency (LEP).

Provider Requirements

The provider or its agency is responsible for hiring or contracting with a qualified interpreter or translator to facilitate communication with a member when they are providing an IBHP-reimbursed service.

Definition of qualified interpreter

A qualified interpreter is a person 18 years or older, contracted or employed by the billing provider, who has been evaluated and certified by the billing provider, and for whom records of competency are maintained.

Agencies should develop their own guidelines on qualifications and competency that are in line with best practice standards for the field. These should include:

- Provider is over the age of 18
- Provider has a high school diploma or GED
- Provider is fluent in both English and the language they are interpreting for.

Note: Any additional guidelines and qualifications are at the discretion of providers.

Documentation standards

When using an interpreter, add these additional documentation requirements to service documentation being completed by the rendering provider e.g. therapy progress notes.

- Relationship of interpreter to member.
- If services are not for the member, the name of person and their relationship to the members care (e.g., authorized representative).
- The type of interpretive service provided (e.g., in-person, telehealth).
- Full name (first and last), title or position of person rendering interpretive services.
- Language being interpreted.
- Date, time, and duration of interpretive services.

Note: Whenever possible, the interpreter's signature should be obtained on a log or sign-in sheet. If a signature cannot be captured due to virtual or telephonic interpretation, documentation must include the reason the signature was not obtained and record the interpreter's company name along with all other required information.

Enrollment requirements

- A completed staff roster of interpreters, including full name, languages interpreted, relationship to billing provider (e.g., contracted or permanent employee).
- Providers' proof of internal certification to provide interpretive services.

Reimbursement limitations
Interpretation service reimbursement is unavailable for multilingual providers who share a language with the member.

Idaho Medicaid does not reimburse for:

- Administrative services such as scheduling appointments, making reminder calls, cancelling appointments, no show appointments.
- Interpreter travel time.
- Services provided by an immediate family member such as a parent, spouse, sibling or child.
- Services in conjunction with a non-covered, non-reimbursable, or excluded service.
- Services provided through a Medicaid managed care contractor.
- Teaching sign language.
- The interpreter or translator's waiting time.

Authorization
No authorization is required.

Payment Methodology

Code	Description	Unit
T1013	Language Interpretation Services (sign language or oral interpretation)	Unit = 15 minutes

Mileage Reimbursement

Description
Mileage Reimbursement is not available through Magellan.

Telehealth/Virtual Care

Description
Telehealth/Virtual Care is a method of delivering behavioral health services through interactive telecommunications technology when the member and provider are not in the same physical location. Telecommunications may include live, interactive audio and video communication or, when permitted by applicable state and federal regulations, live audio-only communication.

Telehealth services must be clinically appropriate, provided in accordance with the applicable Medicaid and Idaho Behavioral Health Plan (IBHP) requirements, and meet the same standards of care as services delivered in person.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.

Services

Services that can be provided via telehealth/virtual care are listed in the Magellan Idaho Behavioral Health Plan Rates for Outpatient Providers posted at https://magellanofidaho.com/getting-paid.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Any level provider who is a licensed behavioral health clinician, or a provider qualified to deliver the service working under Magellan's Supervisory Protocol.
- Provider must be licensed in the state in which the member is located at the time of service or be working under the supervision of a provider licensed in the state in which the member is located at the time of service.
- Providers may be physically located outside of Idaho when seeing Idaho members, as long as they are licensed in Idaho. Providers must comply with all applicable Magellan, state, and federal telehealth/virtual care regulations and guidelines.
- Providers must sign and abide by Magellan's Telehealth/Virtual Care Addendum.
- Providers must document the member's location, the provider's location, the modality used (audio-video or audio-only, when permitted), and any other documentation required by state, federal, or payer guidelines.

Billing and Use Requirements

Telehealth facilitation/originating site codes may be used only when:

- A provider or clinic is facilitating a telehealth encounter between a member and a distant-site provider.
- The distant-site provider is rendering the clinical service to the member through telehealth.
- The facilitating provider's activities are limited to supporting and coordinating the telehealth encounter and meet the requirements of the billed code.
- The service is separately reimbursable under applicable Medicaid and Magellan billing guidelines.

Telehealth facilitation/originating site codes may not be billed when:

- The provider delivering the clinical service is employed by, contracted with, or practicing within the same originating clinic or organization.
- The provider is billing for a telehealth service that they personally rendered to the member.

- Activities are administrative in nature, including scheduling, registration, technical assistance, or routine operational support.
- The billed activity is already included in reimbursement for another service.

Documentation must clearly support the circumstances under which any telehealth facilitation or originating site code is billed.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
Q3014	Telehealth Originating Site Facility Fee	

Opioid Treatment Programs

Description

The use of medications, sometimes in combination with counseling and behavioral therapies, that is effective in the treatment of opioid use disorders (OUDs) and can help to sustain recovery.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

Opioid Treatment Programs (OTPs) are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) to treat opioid use disorder (OUD).

There are several treatment options prescribed by these specialty programs based on the member's medical and psychiatric history, SUD treatment history, and member preference. Methadone and buprenorphine are two medication options available through the comprehensive bundle. Naltrexone treatment reimbursement is allowable when prescribed for an approved indication, supported by a qualifying diagnosis, medically appropriate for the member, and provided as part of a comprehensive, documented treatment plan.

OTP required services include a comprehensive physical exam, counseling, and supportive services based on an individualized plan of care. At a minimum, this includes addiction counseling, case management services, and health education.

OTPs also provide counseling, drug testing, substance use education and various office visits for supervised medication administration as required by 42 CFR 8.12.

Treatment includes medication dispensing and/or administration, individual and group therapy, and toxicology testing if performed (provision of the services by a Medicare-enrolled opioid treatment program).

All services must be provided in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment care needs.

This service is not currently developed for youth in Idaho.

Provider Requirements

OTPs in compliance with the federal opioid treatment standards 42 CFR Part 8 found at: https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/42-cfr-part-8, certified by SAMHSA, and contracted with the IBHP, can provide this benefit.

Authorization

No authorization is required.

Payment Methodology

Services*

Code	Description
G2074	Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed.
G2068	Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed.
G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed

*Weekly Bundle, SUD services included in the bundle cannot be billed independently along with the bundle.

Medications

Code	Description	Unit
*J2315	Naltrexone Allowed in addition to G2074	380 mg/month

* This is not a covered medication through the IBHP. Please refer to Medicaid pharmacy benefit. This is only for those members eligible for other-state funding.

Magellan covers medically necessary intensive inpatient, residential and outpatient treatment services for adults and youth who have a diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) for SUD. Both severity of illness and intensity of services criteria must be met for the American Society of Addiction Medicine (ASAM) Level of Care requested. ASAM uses separate criteria and levels of care benchmarks for adults and adolescents.

The goal of *ASAM Criteria* is to recommend the least intensive treatment program that can address the needs of the individual.

ASAM Levels of Care – SUD Treatment Programs

ASAM Criteria

Level	Description
ASAM Level 1.0	Outpatient (OP) services delivered in a variety of community settings like behavioral health clinics, medical offices and virtually.
ASAM Level 2.1	Intensive Outpatient Programs (IOP) are structured programs available to individuals with SUDs that can be addressed and managed in a level of care that is less intensive than partial hospitalization but that require a higher level of care.
ASAM Level 2.5	Partial Hospitalization Programs (PHP) for SUD provide high-intensity outpatient treatment services for individuals. These programs are defined as structured and medically supervised day, evening and/or night treatment programs. Oversight of the program must be provided by a licensed physician, but day-to-day activity can be done by another provider.
ASAM Level 3.1	Clinically managed low-intensity residential treatment services intended for individuals who require additional time in a structured residential setting in order to practice coping skills and prepare for successful transition to a lesser level of care.
ASAM Level 3.2	Clinically managed residential withdrawal management service for individuals with a moderate risk of withdrawal from alcohol or drugs in a residential setting but do not need the level of medical supervision that would be found in more intensive levels of care.

ASAM Level 3.3	Clinically managed population-specific high-intensity residential treatment services for individuals with functional limitations who require treatment that is slower paced, more concrete, and more repetitive until he or she can be transferred to another level of care.
ASAM Level 3.5	Clinically managed high-intensity residential services intended for individuals who are medically stable but cannot safely participate in substance use disorder treatment without continuous 24-hour supervision by behavioral health professionals.
ASAM Level 3.7	Medically monitored intensive residential or inpatient treatment for individuals who need withdrawal management and monitoring in a 24-hour setting but do not need daily physician interaction. Services may be provided in an acute inpatient setting or in a residential treatment facility.
ASAM Level 4.0	Medically managed intensive inpatient services for individuals delivered in an acute inpatient setting. This level of care provides medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, and/or biomedical distress.

Alcohol and/or Drug Assessment

Description

Alcohol and drug assessments are used to determine if a member has a SUD and help providers determine the best way to treat it.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

The Comprehensive Diagnostic Assessment (CDA) must include the six ASAM dimensions:

- Dimension 1 – Intoxication, Withdrawal Potential and Addiction Medications
- Dimension 2 – Biomedical Conditions and Complications
- Dimension 3 – Emotional, Behavioral, and Cognitive Conditions and Complications
- Dimension 4 – Readiness to Change
- Dimension 5 – Relapse, Continued Use, or Continued Problem Potential
- Dimension 6 – Recovery Environment

The Global Appraisal of Individual Needs (GAIN) may still be used by GAIN-certified providers to meet the substance use assessment requirement required with a CDA.

Provider Requirements

A Comprehensive Diagnostic Assessment (CDA) must be completed for all Substance Use Disorder (SUD) admissions by a qualified independently licensed clinician or by a master's-level clinician practicing under an approved supervision protocol.

Providers may use an assessment that combines both the CDA requirements and the ASAM assessment requirements into a single document. However, unlicensed staff may not independently complete the full CDA. Additionally, providers must be able to clearly distinguish and identify the elements that satisfy CDA requirements separately from those that satisfy ASAM requirements for compliance and audit purposes.

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed clinicians and paraprofessionals as defined per licensure by the Division of Occupational & Professional Licenses, IBADCC-certified alcohol/drug counselor, an IBADCC-certified advanced alcohol/drug counselor, a master addictions counselor certified by the national board for certified counselors or the NCCAP, or a licensed professional, as defined by Idaho Code 39-305A.
- Paraprofessionals (defined as individuals who are not independently licensed, including ADC). Paraprofessionals also includes individuals providing outpatient SUD treatment services within the IBHP, who may not be required to have a bachelor's degree; however, they must meet the minimum relevant certification available for the service rendered (e.g., SUDA).
- SUD providers must be trained in the ASAM Criteria®. This training must be documented in the individual's personnel file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
H0001	Individual Assessment and Treatment Plan for Substance Abuse (Use) (including administration of the GAIN)	Unit = 15 minutes

SUD Individual Therapy

Description

Individual therapy with a provider who is an expert in treating people with an SUD.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

Individual SUD counseling generally focuses on motivating the member to stop using substances. Treatment then shifts to helping the member stay substance free. The clinician uses therapeutic interventions to help the member see the problem and become motivated to change, change their behavior, repair damaged relationships with family and friends, build new friendships with individuals who do not use substances and create a recovery lifestyle.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed clinicians and paraprofessionals as defined per licensure by the Division of Occupational & Professional Licenses, IBADCC-certified alcohol/drug counselor, an IBADCC-certified advanced alcohol/drug counselor, a master addictions counselor certified by the national board for certified counselors or the NCCAP, or a licensed professional, as defined by Idaho Code 39-305A.
- Paraprofessionals (defined as individuals who are not independently licensed, including ADC). Paraprofessionals also includes individuals providing outpatient SUD treatment services within the IBHP, may not be required to have a bachelor's degree; however, they must meet the minimum relevant certification available for the service rendered (e.g., SUDA).
- SUD providers must be trained in the ASAM Criteria®. This training must be documented in the individual's HR file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
H0004	Individual Counseling - SUD	Unit = 15 minutes

SUD Group Therapy by a Qualified SUD Professional

Description

Group therapy with a provider who is qualified to treat people with an SUD. Group members with similar substance use conditions talk to and support each other. Members can see they are not alone and learn from each other.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

SUD treatment providers employ a variety of group treatment models to meet member needs during the multiphase process of recovery. A combination of group goals and methodologies are the primary way to define the types of groups used. Adults and youth need to have separate and distinct groups; these populations cannot be treated together.

SUD groups:

- Help members learn to manage their SUD and other needs by allowing them to see how others deal with similar challenges.
- Reduce the sense of isolation that most individuals who have substance use disorders experience.
- Enable members who have SUD to witness the recovery of others.
- Encourage, coach, support, and reinforce as members undertake difficult or anxiety-provoking tasks.
- Offer members the opportunity to learn or relearn the social skills they need to be successful with everyday life instead of resorting to substance use.
- May add needed structure and discipline to the lives of members struggling with SUD.
- Groups size is limited to no more than 12 participants.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed clinicians and paraprofessionals as defined per licensure by the Division of Occupational & Professional Licenses, IBADCC-certified alcohol/drug counselor, an IBADCC-certified advanced alcohol/drug counselor, a master addictions counselor

certified by the national board for certified counselors or the NCCAP, or a licensed professional, as defined by Idaho Code 39-305A.

- Paraprofessionals (defined as individuals who are not independently licensed, including ADC). Paraprofessionals also includes individuals providing outpatient SUD treatment services within the IBHP may not be required to have a bachelor's degree; however, they must meet the minimum relevant certification available for the service rendered (e.g., SUDA).
- SUD providers must be trained in the ASAM Criteria®. This training must be documented in the individual's personnel file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
H0005	Group Counseling – Alcohol and/or Drug Services	Unit = 15 minutes

Intensive Outpatient Program – Substance Use Disorder

ASAM Level 2.1

Description

Intensive Outpatient Programs - Substance Use Disorder (IOP-SUD) are structured programs available to adults and adolescents who are recovering from substance use disorders (SUDs) that can be addressed and managed in a level of care that is less intensive than partial hospitalization, but that require a higher level of care than traditional outpatient therapy (ASAM 1.0). IOP-SUD is provided in a manner that is strengths- and outcome-based, culturally responsive, and responsive to each member's individual psychosocial, developmental, and treatment needs. All services are outcome-based and are individualized to the youth's or adult's treatment needs and preferences within the program guidelines. The program may function as a step-down program from hospitalization, partial hospitalization, or residential treatment. It may also be used to prevent or minimize the need for a more intensive level of treatment. Common treatment duration is six to eight weeks.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

IOP-SUD is appropriate for individuals who live in the community without the restrictions of a 24-hour supervised treatment setting during non-program hours. Services for youth are offered separately from services for adults. Services are provided in-person and may include telehealth. IOP-SUD programs maintain 9 to 19 hours of service weekly for adults and 6 to 19 hours of service for adolescents.

During IOP, a psychiatric evaluation needs should be available if clinically indicated. These evaluations can be performed by a physician, a Nurse Practitioner (NP), or a Physician's Assistant (PA) with the proper experience and training for whom this service is in their scope of practice. After the initial evaluation, the following ones can be brief updates. Medications are optional, but evaluations are required if clinically indicated. The psychiatric evaluations can be done internally or externally. If done externally, then the outside practitioners would need to

communicate with the IOP staff and provide their documentation. The diagnoses and treatment plans of the various providers must be unified. Care coordination is a critical component of IOP treatment.

Required IOP-SUD Components:

- Comprehensive Diagnostic Assessment including ASAM dimensions and or GAIN and treatment planning
- The following services are provided in the amounts, frequencies, and intensities as appropriate to the members' treatment needs:
    - Individual therapy*, family therapy, group therapy, and/or psychoeducation
    - Skill-building activities
    - 24-hour crisis services
    - Medication management (can also be billed outside of the bundled rate for external providers)
    - Substance use screening and monitoring, and drug testing (as appropriate)
    - A psychiatrist must be available to consult with the program during and after normal program hours
    - Care coordination/transition management/discharge planning

*Individual therapy is required for all members in IOP Services.

Service Delivery Guidelines

- IOP services must include a minimum of 9 to 19 hours per week of structured, therapeutic programming.
- Each IOP program day must include a minimum of three (3) hours of services.
- At least six (6) hours per week must consist of core clinical services, including individual therapy, group therapy, and family therapy.
- Groups size is limited to no more than 12 participants.
- The remaining weekly hours may include supportive and adjunctive services such as psychoeducation, psychiatric or medication evaluation, case management, skills development, clinical assessment and treatment plan updates, and recovery-focused activities.
- If the required minimum three (3) hours of services are not delivered for a given day, the provider may not bill for IOP services for that day.

EBP usage:

- Providers must complete formal training in the EBP model prior to independently facilitating the group.
- Documentation of training and certification (when applicable) must be maintained and made available upon request.
- Providers must demonstrate ongoing competency through supervision and continued learning consistent with the model's requirements.

    - *Example:* If a model such as CBT, DBT, seeking safety, moral reconation therapy (MRT), or motivational interviewing requires formal training or certification, only trained staff may facilitate the group.
- Paraprofessional staff may support EBP groups only under the supervision of a qualified licensed or trained clinician.
- Paraprofessionals cannot independently deliver EBP interventions that require clinical judgment, training, or licensure.
- Supervising clinicians are responsible for ensuring adherence to model fidelity.
- If a group is not using an approved EBP curriculum, it must be identified as psychoeducation/supportive services, not an EBP.
    - Example: Running a group called "CBT group" without a CBT curriculum or without trained staff is not permitted.

When a member is participating in IOP-SUD, only the following services can be received outside of the program:

- Separate case management /CFT
- Respite
- Youth support
- Family support
- Recovery coaching
- Psychological/neuropsychological testing.

IOP services do not include overnight housing and cannot be co-located in safe and sober housing.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Doctoral-level providers and licensed prescribing practitioners
- Licensed behavioral health clinicians
- Master's-level behavioral health clinicians under Magellan's approved supervision policy
- Bachelor's-level and/or paraprofessionals working under Magellan's approved supervision policy.

Other professionals that may provide a necessary component of the program must provide appropriate services within the scope of their practice. They may or may not be reimbursable by the IBHP, depending on whether the services are outside of the scope of the IBHP.

SUD Providers

- SUD providers will be licensed clinicians and paraprofessionals as defined per licensure by the Division of Occupational & Professional Licenses, IBADCC-certified alcohol/drug counselor, an IBADCC-certified advanced alcohol/drug counselor, a master addictions

counselor certified by the national board for certified counselors or the NCCAP, or a licensed professional, as defined by Idaho Code 39-305A.

- Paraprofessionals (defined as individuals who are not independently licensed, including ADC). Paraprofessionals also includes individuals providing outpatient SUD treatment services within the IBHP may not be required to have a bachelor's degree; however, they must meet the minimum relevant certification available for the service rendered (e.g., SUDA).
- Substance use disorder providers must be trained and proficient in applying the ASAM Criteria®. This training must be documented in the individual's HR file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.

Authorization

17 and under: No authorization is required
18+: Prior authorization after threshold of 50 units

Payment Methodology

Code	Description	Unit
H0015 or Rev code 0906 w/ H0015	Intensive Outpatient Program, Substance Use Disorder ASAM 2.1 including assessment, counseling, crisis intervention, and activity therapies or education.	Unit = per diem

Partial Hospitalization Program – Substance Use Disorder

ASAM Level 2.5

Description

Partial Hospitalization Programs (PHP) are structured, intensive, and time limited services provided by a hospital, free-standing facility, or provider group utilizing evidence-based medical and clinical practices that are provided under the direction of a medical director.

Partial Hospitalization Programs - Substance Use Disorder (PHP-SUD) are a facility-based, structured bundle of services for adults and adolescents who are recovering from substance use disorders (SUDs) that can be addressed and managed in a level of care that is less intensive than hospitalization but that require a higher level of care than Intensive Outpatient - Substance Use Disorder IOP-SUD programs. PHP-SUD offers intensive outpatient treatment that allows members to receive the same level of care as those who enter residential facilities and still maintain their daily routines and continue living at home during treatment. All services are

individualized to the member's treatment needs and preferences within the program guidelines. Services must be delivered in a manner that is strengths-based and with cultural responsiveness, **under the supervision of a licensed physician**, MD/DO with the proper experience and training for whom this service is in their scope of practice. Common duration is four to six weeks.

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

PHP-SUD offers therapy sessions and other treatments and the opportunity to practice new coping skills. Services for youth are offered separately from services for adults. Oversight of the program must be by a licensed physician, but day-to-day activity can be done by another provider. Services are delivered a minimum of 20 hours per week and no less than four days/week.

During PHP, a psychiatric evaluation needs to be completed at least monthly. These evaluations can be performed by a physician, a Nurse Practitioner (NP), or a Physician's Assistant (PA) with the proper experience and training for whom this service is in their scope of practice. After the initial evaluation, the following ones can be brief updates. Medications are optional but evaluations are required. The psychiatric evaluations can be done internally or externally. If done externally, then the outside practitioners would need to communicate with the PHP staff and provide their documentation. The diagnoses and treatment plans of the various providers must be unified. Care coordination is a critical component of PHP treatment.

Evidence of collaboration and coordination of care with external providers must be maintained and be available upon request.

Required PHP-SUD components:

- Comprehensive Diagnostic Assessment with ASAM dimensions and or GAIN and treatment planning
- The following services are provided in the amounts, frequencies, and intensities as appropriate to the members' treatment needs:
    - Individual therapy*, family therapy, group therapy, and/or psychoeducation
- Skill-building activities
- 24-hour crisis services
- Psychiatric evaluation (can also be billed outside of the bundled rate for external providers)

    - For other state funded members, the psychiatric evaluations are a part of the PHP-SUD components and need to be delivered internally as part of this bundle.

- Medication management (can also be billed outside of the bundled rate for external providers)
- Substance use screening and monitoring, and drug testing (as appropriate)
- A registered nurse (RN) or higher must be available 24 hours per day as part of the program
- A physical exam: If stepping up or entering a PHP program, a new exam is to be done within one program day. If stepping down from a higher level of care within seven days of discharge, a previous exam done by a behavioral health provider (inpatient or residential level of care) is accepted.
- Care coordination/transition management/discharge planning.
- Groups size is limited to no more than 12 participants.

*Individual therapy is required for all members in PHP Services.

Note: Any external services e.g. psychiatric evaluation or medication management must be coordinated with the PHP program and integrated with the treatment plan.

Service Delivery Guidelines

- PHP services must include a minimum of 20 hours per week of structured, therapeutic programming.
- Each PHP program day must include a minimum of five (5) hours of service.
- Over the course of the week, at least twelve (12) of the required weekly hours must consist of core clinical services such as individual therapy, group therapy, and family therapy.
- The remaining minimum of eight (8) weekly hours may include supportive and adjunctive services such as psychoeducation, psychiatric or medication evaluation, case management, skills development, clinical assessment and treatment plan updates, and recovery-focused activities.
- If the required minimum five (5) hours of services are not delivered for a given day, the provider may not bill for PHP services for that day.

EBP usage:

- Providers must complete formal training in the EBP model prior to independently facilitating the group.
- Documentation of training and certification (when applicable) must be maintained and made available upon request.
- Providers must demonstrate ongoing competency through supervision and continued learning consistent with the model's requirements.
    - *Example:* If a model such as CBT, DBT, seeking safety, moral reconation therapy (MRT), or motivational interviewing requires formal training or certification, only trained staff may facilitate the group.

- Paraprofessional staff may support EBP groups only under the supervision of a qualified licensed or trained clinician.
- Paraprofessionals cannot independently deliver EBP interventions that require clinical judgment, training, or licensure.
- Supervising clinicians are responsible for ensuring adherence to model fidelity.
- If a group is not using an approved EBP curriculum, it must be identified as psychoeducation/supportive services, not an EBP.
    - *Example:* Running a group called "CBT group" without a CBT curriculum or without trained staff is not permitted.

When a member is participating in PHP, only the following services can be received outside of the program:

- Separate case management
- Child and family teams (CFT)
- Wraparound Intensive Services (WInS), intensive care coordination, targeted care coordination (through Dec. 31, 2024)
- Respite
- Youth support
- Family support
- Recovery coaching
- Medication management for external providers only
- Psychological/neuropsychological testing.

PHP services do not include overnight housing and cannot be delivered via telehealth.

PHP services cannot be co-located in safe and sober housing

***Physical exam requirements may be completed via telehealth if a RN or higher-level medical practitioner is physically present with member to assist in physical exam being conducted by medical practitioners via telehealth.**

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Doctoral-level providers and licensed prescribing practitioners
- Licensed behavioral health clinicians
- Master's-level behavioral health clinicians under Magellan's approved supervision policy
- Bachelor's-level and/or paraprofessionals working under Magellan's approved supervision policy.

Other professionals that may provide a necessary component of the program must provide appropriate services within the scope of their practice. They may or may not be reimbursable by the IBHP, depending on whether the services are outside of the scope of the IBHP.

SUD providers:

- SUD providers will be licensed clinicians and paraprofessionals as defined per licensure by the Division of Occupational & Professional Licenses, IBADCC-certified alcohol/drug counselor, an IBADCC-certified advanced alcohol/drug counselor, a master addictions counselor certified by the national board for certified counselors or the NCCAP, or a licensed professional, as defined by Idaho Code 39-305A.
- Paraprofessionals (defined as individuals who are not independently licensed, including ADC). Paraprofessionals also includes individuals providing outpatient SUD treatment services within the IBHP may not be required to have a bachelor's degree; however, they must meet the minimum relevant certification available for the service rendered (e.g., SUDA).
- Substance use disorder providers must be trained in the ASAM Criteria®. This training must be documented in the individual's HR file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.

Authorization

Authorization is required.

Payment Methodology

Code	Description	Unit
H0035 or Rev code 0913 w/ H0035	Partial Hospitalization Program - Substance Use Disorder ASAM 2.5, all-inclusive payment of 5 or more hours (full day)	Unit = per diem

Low-Intensity Residential Treatment - Substance Use Disorder

ASAM Level 3.1

Description

ASAM Level 3.1 provides clinically managed low-intensity residential treatment services intended for adults and youth who require additional time in a structured residential setting in order to practice coping skills and prepare for successful transition to a lesser level of care.

Member Eligibility

- Not a Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out. This funding can be used for youth and adults.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

Services are provided in a 24-hour environment such as a group home or halfway house. SUD trained professional staff are on site 24 hours a day. Both clinic-based services and community-based recovery services are provided at least 5 hours per week, including medication management, peer support, case management, recovery skills, Intensive Outpatient Program, and other similar outpatient services. Level 3.1 agencies may allow clients to leave the facility with permission during the day when not in programming for a job or medical appointments, etc.

Provider Requirements

SUD residential treatment facilities must meet the following requirements:

- Have a National Provider Identifier (NPI).
- Have current national accreditation to provide behavioral healthcare by one of the following bodies:
    - The Commission on Accreditation of Rehabilitation Facilities (CARF),
- Have current ASAM 3.1 Level of Care Certification from CARF. Staff must meet the ASAM standards for the level of service provided.
- Each adolescent residential treatment program must be licensed as a Children's Residential Care Facility under IDAPA 16.04.18.

Authorization

Prior authorization is required.

Any youth placed in a residential facility in another state must have an Interstate Compact completed upon admission to the facility.

Payment Methodology

Code	Description	Unit
H0018	ASAM 3.1 (Adults)	Unit = Per Diem
H0043	ASAM 3.1 (Adolescents)	Unit = Per Diem

Clinically Managed Residential Withdrawal Management Services -Substance Use Disorder

ASAM Level 3.2

Description

ASAM Level 3.2 provides clinically managed withdrawal management for adults with a moderate risk of withdrawal who require support in a structured and supervised medically supported environment. ASAM level 3.2 also includes the administration and/or monitoring of non-narcotic, non-scheduled or non-addiction medications.

Member Eligibility

- Not a Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid who are 18 or older. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

Services are provided in a 24-hour medically supported environment provided in a residential setting where the individual is provided supportive care during the withdrawal process. Individuals are stable and not at immediate risk of serious medical complications due to withdrawal. The components of Withdrawal Management services include Intake, Observation, Medication Services, and Discharge services. Physical care, education, and counseling are provided as appropriate for the client's health and safety during his process of physical withdrawal from acute alcohol intoxication or withdrawal, or from one or more other addictive substances. Social detoxification provides access into care and treatment of alcohol or substance use disorders through monitored withdrawal, evaluation of present or potential

alcohol or substance dependency and other physical ailments, and intervention into the progression of the disease through timely utilization or resources. Length of stay in a social detoxification program varies from three (3) to five (5) days depending on the severity of the disease and withdrawal symptoms.

Provider Requirements

SUD residential treatment facilities must meet the following requirements:

- Have a National Provider Identifier (NPI).
- Have current national accreditation to provide behavioral healthcare by one of the following bodies:
    - The Commission on Accreditation of Rehabilitation Facilities (CARF),
- Have current ASAM 3.1 Level of Care Certification from CARF. Staff must meet the ASAM standards for the level of service provided.

Authorization

Prior authorization is required after a threshold of five (5) days.

Payment Methodology

The Threshold is five (5) days

Code	Description	Unit	Threshold
H0008	Adult Social Detox (ASAM Level 3.2) clinically managed, residential withdrawal management services.	Unit = Per Diem	Five (5) days

Clinically Managed Population-Specific High-Intensity Residential Treatment

ASAM Level 3.3

Description

ASAM Level 3.3 provides clinically managed population-specific high-intensity residential treatment services for adults with functional limitations who require treatment that is slower paced, more concrete, and more repetitive until he or she can be transferred to another level of care. It offers 24-hour supportive treatment in a safe and structured environment to help individuals initiate or continue a recovery process, develop/practice early recovery skills such as resilience and refusal; experience the support of others in a recovery-oriented setting. Services are provided under the direction of a physician. Services include individual and group therapy and counseling, family counseling, clinical monitoring, room and board, random drug screening,

medications and supplies, and arranged medical and mental health services as appropriate to the severity and urgency of the condition.

Member Eligibility

- Not a Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out. This funding can be used for youth and adults
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

Level 3.3 services may be offered in a freestanding, licensed facility in a community setting or a specialty unit within a licensed health care facility. Services must be based on a comprehensive diagnostic assessment which validates this ASAM level of care and requires an individualized plan of care. The plan of care must:

- Be developed with the participant and their legal guardian, if applicable, unless otherwise clinically indicated by an appropriately licensed clinical professional.
- Be reviewed by a licensed clinical professional at regular intervals. Reviews must include the need for continuing services, and recommended adjustments based on the participant's condition.
- Identify criteria for discharge. These may include the following:
    - Treatment goals have been met.
    - A lower level of care can be reasonably expected to meet the participant's current needs.
    - The participant and/or the family/guardians/primary caregivers withdraw the participant from treatment.
    - The participant has remained stable for a reasonable period of time and/or seems to have reached the maximum therapeutic benefit.
    - Continued stay guidelines are no longer met.

Covered services include, at minimum, psychological services, therapeutic and behavior modification services, psychotherapies (individual, group, family), nursing services, family visits, and psycho-educational services. Daily scheduled professional substance use disorder and mental health services are provided to facilitate skills needed for productive daily activity, and as applicable, successful reintegration into community living.

Intensive Care Coordination is provided by Magellan when a member is placed in residential care and the Multidisciplinary Team will include the residential care provider. The Individualized Treatment Plan will address the transition out of residential care and family involvement while the member is in the residential care facility.

Provider Requirements

SUD residential treatment facilities must meet the following requirements:

- Have a National Provider Identifier (NPI).

- Have current national accreditation to provide behavioral healthcare by one of the following bodies:
    - The Commission on Accreditation of Rehabilitation Facilities (CARF),
- Have current ASAM 3.3 Level of Care Certification from CARF for the level(s) the facility intends to deliver. Staff must meet the ASAM standards for the level of service provided.

Authorization

Prior authorization is required.

Payment Methodology

Code	Description	Unit
1002	ASAM 3.3	Unit = Per Diem
H0010	ASAM 3.3	Unit = Per Diem

Residential Treatment - Substance Use Disorder

ASAM Level 3.5/3.7

Description

A SUD Residential Facility (SUDRF), previously known as Substance Abuse Residential Facility (SARF), is a stand-alone, non-hospital facility that provides residential SUD services and co-occurring psychiatric care. Residential treatment offers 24-hour supportive treatment in a contained, safe, and structured environment to help individuals initiate or continue a recovery process, develop/practice early recovery skills such as resilience and refusal; experience the support of others in a recovery-oriented setting; and prepare for a successful transition to the community. Services are provided under the direction of a physician. Services include individual and group therapy and counseling, family counseling, laboratory tests, medications, and supplies, psychological testing, and room and board.

ASAM Level 3.5 is clinically managed high-intensity residential services intended for individuals who are medically stable but cannot safely participate in substance use disorder treatment without continuous 24-hour supervision by behavioral health professionals.

ASAM Level 3.7 is medically monitored intensive residential or inpatient treatment for individuals who need withdrawal management and monitoring in a 24-hour setting but do not need daily physician interaction. Services may be provided in an acute inpatient setting or in a residential treatment facility.

Member Eligibility

- Medicaid benefit for 18 years of age and older:
    - For ASAM 3.5/3.7 Certified facilities ,Medicaid reimbursement is allowable for stays up to 59 consecutive days with discharge on the 60th day.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. This funding can be used for adults. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

SUDRF services must be based on a comprehensive diagnostic assessment which validates this ASAM level of care and requires an individualized plan of care. The plan of care must:

- Be developed with the participant and their legal guardian, if applicable, unless otherwise clinically indicated by an appropriately licensed clinical professional.
- Be reviewed by a licensed clinical professional at regular intervals. Reviews must include the need for continuing services, and recommended adjustments based on the participant's condition.
- Identify criteria for discharge. These may include the following:
    - Treatment goals have been met.
    - A lower level of care can be reasonably expected to meet the participant's current needs.
    - The participant and/or the family/guardians/primary caregivers withdraw the participant from treatment.
    - The participant has remained stable for a reasonable period of time and/or seems to have reached the maximum therapeutic benefit.
    - Continued stay guidelines are no longer met.

Covered services include, at minimum, psychological services, therapeutic and behavior modification services, psychotherapies (individual, group, family), nursing services, family visits, and psycho-educational services. In addition, Level 3.7 facilities provide active intoxication and withdrawal management (including all medications and laboratory tests) and are capable of caring for most chronic conditions including exacerbations in the context of withdrawal and withdrawal management.

Policies and procedures for both 3.5 and 3.7 facilities must include medical screening and care for conditions requiring minor treatment and first aid as well as medical emergencies. A written provision for referral or transfer to a medical facility must be present when additional medical care is warranted.

Intensive Care Coordination is provided by Magellan when a member is placed in residential care and the Multidisciplinary Team will include the residential care provider. The Individualized

Treatment Plan will address the transition out of residential care and family involvement while the member is in the residential care facility.

Provider Requirements

SUD residential treatment facilities must meet the following requirements:

- Have a National Provider Identifier (NPI).
- Have current national accreditation to provide behavioral healthcare by one of the following bodies:
    - The Commission on Accreditation of Rehabilitation Facilities (CARF)
- Have current ASAM 3.5 and/or 3.7 Level of Care Certification from CARF for the level(s) the facility intends to deliver. Staff must meet the ASAM standards for the level of service provided.
    - Provide at least two forms of Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD).

Staff Type	**ASAM 3.5**	**ASAM 3.7**
Independently licensed clinicians or master level clinicians under supervisory protocol	Required	Required
CADCs/SUD counselors	Required	Required
Physician access	Consultation available	Active medical oversight
Nursing	Available as needed	24-hour nursing
Withdrawal management	Limited	Expected capability
Peer supports	May be used	May be used
Case Managers	May be used	May be used
Residential staff	24-hour supervision	24-hour supervision
Medical monitoring	No	Yes
Core clinical services including individual, family and group therapy must be provided at a minimum of 20 hours per week and delivered by the appropriate licensed and or certified required staff.		

Authorization

- Prior authorization is required for ASAM 3.5.
- Notice of admission is required for ASAM 3.7.

Payment Methodology

Code	Description	Unit
0192 or H0017	ASAM 3.5	Unit = Per Diem
0193 or H0017	ASAM 3.7	Unit = Per Diem

Inpatient SUD

ASAM Level 4.0

Description

ASAM Level 4.0 is medically managed intensive inpatient services for adults delivered in an acute inpatient setting. This level of care provides medically directed acute withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, and/or biomedical distress.

Member Eligibility

- Medicaid benefit for members 18 years of age or older.
- State funded benefits do not cover SUD medically managed intensive inpatient treatment.

Services

ASAM Level 4.0 provides medically managed intensive inpatient hospital services including semi-private accommodations, unless private accommodations are medically necessary and ordered by a physician, or if semi-private accommodations are unavailable in the facility.

Magellan assigns regionally based UM care managers and Transition Coordinators to inpatient facilities, providing designated support and discharge planning for all members who are admitted.

Provider Requirements

Inpatient SUD services are provided by the following provider types in accordance with IDAPA 16.03.09.700-706 and the requirements of the IBHP Contract.

- Acute Care Hospitals
- Psychiatric Hospitals

Certification/Accreditation

Have current national accreditation to provide behavioral healthcare by one of the following bodies:

- The Commission on Accreditation of Rehabilitation Facilities (CARF)

Facilities that provide ASAM Level 4.0 or 3.7, including hospital IMDs, must have a certification from the Commission on Accreditation of Rehabilitation Facilities (CARF). Staff must meet the ASAM standards for levels of service provided.

Authorization

Notice of admission (NOA) is required. With the NOA process, Magellan applies the same pre-screening process to determine the scope of benefits covered and the member's eligibility status, with a review of facility information to justify a continued stay.

Payment Methodology

- A variety of payment methodologies will be employed when reimbursing providers of inpatient services, including but not limited to per diems and APR DRGs.

Aftercare (Group) SUD

Description

After a member has successfully completed treatment for a SUD, they can meet with a group of others who have successfully completed treatment on a regular basis. Facilitated by a SUD professional, the group members support and help each other in recovery.

Member Eligibility

- Not a Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

A type of ongoing group, leveraging evidence-based models, that is provided to clients after successfully completing treatment to assist with maintaining recovery.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Licensed clinicians and paraprofessionals as defined per licensure by the Division of Occupational & Professional Licenses, IBADCC-certified alcohol/drug counselor, an IBADCC-certified advanced alcohol/drug counselor, a master addictions counselor certified by the national board for certified counselors or the NCCAP, or a licensed professional, as defined by Idaho Code 39-305A.
- Paraprofessionals (defined as individuals who are not independently licensed, including ADC). Paraprofessionals also includes individuals providing outpatient SUD treatment services within the IBHP may not be required to have a bachelor's degree; however, they must meet the minimum relevant certification available for the service rendered (e.g., SUDA).
- SUD providers must be trained in the ASAM Criteria®. This training must be documented in the individual's HR file through certificates, transcripts or CEUs. Documentation/attestation from a clinical supervisor that clinical supervision has included ASAM practice dimensions and placement criteria and that the individual is competent in ASAM is also acceptable.

Authorization
No authorization is required.

Payment Methodology

Code	Description	Unit	Duration/Setting
H0047	Aftercare for SUD	Unit = 15 minutes	Up to 3 hours/week for six months following discharge from treatment program.

Alcohol and Drug Testing

Description
The collection and analysis of blood, urine, hair, saliva, or another specimen type to evaluate for the presence of chemicals and contaminants left behind in the body after drug or alcohol use.

Member Eligibility
- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services
Presumptive/qualitative drug testing is used when necessary to determine the presence or absence of drugs or a Drug Class. Presumptive/qualitative drug testing is an important part of treatment for Substance Use Disorder (SUD).

Provider Requirements
- To be reimbursable, presumptive/qualitative drug tests must be determined to be the least restrictive, therapeutic, and medically necessary by a licensed or certified healthcare professional enrolled with the IBHP.
- Provider Proficiency (ASAM 3rd Edition): Providers responsible for ordering tests should be familiar with the limitations of presumptive and definitive testing. The IBHP does not cover definitive testing.
- All presumptive/qualitative drug testing services must be provided by or under the direction of a qualified behavioral health provider.

Authorization
No authorization is required.

Payment Methodology

The threshold is 24 units/tests (combination of 80305, 80306, 80307) per member per calendar year. Services over 24 units/tests must be prior authorized.

Code	Description	Unit
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service. (24 presumptive/quantitative drug tests per calendar year combination of 80305/80306/80307 tests).	Unit = Date of Service
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service. (24 presumptive/quantitative drug tests per calendar year combination of 80305/80306/80307 tests).	Unit = Date of Service
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service. (24 presumptive/quantitative drug tests per calendar year combination of 80305/80306/80307 tests).	Unit = Date of Service

Case Management for Individuals with Substance Use Disorder (SUD) – Basic and Intensive for an Individual / Basic and Intensive for Family

Description

Case management (CM), provided by a community-based provider, is available to members with a Substance Use Disorder (SUD) diagnosis who need help navigating the system or coordinating care. Case management refers to outcome-focused, strengths-based activities that assist members and their families by locating, accessing, coordinating and monitoring substance use, mental health, physical health, social services, educational, and other services and supports. Case management includes in-person activities or collateral contacts that directly benefit the member and the member's family. Case managers maintain reasonable caseloads, consistent with accepted industry standards based on intensity of their client's acuity, needs, and strengths.

Member Eligibility

- Not a Medicaid benefit. Please see case management – MH section for Medicaid-covered case management, which can be used for individuals with mental health, substance use, and co-occurring disorders.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

Services must not be a duplication of case management services a member may be receiving through Medicaid.

Services are community-based and may be provided via telehealth. Case management responsibilities include but are not limited to:

- Formally and informally assessing member's needs, through working with the member, completing needed documentation, gathering information from other sources (as necessary) to form a complete assessment of the member.
- Working with the member to develop a Case management plan that includes the members' strengths and needs as identified in the assessment of the member. The Case management plan must specify goals and actions that address the medical, social,

education, and other services/supports needed by the member including family engagement and/or enhancing sober supports.

- Case managers ensure members have a voice and choice in where, when, and from whom they receive medically necessary covered benefits.
- Working with the member through their transitions in the continuum of care, including, but not limited to, working with discharge coordinators from inpatient stays, Crisis Centers, EDs, and residential placements to assist with meeting the members' needs in the community.
- Advocating for members by educating, locating, accessing, linking, coordinating, advocating for, and monitoring services and supports that assist the member in meeting their needs.
- Monitoring appropriateness of care and adjusting as needed.
- Being knowledgeable and informed about the different Medicaid and state-funded programs and across-system processes.

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Provider who holds at least a bachelor's degree in a human services field.
- **Health and Human Services Field** means a degree in a discipline focused on the promotion of health, behavioral health, human development, social functioning, community well-being, or the delivery of health and social services. Examples include Social Work, Psychology, Counseling, Human Services, Nursing, Public Health, Sociology, Child Development, Marriage and Family Therapy, Addiction Studies, Behavioral Health, and other closely related fields.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
H0006	Case Management for SUD participants	Unit = 15 minutes
H0006 HS	Case Management for family of SUD participants	Unit = 15 minutes

Case management directly with the client must be billed to Medicaid if the member is enrolled in Medicaid. Case management without the client present can be funded as a Medicaid supplemental service.

Child Care

Description
Members with SUD who have children can get free or low-cost childcare while they are at an appointment receiving SUD services.

Member Eligibility
- Not a Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services
Care and supervision of a client's child(ren) while the client is participating in SUD clinical treatment and/or RSS.

Provider Requirements
Childcare provider must be enrolled with the Idaho Childcare Program (ICCP).

Authorization
Authorization is required.

Payment Methodology

Code	Description	Unit
T1009	Childcare for SUD	Unit = 15 minutes

Life Skills for SUD - Individual and Group

Description
Life skills are abilities and positive behaviors that enable individuals to effectively deal with the demands and challenges of life. Life skills services are non-clinical and are designed to enhance personal or family relationships, reduce work or family conflict, and develop attitudes and capabilities that support the adoption of healthy, recovery-oriented behaviors and healthy re-engagement with the community for participants.

Member Eligibility
- Not a Medicaid benefit.

- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

These programs may be provided on an individual basis or in a group setting and can include activities that are culturally, spiritually, and/ or gender specific. Key areas of focus in life skills services include:

- Effective communication and interpersonal skills
- Decision-making and problem-solving
- Critical thinking
- Emotional intelligence
- Assertiveness and self-control
- Resilience

Provider Requirements

Services may be provided by one of the following professionals operating within the scope of their practice:

- Individuals who have completed training to deliver the service or have a record of performance in the provision of the life skills service of at least one year.

Authorization

No authorization is required.

Payment Methodology

Code	Description	Unit
H2015	Life Skills Individual	Unit = 15 minutes
H2015	Life Skills Group	Unit = 15 minutes

Recovery Coaching Services

Description

Recovery coaching services are non-clinical services provided by Idaho-certified recovery coaches who support members aged 18 and older who have a primary diagnosis of a substance use disorder. Recovery coaching services are delivered in a range of environments that are chosen by the member including the home, community, and/or agency settings. Services may be initiated when there is a reasonable likelihood that such services will support the member in working toward self-directed recovery/wellness, building hope, empowerment, and resilience,

and natural supports in the community of their choice. Recovery Coaching Services may be delivered in-person or via telehealth and can be offered individually or in group settings.

Recovery coaching exists under the umbrella of peer support services. A Certified Recovery Coach supports members who are experiencing substance use challenges, helps members navigate barriers and obstacles in their recovery journey, and supports members in building natural supports in the community. Peer recovery coaching services include but are not limited to:

- Supporting the member in defining what is important to them related to their recovery, resiliency, and wellness.
- Supporting the member in choosing self-directed recovery/wellness goal(s) and how the peer recovery coach can support the member.
- Supporting the member in engaging in recovery support services, resources, and/or treatment based on the member's needs and goals.
- Collaborating with family members, service and treatment providers, other programs, and natural supports to assist the member's self-directed recovery/wellness (with the consent of the member).

Member Eligibility

- Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding;
    - Member is 18 years of age or older.
    - Member is living with a substance use disorder or co-occurring condition.
    - A licensed professional through the completion of a CDA has determined that recovery coaching will assist in the member's social, interpersonal, familial, and/or personal wellness.
    - The member is not at imminent risk to self, others, or property.
    - The member has demonstrated a need for support in self-directed recovery/wellness, building resilience, and living successfully in their community.

Services

The recovery coach will describe recovery coaching to the member so there is shared understanding about the role of a recovery coach and ensure the member voluntarily confirms the service is a good fit.

- **Recovery and wellness support, which includes**
    - Building rapport and establishing a peer-to-peer relationship rather than a hierarchical relationship
    - Applying principles of cultural awareness, competency, and humility

- Supporting the member with setting wellness goals and determining steps they would like to take to work toward their goals
- Assisting the member in identifying and building on their strengths and resiliencies
- Strategically sharing lived experience to relate to the member, using active listening, empathy, validation, and healthy boundaries
- Assisting the member in identifying natural support
- Supporting the member in connecting with other providers and/or resources when the member needs support that is outside the peer support role

- **Mentoring which includes**
  - Role modeling healthy behaviors, boundaries and communication skills
  - Supporting the member in determining activities they do or would like to try for wellness
  - Supporting the member in making self-directed choices
  - Supporting the member in identifying and establishing healthy relationships and boundaries
  - Supporting the member in practicing effective communication, conflict resolution, and problem solving

- **Self advocacy and empowerment**
  - Supporting members in developing self-advocacy skills and effectively communicating their needs, preferences, and recovery and wellness goals.
  - Advocating within systems to promote person-centered recovery/wellness support services
  - Helping the member understand their rights and responsibilities
  - Promoting the member's choice and self-determination
  - Discussing holistic approaches and multiple pathways to recovery/wellness based on what the member determines works for them
  - Using person-centered language with members and coworkers

- **Ethical responsibility**
  - Demonstrating alignment with the responsibilities and limitations of the Recovery Coach role
  - Maintaining privacy, confidentiality, and accurate documentation
  - Using supervision to address and resolve issues
  - Disclosing to supervisor personal relationships or limitations that may impact ability to perform peer support job duties

Recovery Coach services do not include the following:

- Recovery Coach services are not a replacement for case management. Recovery Coach services do not include functions typically performed by case managers such as care coordination or service linkage.
- Recovery Coach services are not a replacement for Skills-Building/CBRS. Recovery Coach services do not include functions typically performed by Skills-Building/CBRS such as teaching skills.
- Recovery Coach services are not a replacement for clinical services. Recovery Coach services do not include clinical or diagnostic functions such as processing trauma, therapeutic counseling, medication management, or medication monitoring.
- Recovery Coaching does not include routine transportation of members. Time spent in transit with a member may be reimbursable only when it is directly connected to a documented recovery goal and when transportation justification is clearly reflected in the member's service record. Transportation should be limited, infrequent, and non-recurring, and does not include routine activities such as regularly transporting a member to the grocery store. All available natural supports for transportation must be explored, exhausted, and documented in the member's service record before a Recovery Coach provides transportation.
- Recovery coaching does not include ongoing accompaniment of members at support group meetings. The Recovery Coach can support a member in attending a support group meeting for the first time. The Recovery Coach should assist the member in brainstorming about what will help them sustain their support group meeting attendance when the Recovery Coach is not accompanying them.

Goals and Documentation

- The recovery coach will support the member in defining what is important to them related to their recovery, resiliency, and wellness.
- Within 30 days of first engagement with the member, the recovery coach will support the member in defining a minimum of one recovery/wellness goal(s) and how the recovery coach will support the member.
- Goal documentation should follow best practices, for example SMART goals, PACT goals, or other goal setting formats.
- The member's recovery/wellness goal(s) should be self-directed, strengths-based, and chosen by the member. The recovery coach will collaborate with the member to specify the recovery coach's role in supporting the member and the frequency by which recovery coaching services will be delivered.
- Documentation should demonstrate a strengths-based, recovery and resiliency focus and the recovery coach's individualized support and benefit to the member.
- With the consent of the member, the recovery coach collaborates with family members, service and treatment providers, other programs, and natural supports to assist the member's self-directed recovery/wellness.

- Recovery Coaching Services are coordinated with other mental health/substance use professionals and adjunct social service agencies that are engaged with the member, when appropriate.
- Recovery Coaching Services should adhere to the Magellan supervisory protocol.

Groups

- Recovery coaching services can be billed at the group rate for a minimum of one IBHP member.
- The number of recovery coaching group facilitators should be appropriate for the size of the group. When two or more providers facilitate a recovery coaching group, only one provider can submit a claim for a member. Two or more providers facilitating the same group cannot bill for the same members within the group.
- Recovery coaching groups are non-clinical and must be facilitated by peer recovery coaches (PRC).
- Magellan encourages best practices in group facilitation for recovery coaching providers rendering recovery coaching in a group setting. The recovery coach supervisor, as defined by the Magellan supervisory protocol, should ensure that recovery coach group facilitators are equipped with the knowledge and skills to effectively lead groups. The supervisor should also determine whether initial or ongoing guidance on group facilitation is needed and determine how they will assist and supervise the recovery coach's development in providing group services. Find additional resources on the peer services page on MagellanofIdaho.com.
- Recovery coaching groups should incorporate trauma-informed principles. Group facilitators should strive to create a person-centered, recovery-oriented, culturally sensitive, and inclusive environment in which to conduct groups.
- Recovery coaching groups may support members in:
    - Discussing their experiences living with substance use challenges and learning from one another.
    - Developing a social support network and encouraging social interaction to develop confidence and assertiveness.
    - Reducing isolation and increasing hopefulness by hearing personal recovery stories and interacting with others who have similar life experiences.
    - Learning about themselves, discussing the direction they would like their lives to go, and determining steps for working toward their goals.
    - Receiving feedback from other peers instead of just professionals.

Provider Requirements

Providers of recovery coaching services must:

- Be 18 years of age or older.
- Have a high school diploma or equivalent.
- Be an individual with their own personal lived experience in recovery from a substance use condition.
- Be a current PRC, Provisional Peer Recovery Coach (P-PRC), as defined by the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC), with active certification.

- Provide services within an agency in the IBHP network.

Fidelity to Best Practices

- The member voluntarily chooses to participate in recovery coaching services.
- Recovery coaching services are non-clinical, and they are distinct from case management, Skills-Building/CBRS, and therapy.
- Recovery coaching services are inherently individualized, flexible, and based on the strengths and needs of the member.
- Magellan endorses the National Practice Guidelines for Peer Supporters published by the National Association of Peer Supporters (N.A.P.S.) as a framework for providing ethical and effective peer support/recovery coaching services. The guidelines can be found at magellanofidaho.com/idaho-peer-services.

Authorization

No initial prior authorization is required. 416 units of recovery coach services can be provided per member, per calendar year. Additional services must then be prior authorized via Magellan's prior authorization process. 16 units of recovery coach services may be initiated prior to the completion of the Comprehensive Diagnostic Assessment (CDA) as long as the member is also receiving Crisis Psychotherapy, Crisis Intervention, and/or Case Management prior to their CDA.

Payment Methodology

Code	Service	Unit	Threshold
H0038	Recovery Coaching One-on-One	Unit = 15 minutes	416 units per member, per calendar year Including individual and groups
H0038	Recovery Coaching Groups	Unit = 15 minutes	

Recovery coaching services can be billed at the group rate for a minimum of one IBHP member and up to 12 peers. Please visit magellanofidaho.com/w/rate-schedules to see applicable modifiers in the rate schedule.

Safe and Sober Housing (SSH), Enhanced Safe and Sober Housing (ESSH)

Description

An important component of a comprehensive Recovery-Oriented System of Care is providing a dignified, safe recovery environment where people in early recovery, as well as those who have a history of recovery, are given the time needed to rebuild their lives. Adult Safe and Sober Housing (SSH) is a staffed recovery residence that provides a safe, clean, and sober environment for adults with substance use disorders who are transitioning back into the community. Adult

Enhanced Safe and Sober Housing (ESSH) is focused on serving those individuals with a substance use disorder; a co-occurring mental health/SUD disorder, bed availability is prioritized for those who are transitioning out of one of the state psychiatric hospitals or a community hospital. This type of housing provides additional care to individuals needing a greater level of support than what is offered in traditional safe and sober housing.
Both types of temporary housing programs encourage recovery from alcohol and other drug use by providing a peer-to-peer recovery support system with staff to oversee the facilities and encourage the recovery process. Length of stay varies depending on the participant's needs, progress, and willingness to abide by residence guidelines and payment arrangements. While a participant resides in the recovery residence, they build a network of recovery resources that will continue to support the individual's recovery as they transition to living independently and productively in the community.

Clinical service programs may not be co-located in safe and sober homes. They must be located in separate buildings. SSHs do not provide clinical services.

Member Eligibility

- Not a Medicaid benefit.
    - Benefits may also be available for other eligible IBHP members without Medicaid to eligible adults 18 years old and older. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out. Individuals enrolled in Medicaid may be eligible for services that are not covered under their Medicaid benefit plan.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.
- To be eligible for Adult Safe and Sober Housing, an individual must be engaged in SUD treatment or has successfully completed treatment in the last 6 months.
- Members entering safe and sober housing should be medically stable and not actively experiencing detoxification or withdrawal symptoms that require medical management. Prior to admission, appropriate screening should be completed to confirm that the member is medically cleared and able to safely participate in the program.
- To be eligible for enhanced safe and sober housing, an individual must meet ALL of the following (A, B, and C).
    A. Individual must be engaged in SUD treatment or has successfully completed treatment in the last 6 months.
    B. Individual is experiencing or are at risk for homelessness or has a co-occurring diagnosis of substance use and Serious Mental Illness (SMI).
    C. Individual is part of one of these priority populations:
        1. State hospital discharges;
        2. Community hospital discharges;
        3. Mental health court participants.

Services

Guiding Principles:
All safe and sober housing and enhanced safe and sober housing are guided by the 10 principles as identified by the Substance Abuse and Mental Health Services Administration (SAMHSA). Best practices in the following areas support the principles of recovery housing:

1. Have a clear operational definition.
2. Recognize that a substance use disorder is a chronic condition requiring a range of recovery supports.
3. Recognize that co-occurring mental disorders often accompany substance use disorders.
4. Assess applicant needs and the appropriateness of the resident to meet these needs.
5. Promote and use evidence-based practices.
6. Maintain written policies, procedures, and resident expectations.
7. Ensure quality, integrity and resident safety.
8. Learn and practice cultural competence.
9. Maintain ongoing communication with interested parties and care specialists.
10. Evaluate program effectiveness and resident success.

Safe and Sober Housing:
A staff person must be available to residents 24 hours per day, seven days a week, and conduct daily site visits. At a minimum, staff must include:

1. A house manager who is on site at a minimum of 20 hours a week; a housing coordinator who is off site but monitors house activities at least daily.
2. House manager/coordinators should complete the following activities as part of their monitoring.
    a. Environmental inspection
    b. Monitoring cleanliness of home
    c. Searches as indicated and in compliance with SSH policies and procedures
    d. Coordination with treatment providers for each member
3. House managers and coordinators have at least one year of experience or training working with substance use disorder clients.
4. Daily check-ins are conducted by staff, house manager and/or house coordinator.
5. Daily check-ins include interacting with participants and confirming the well-being of each participant.
6. Staff model genuineness, empathy, and respect, and maintaining clear personal and professional boundaries with participants.
7. Staff are informed of and understand how co-occurring disorders and their symptoms can contribute to a participant's susceptibility to relapse.
8. Staff treat all participants with compassion and understanding regardless of mental health status.
9. Consistent with SAMHSA efforts to expand the use of naloxone, Magellan supports the recommendation that each house maintains naloxone on site and establishes a policy that addresses its use including:
    a. Staff training on how to recognize signs of opioid overdose;
    b. When and how to administer naloxone;
    c. How to support the client; and

d. When and how to engage EMS.

Enhanced Safe and Sober Housing:
A staff person must be *on site* and available to residents 24 hours per day, seven days a week. At a minimum, staff must include:

1. A program manager.
2. Staff person on site 24/7.
3. Must provide recovery wellness/recovery coaching/peer support specialist services.
4. A minimum of two hours per week of recovery coaching services, and participants are encouraged to participate in outside treatment or aftercare activities.
5. Collaboration with Idaho Housing and Finance and other housing agencies to help participants obtain a voucher for permanent housing.
6. Programs operate under the understanding that relapse does not necessarily result in automatic termination and instead establishes a plan for reestablishing compliance.
7. Programs are encouraged to provide application assistance for Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) for any participant that qualifies.
8. Consistent with SAMHSA efforts to expand the use of naloxone Magellan supports the recommendation that each house maintains naloxone/on site and establishes a policy that addresses its use including:
    a. Staff training on how to recognize signs of opioid overdose;
    b. When and how to administer naloxone;
    c. How to support the client; and
    d. When and how to engage EMS.

Provider Requirements

- SSH providers are stand-alone facilities approved by Magellan**.**
- As part of the credentialing and re-credentialing process, Magellan performs an initial and annual facility walk-through and chart reviews to ensure providers meet requirements.
- Providers must allow members choice of where they receive their services while residing in any SSH program. Member choice of service providers must be included in the member rights all members receive, and be reviewed with members at the time of admission.
- When submitting authorization requests for SSH, providers must include proof of enrollment or completion (within last 5 months) of treatment in a SUD ASAM level of care.
- Upon discharge from safe and sober housing, providers must submit discharge paperwork to Magellan.
- Providers must ensure that the diagnosis submitted on the authorization request aligns with the member's primary substance use disorder and is consistent with the eligibility requirements of the applicable funding source (SOR or SUPTR).

Authorization

Authorization is required. The benefit is limited to 180 days per episode for both ESSH and SSH.

Payment Methodology

Code	Description	Unit
H0044	Adult Safe & Sober Housing	Unit = Per diem (not including day of discharge)
H0044 (HF)	Enhanced Adult Safe and Sober Housing	Unit = Per diem (not including day of discharge)
S5199	Basic Housing Essentials (ESSH)	Unit = Dollar (Members are limited to $125.00 per treatment episode)
H0044	Program Fees SSH (Note: Program Fees are included in the daily rate for ESSH and not authorized separately)	Unit = Dollar ($100 per month)

Program Fees

SSH providers may not charge DBH-funded residents for SSH services. SSH providers may be reimbursed for program fees. Program fees should be equal between residents who are receiving funding and residents who are not. The fees may be imposed to cover the following expenses, and itemized records must be kept:

- Basic utilities
- Telephone services
- Cable/satellite TV
- Internet services (if available to client)
- Amenities fund to cover wear and tear on home living items (e.g., dishes, furniture, etc.)
- Cleaning supplies provided by provider

Payment Methodology

Code	Description	Unit
H0044	Adult Safe & Sober Housing	Unit = Per diem (not including day of discharge)
H0044 (HF)	Enhanced Adult Safe and Sober Housing	Unit = Per diem (not including day of discharge)
H0044	Program Fees SSH	Unit = Dollar ($100 per month)

	(Note: Program Fees are included in the daily rate for ESSH and not authorized separately)	

Basic Housing Essentials

Description

These are basic items – bedding, towels, soap, toothpaste, etc., – for members aged 18 and older who are engaged in an Enhanced Safe and Sober Housing (ESSH) Program.

Member Eligibility

- Not a Medicaid benefit.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

Used to cover costs such as bedding, towels, and hygiene items.

Provider Requirements

N/A.

Authorization

No authorization is required outside of ESSH authorization.
Members are limited to $125.00 per treatment episode.

Payment Methodology

Code	Description	Unit
S5199	Basic Housing Essentials	Unit = Dollar (Members are limited to $125.00 per treatment episode)

Transportation Flat Fee and Pick Up

Description

Adults and children with SUD who do not have Medicaid can get free or low-cost travel to a treatment facility and appointments.

Member Eligibility

- Not a Medicaid benefit.
    - Medicaid members can access Non-Emergency Medical Transportation (NEMT) provider network.
- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

Bus ticket and airfare, ground transportation to treatment appointments, 12-step etc. Authorization date will cover the day of purchase only.

Provider Requirements

Transportation provider must be in the Medicaid Non-Emergency Medical Transportation (NEMT) provider network.

Authorization

No authorization is required.

Payment Methodology

Code	Description
T2003	Transportation for SUD

Transportation of a Client

Description

Adults and children with SUD who do not have Medicaid can get free or low-cost travel to a treatment facility and recovery/treatment-related appointments.

Member Eligibility

- Not a Medicaid benefit.
    - Medicaid beneficiaries can access Non-Emergency Medical Transportation (NEMT) provider network.

- Benefits may also be available for other eligible IBHP members without Medicaid. These benefits are funded through the IDHW. Funding is limited and may only be used until funding has run out.
    - This is a covered service under SUD funding; funding is limited and may only be used until funding has run out.

Services

Transportation services are provided to clients who are engaged in treatment and/or recovery support services and who have no other means of obtaining transportation to and from those services. Reimbursement is not available for transportation services to and from employment and to and from school.

Provider Requirements

Transportation provider must be in the Medicaid NEMT provider network.

Authorization

No authorization is required.

Payment Methodology

Code	**Description**
A0080	Transportation for SUD