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Clinical UM Guideline

Subject: Intensive In-home Behavioral Health Services
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Description

This document addresses intensive in-home behavioral health services (II-HBHS). II-HBHS are a range of therapy services provided face-to-face in the home to address symptoms and behaviors that, as the result of a psychiatric disorder or substance use disorder, put the members and others at risk of harm. “Home” describes a family living arrangement that reflects a sustained (months to lifetime) commitment to the member, that is, a commitment based on parenthood, marriage, kinship, adoption, guardianship, or other close personal relationship. The provided service includes member and family interventions intended to help the member and family, especially responsible adults, to address the symptoms and behaviors related to a psychiatric disorder or substance use disorder in a caring fashion that reduces the risk of harm with the goal of returning the member to a status where services can be continued in a setting outside the home. Intensity or hours of II-HBHS is tied to the risk of harm through a treatment plan and goals that specify how hours of service, greater than those typical of office or clinic care, (which is usually no more than an hour per visit and often less than every week), are needed to reduce risk and improve health. A description of the critical relationship between the home environment and the symptoms and behaviors that create risk is a necessary component of the treatment plan. Treatment in the home that addresses individual and family issues related to the setting separates II-HBHS from facility-based services, such as Partial Hospital Programs (PHP) and Intensive Outpatient Programs (IOP). Achieving harm reduction and improved health are anticipated to result in use of office-based services.

The medical necessity criteria outlined in this document relating to psychiatric disorders or mood/behavior disturbance treatment includes two categories; Severity of Illness and Continued Stay. Severity of Illness criteria include descriptions of the member’s condition and circumstances. For continued authorization of the requested service, Continued Stay criteria must be met, along with Severity of Illness criteria.

The member’s symptoms or condition should meet diagnostic criteria for a behavioral health condition, as defined in the most recent edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). The diagnosis should be consistent with symptoms and the primary focus of treatment.

Note: Benefits, state mandates and regulatory requirements should be verified prior to application of criteria listed below. This document does not address Adaptive Behavioral Treatment (ABT) or Applied Behavior Analysis (ABA).

Please see the following related documents for additional information:

- CG-MED-19 Custodial Care
- CG-MED-23 Home Health

Clinical Indications

Medically Necessary:

Intensive in-home behavioral health services may be considered **medically necessary** when **ALL** of the following selection criteria are met (A, B and C):

A. There is documentation that **all** of the following **Severity of Illness** criteria are met (1 through 7):
   1. Specific psychiatric symptoms or disturbances of mood or behavior, consistent with the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders/International Classification of Diseases diagnosis listed, are linked to functional impairment and risk of serious harm; **and**
   2. There are specific deficits directly related to the intensive in-home behavioral health services; **and**
   3. The member and significant others demonstrate motivation for treatment, are capable of benefiting from the treatment approach planned, and participate in treatment; **and**
   4. The symptoms and functional impairment associated with the individual’s psychiatric disorder or mood/behavioral disturbance are expected to improve with intensive in-home behavioral health services based on targeting achievable individual goals; **and**
   5. There is a described risk for behavioral or functional regression without intensive in-home behavioral health services; **and**
   6. There is demonstrated evidence of significant variability in the day-to-day capacity of the member to cope with life situations; **and**
   7. There is need for direct monitoring less than daily but more often than weekly; **and**

B. A diagnosis has been documented by a licensed medical professional acting within their scope of licensed practice which confirms a psychiatric diagnosis or significant mood or behavioral disturbance, as defined within the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases; **and**

C. A person-centered treatment plan has been developed that includes **all** of the following (1 through 4):
   1. Identifies specific behavioral, psychological, family-based, or community-based behavioral impairments or symptoms that interfere with normal functions, (which may include social, adaptive, psychological or other functional impairments to performing activities of daily living and social interactions); **and**
   2. Specific individual age-appropriate goals have been documented which can be objectively measured based on standardized assessments related to the diagnosed condition or conditions and linked to specific targeted symptoms, behaviors and functional impairments which are to be addressed by the treatment plan*; **and**
   3. A specific timeline is documented in the treatment plan which specifies the intensity of services (number of visits per week and hours per visit) and duration of intensive in-home behavioral health services, (which is usually not less than for 1 month and not more than for 6 months), after which a follow/up re-evaluation is to be performed by an appropriately licensed medical professional for the purpose of determining the individual’s symptomatic or behavioral progress and possible need for continuation of services; **and**

4. Specific intensive in-home behavioral health services are to be delivered by appropriately licensed or certified providers acting within their respective scopes of practice.

***Note:** Each goal specified within the individualized treatment plan should include documentation of:

- Baseline behavioral measurements of function;**and**
- The individual's symptomatic or behavioral progress, to date, with assessment of specific measures of progress made (for example, in areas such as social skills, communication skills, activities of daily living or specifically targeted functional impairments); **and**
- The anticipated **duration of treatment** which includes a timeline for achievement based on both the initial assessment and subsequent reassessments to be performed *not less often than every 4 weeks.* ***The duration of treatment, along with the treatment plan goals and documented behavioral progress, is to be reassessed every month over the duration of the intensive in-home behavioral health services interventions*** initially considered medically necessary when the above criteria are met.

Continuation of intensive in-home behavioral health services is considered**medically necessary** when the member continues to meet Severity of Illness criteria (see above) and has demonstrated **one** of the following (A or B):

A. Measurable progress with the symptoms and behaviors associated with the psychiatric diagnosis or disturbance of mood or behavior is documented *not less often than every 4 weeks* and all the following are met (1 through 3):
    1. The member and significant others are cooperative with treatment;**and**
    2. The member and significant others are meeting treatment plan goals;**and**
    3. The member's symptoms or disturbances of mood or behavior are at risk for relapse or deterioration without continued intensive in-home behavioral health services; **or**
B. If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still considered achievable by the appropriately licensed medical professional who conducts the re-assessment.

Not Medically Necessary:

Intensive in-home behavioral health services are considered**not medically necessary** when the above criteria are not met or when a reassessment performed by an appropriately licensed medical professional has determined either (A or B):

A. No measurable improvement in symptoms or functional impairments has been documented;**or**
B. The individual's condition (symptoms or ability to function) has deteriorated and now warrants a more intensive level of care (for example, inpatient or more intensive supervised outpatient behavioral health care).

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Note: The following list of procedure codes are examples only and may not represent all codes being used for behavioral health services. Please contact the member's plan for applicable coding conventions as these may vary.

When services may be Medically Necessary when criteria are met:

HCPCS	
H0004	Behavioral health counseling and therapy, per 15 minutes
H0006	Alcohol and/or drug services; case management
H0023	Behavioral health outreach service (planned approach to reach a targeted population)
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H2015	Comprehensive community support services, per 15 minutes
H2019	Therapeutic behavioral services, per 15 minutes
H2020	Therapeutic behavioral services, per diem

ICD-10 Diagnosis	
F01.50-F99	Mental, behavioral and neurodevelopmental disorders

When services are Not Medically Necessary:
For the procedure and diagnosis codes listed above when criteria are not met or for situations designated in the Clinical Indications section as not medically necessary.

Discussion/General Information

Intensive in-home behavioral health services (II-HBHS) are multi-disciplinary, evidence-based interventions targeting children, adolescents and adults considered to be at high risk for hospitalization, re-hospitalization, or other types of facility-based services, due to severe behavioral health disorders and behaviors. Unlike medical Home Health Services for treatments, such as physical therapy, occupational therapy, etc., individuals receiving II-HBHS are *not* necessarily confined to home, (that is, homebound). These services or treatments are provided in the home because it is the best setting for addressing ongoing behavioral impairments related to individual, family or social interactions that put the member and others at risk. In-home treatment is oriented to the specific dysfunctional behaviors that are adversely affecting the individual's ability to function or to perform activities of daily living (ADL) in the member's environment. The services should have a positive effect on those close to the member, for the purpose of improving the home environment. II-HBHS is a combination of individual, group and family therapy.

Psychiatric disorders that impact the individual's ability to function or to perform ADL can include a wide range of behavioral health diagnoses. The illnesses are described in current diagnostic sources, which primarily include the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (DSM, ICD). The type of service needed reflects the gravity and acuity of symptoms. The initial course of II-HBHS requires determination of the appropriate intensity of care (number of visits per week and hours per visit) and duration of care (usually 1 to 6 months for initial services), in order to help ensure the potential safety of the member and any minor dependents. Safety concerns of other family members, people close to the individual and society at large should also receive attention. The criteria in this document are intended to address those at-risk individuals who, due to either psychiatric disorders or disturbances of mood or behavior, are considered to be

in need of focused, ongoing, in-home services to assist with targeted behavioral impairments in performing ADL or other targeted functional activities. There should be a reasonable expectation that the member's symptoms or level of functioning will be stabilized or improved within a reasonable period of II-HBHS known to be effective for the individual's symptoms or mood/behavioral disturbance.

II-HBHS should include focused individualized coordination of care utilizing a detailed treatment plan which is determined by an appropriately trained and licensed medical professional, acting within their scope of practice, in collaboration with the member and close family members and significant others. Continued services require reassessment by the medical professional at set time intervals, in order to determine if the individual is demonstrating behavioral improvement and willingness to participate in the treatment plan. The core clinical staff members involved in the delivery of II-HBHS may include: psychiatrists, psychologists, social workers, counselors (including addiction counselors when appropriate), medical and nursing personnel. Occupational, recreational and creative arts therapists may also provide services. Paraprofessionals, that is, non-degreed individuals, students and interns under the supervision of appropriate professionals, may also be included.

II-HBHS are usually provided at least 2-3 times per week for 1-2 hours per visit for the initial intensity of care, which varies depending on individual severity of symptoms and circumstances, but usually extends for an initial duration of care of at least 4 weeks before reassessment is conducted. With symptom improvement, a gradual decrease in services per week may occur to help plan for successful discharge and greater independent functioning. Examples of active, age-appropriate treatment may include: individual psychotherapy, family therapy, psycho-educational (theme-specific) groups, skills training, expressive/activity therapies, medication evaluation/management, and group therapy. For children and adolescents, family therapy, (including significant others), should be provided at least one time each week. Group therapy should be individualized to meet the member's needs, based on specific clinical needs or functional level.

Throughout provision of II-HBHS a detailed clinical record should be maintained. The record should contain an initial assessment, physician orders and certification of need for this level of care, psychiatric assessment, and an individualized, age-appropriate treatment plan with goals that address the individual's needs. Goals should be achievable within the timeframe of the program. Member and family signatures, especially the signature of a responsible adult, should be part of the treatment plan. The record should contain information about medication management, progress notes and, at completion, a discharge summary to be shared with all involved providers, especially those who will be providing any ongoing care, as warranted.

Individualized goals should target resolution of specific symptoms or stabilization of mood and/or behavior consistent with the DSM/ICD diagnosis. Goals should also target specific domains of functional impairment. Goals should be achievable within the timeframe of the program. If a substance use disorder is known to be present or thought to be present, a substance use evaluation should have also been performed and treatment provided with the cooperation of the member. Community/natural supports and resources should be identified and utilized or skills to develop community/natural supports should be a treatment goal, including school/work interventions, self-help or diagnosis-specific support groups, spiritual/religious, and community recreational activities. Family member(s) and significant other's participation in treatment or family therapy should also be documented. Treatment should not be duplicative of services being provided by another clinician for the same functional impairments/diagnoses. There should be adherence to documentation and treatment plan guidelines.

In 2014, Love and colleagues published observations based on archival data from a convenience sample of youth clients in a child mental health system. The purpose of this observational data collection was to examine the frequency of therapist-identified treatment targets and progress ratings for these targets during the first six months of II-HBHS. The study sample consisted of 790 youths aged 7–18 (M=14.08; standard deviation [SD]=2.87) receiving II-HBHS from a comprehensive, state-funded, mental health system for a minimum of 90 days (to ensure sufficient exposure to therapy). The mean treatment episode length was 229 days (SD=132.5), with a range of 788 days (90 minimum, 878 maximum; 25th quartile=136, 50th quartile=188, 75th quartile=282). All study questions were addressed using data from the first 180 days (6 months) of treatment, in order to allow sufficient time for treatment response to emerge while reducing the likelihood that episode length would be a confounding variable in the results. The mean number of records for this period was 5.14 (SD=1.47), which indicated that, on average, youth treatment data were available for at least 5 of the 6 months encompassed by the study window. The Monthly Treatment and Progress Summary (MTPS) was used for each subject, which is a therapist-report measure that tracks service utilization information, including service format and setting, treatment targets, therapist intervention strategies, and clinical progress ratings on identified targets. The MTPS also includes a list of 48 predetermined treatment targets from which the therapist checks off up to 10 targets that were the focus of treatment during the reporting month. On average across the sample, 47.9% of the targets chosen at least once during a youth's treatment episode aligned with one of the four most common DSM categories of childhood disorders. The most frequently endorsed diagnosis-aligned targets were oppositional/non-compliant behavior (71.5%), activity involvement (66.2%), anger (64.3%), and aggression (47.9%), which is consistent with the high prevalence of disruptive behavior and depressive mood disorders present in this age group sample. The mean level of improvement across all targets was 3.10 (SD=0.42) on the 0-to-6 scale, which aligns with the fourth MTPS rating anchor which was "Some improvement" (31–50%).

Among targets appearing in at least 5% of the sample, "Treatment Engagement" demonstrated the highest level of improvement (M=3.75; SD=1.54), while "Learning Disorder" demonstrated the lowest (M=2.63; SD=1.36). Several of the most commonly endorsed targets were among those demonstrating the higher levels of improvement, including "Activity Involvement" (M=3.64; SD=1.50), "Positive Peer Interaction" (M=3.62; SD=1.32), and "Aggression" (M=3.61; SD=1.40). Among targets showing the least improvement, several were associated with neurobiological impairments, including "Learning Disorder, Mania (M=2.36; SD=1.74) and Psychosis (M=2.44; SD=2.06)." The mean rate to highest improvement was 81 days (SD=17.4), which were considered significant and positively correlated ($r=0.66$; $p<0.001$), indicating a trend towards higher levels of improvement taking longer to be achieved. The authors concluded that, while the results were promising, limitations and confounding factors, (such as differing subject age at entry and types of comorbidity, differing therapist training and experience, and differing types and ordering of interventional strategies) remain to be investigated further regarding the best use of treatment targets in delivering II-HBHS (Love, 2014). These reports give a clear picture of troublesome symptoms and behaviors thought to merit II-HBHS and support the inclusion of family and significant others.

To date, published research suggesting beneficial outcomes specific to II-HBHS is limited but encouraging. In 2003, Timko and colleagues published results of a comparative study of standard vs. intensive outpatient care for substance abuse and psychiatric treatment which provided the following conclusions:

> Intensive outpatient mental health programs are proliferating rapidly. However, findings suggest that intensive treatment may be no more effective than standard treatment. This study compared standard to intensive outpatient programs, within both the psychiatric and substance abuse systems of care, on organization, staffing, and treatment orientation, clinical management practices, and services. A total of 723 (95% of those eligible) Department of Veterans Affairs programs were surveyed nationwide. Psychiatric intensive programs have responded appropriately to their more severely ill patients, in terms of the amount and orientation of care and having a rehabilitation focus. However, the relative lack of basic psychiatric services in psychiatric intensive programs and the overall similarity of substance abuse standards and intensive programs may explain why intensive programs have not yielded patient outcomes that are superior to those of standard programs. Mental health system planners should consider

differentiating intensive programs using broader criteria and methods.

Some research has been published regarding the impact of II-HBHS on outcomes for perinatal women and their young children, particularly for at-risk individuals in lower socio-economic groups with depressive mood disorders occurring during the pregnancy or demonstrating symptoms during the post-partum period (up to 6 months following delivery). The available evidence has shown some significant improvements in the mothers' depressive mood and social functioning at 6 months post-partum with in-home interventions. However, additional research is needed to further elucidate the potential for positive outcomes in parenting skills and child adjustments (Ammerman, 2013, 2015; Tandon, 2014).

In addition to medical literature, federal and state sources provide information about II-HBHS. This guideline incorporates this information and is largely based on federal and state regulations regarding II-HBHS which include:

- Intensive, home-based services designed to address specific mental or nervous conditions in a child;
- Evidence-based family-focused therapy that specializes in the treatment of juvenile substance use disorders;
- Short-term family therapy intervention;
- Intensive, family-based and community-based treatment programs that focus on addressing environmental systems that impact chronic and violent juvenile offenders;
- Other home-based therapeutic interventions for children;
- Psychological and neuropsychological testing conducted by an appropriately licensed health care provider;
- Evidence-based maternal, infant and early childhood home visitation services, as described in Section 2951 of the Patient Protection and Affordable Care Act P. L. 111-148, as amended from time to time, that are designed to improve health outcomes for pregnant women, postpartum mothers and newborns and children, including, but not limited to, maternal substance use disorders or depression and relationship-focused interventions for children with mental or nervous conditions or substance use disorders;
- Chemical maintenance treatment, as defined in Section 19a-495-570 of the regulations of Connecticut state agencies; and
- Extended day treatment programs.

Definitions

Intensive In-home Services (IIH): According to the state of Virginia Department of Medical Assistance Services (DMAS), IIH services for children/adolescents under age 21 are intensive, time-limited interventions provided typically, but not solely, in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement, due to the documented clinical needs of the child (Virginia DMAS, H-2012; 2013).

Serious Emotional Disturbance: A person under the age of 21 years who is all of the following:

- Diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association; and
- Exhibits behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community, which behaviors are not considered a temporary response to a stressful situation.

Severe Mental Illness (also known as serious and persistent mental illness): A mental, behavioral or emotional disorder according to the most recent edition of the DSM, in members 18 years and older, that results in functional impairment which substantially interferes with, or limits, one or more major life activities (for example, maintaining interpersonal relationships, ADL, self-care, employment, recreation) that have occurred within the last year. All of these disorders may have acute episodes, as part of the chronic course of the disorder. An organization may also use its state definition or the definition of another appropriate regulatory authority (SAMHSA, 2022).

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Peer Reviewed Publications:

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Government Agency, Medical Society, and Other Authoritative Publications:

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The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.

History

Status	Date	Action
Reviewed	11/09/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated References section.
Reviewed	11/10/2022	MPTAC review. Updated References section.
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