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

Effective July 1, 2024

Note: Continued changes will be made to enhance the Idaho Behavioral Health Plan service delivery. 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.
- State funded benefits may also be available.

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.

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 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.
- State funded benefits may also be available.

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.

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 Division of Occupational and Professional Licenses and IDAPA; and/or practicing under a supervisory protocol.

Authorization
Authorization is not 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.
- State funded benefits may also be available.

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.

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 and IDAPA; and/or practicing under a supervisory protocol.

Authorization
No authorization 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.
- State funded benefits may also be available.

Services
Multiple-Family Group Psychotherapy treatment allows beneficiaries and their families with similar issues to meet face-to-face 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 Division of Occupational and Professional Licenses and IDAPA; and/or practicing under a supervisory protocol.

Authorization
No authorization 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). FPE is based on a core set of practice principles as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA). These principles form the foundation of the evidence-based practice and guide practitioners in delivering effective FPE services. 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. These sessions are components of the evidence-based protocol as defined in the SAMHSA Evidence-Based Practice KIT for Family Psychoeducation. Providers may follow a different Evidence-Based Practice (EBP) from the one defined by SAMHSA for Family Psychoeducation as 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).

Member Eligibility
- Medicaid benefit.
- State funded benefits may also be available.

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 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.
- State funded benefits may also be available for youth ages 15-30 years old.

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 Division of Occupational and Professional Licenses 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; obtain certification within first year.

Authorization

Notice of Admission.

Payment Methodology

Code	Description	Unit
H0046	Early Serious Mental Illness (ESMI)	Unit = Monthly
H2024	Supported Education and Employment Specialist (SEES)	Unit = Monthly

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 CoE ESMI Competency Center.

Fidelity Monitoring

The CoE 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.
- State funded benefits may also be available.

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 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.
- State funded benefits may also be available.

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 required.

Payment Methodology

Code	Description

96372	Therapeutic injection; subcutaneous or intramuscular

Electroconvulsive Therapy (ECT)

Description

Electroconvulsive therapy (ECT) is a medical treatment most used in patients with severe major depression or bipolar disorder that has not responded to other treatments. ECT involves a brief electrical stimulation of the brain while the patient is under anesthesia. ECT can be delivered during an inpatient mental health stay or in the community.

Member Eligibility

- Medicaid benefit.
- State funded benefits may also be available.

Services

ECT treatments are typically delivered two to three times a week for a total of six to 12 sessions depending on the severity of the member's symptoms and how quickly the member responds to treatment.

Provider Requirements

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

- Psychiatrists along with Nurse and/or Physician Assistant.

Authorization

Authorization is required.

Payment Methodology

Code	Description	Unit
90870	Other Psychiatric services or procedures. Outpatient setting.	Unit = Per Visit
0901	Electroconvulsive therapy (ECT)	Unit = Per Session

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

- State funded benefits may be available.

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.
- State funded benefits may also be available.

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 Division of Occupational and Professional Licenses 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 psychologist.
        - The supervising psychologist must have face-to-face 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

Authorization is not required until the threshold of 14 units 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 units 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.
- State funded benefits may also be available.

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 or psychology extenders as defined per licensure by the Division of Occupational and Professional Licenses 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 face-to-face 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

Authorization is not required until the threshold of 14 units is met.

Payment Methodology

Code	Description	Threshold
96116	Neurobehavioral status exam by professional; first hour	14 units 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	

Code	Description	Threshold
	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	

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 (pending approval of a State Plan Amendment from the Centers for Medicare & Medicaid Services).
- State funded benefits may also be available.

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 at least one contact with the treatment team every 48 hours for an average of two hours of face-to-face contact per week. 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

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

Authorization is required. Magellan will authorize up to six months initially and then as needed through ongoing concurrent reviews.

Payment Methodology

Code	Description	Unit
H0039	ACT Services, Monthly	Unit = 1 Month
T2003 *Add on code	Transportation Flat Fee for Travel Expenses	Unit = 1 Month

Training*

To promote fidelity to the model, Magellan partners with the Division of Behavioral Health (DBH) Center of Excellence (CoE) Assertive Community Treatment (ACT) Competency Center,

also known as Idaho ACT Center of Excellence (ID-ACT-CoE), to deliver ongoing ACT provider training and technical assistance: CoE ACT Competency Center. Magellan requires each team to follow, meet, and maintain fidelity with the National Program Standards for ACT Teams currently available at: National Program Standards for ACT and Substance Abuse and Mental Health Services Administration (SAMHSA) Assertive Community Treatment Guidelines currently available at: SAMHSA Assertive Community Treatment Guidelines.

Fidelity Monitoring*

The CoE monitors fidelity to the ACT model via the national standards and the Tool for Measurement of Assertive Community Treatment (TMACT).

*New IBHP effective July 1, 2024: The DBH CoE will provide training for new ACT providers as a foundation for the implementation of an ACT team. It is anticipated that it will take ACT teams 9 to 18 months to obtain fidelity to the model. The CoE will not begin fidelity reviews until 6 to 12 months after the implementation of an ACT team, allowing ACT teams to have a "grace period" in order to provide services while being trained.

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.
- State funded benefits may also be available.

Services

Magellan does not specify the assessment tool providers should use. However, the tool used should include the following domains: Presenting concerns, 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. The mental status exam includes an evaluation of suicidal or homicidal risk. If a substance use issue is identified, the provider should complete the ASAM assessment and use ASAM Criteria to determine the level of intervention that best meets the needs of the member.

The *Combined Assessment* that Magellan has created includes all of 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 still use it to enter and submit federally required reporting data. The *Combined Assessment* tool allows providers to enter data only into those required sections instead of utilizing the entire tool.

Providers are required to utilize the Magellan Healthcare of Idaho Payer Space in Availity Essentials to access and submit the Comprehensive Diagnostic Assessments (CDA) or upload their assessment 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*

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 around best practices for the completion of the CDA, including when services could begin using an alternative assessment.

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 Division of Occupational and Professional Licenses and/or practicing under Magellan's supervisory protocol.

Authorization

No authorization required.

Payment Methodology

Code	Description	Unit
90791	Comprehensive Diagnostic Assessment	Unit = per session

Functional Assessment

Description

A Functional Assessment is a multi-purpose strengths-based assessment tool that is used 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.
- State funded benefits may also be available.

Services

The Functional Assessment is completed in-person at intake as a result of the Comprehensive Diagnostic Assessment 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.
- 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.

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 required.

Payment Methodology

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

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.

- State funded benefits may also be available.

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

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 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 service is designed to build and reinforce functional skills and confidence. The goal is to improve the person's abilities and confidence for successful independent living.

Member Eligibility

- Medicaid benefit.
- State funded benefits may also be available.

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 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.

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

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 after a threshold of 308 units per calendar year is met.

Payment Methodology

CPT Code	Description	Unit
H2017	Skills Building/CBRS	Unit = 15 minutes
H0032	Individualized Skills Building Treatment Plan – Billed by clinician and paraprofessional for teaming with patient present	Unit = 15 minutes

Skills Training and Development (STAD) or Partial Care

Description

Skills Training and Development (STAD) is treatment for adults and children 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.
- State funded benefits may also be available.

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

Authorization

No authorization required.

Payment Methodology

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

Case Management Mental Health

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 Principles of Care and Practice Model and use Multi-Disciplinary Teams (MDTs for adults with SMI or SPMI.

Case management includes face-to-face 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.
- State funded benefits may also be available.
- 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.
- 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 member's 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.

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.

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
- Licensed Clinicians

Authorization

Authorization is not required until the threshold of 240 units is met.

Payment Methodology

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

Targeted Care Coordination (TCC)

Description

Targeted Care Coordination (TCC) providers are formally trained to facilitate a Child and Family Team (CFT) and create person-centered service plans. Targeted Care Coordinators also assist youth and their family to locate, coordinate, facilitate, advocate for, and monitor services as identified through a child and family teaming process which includes assessment and reassessment of needs and strengths.

Member Eligibility

- Medicaid benefit.
- State funded benefits may also be available.

Note: Providers will be able to continue to serve existing members receiving TCC services and bill for TCC services through Dec. 31, 2024. This will provide Magellan's Intensive Care Coordinators six months to transition members to the new ICC services and to begin offering Idaho WInS services within the network.

With this transition, Magellan will not be endorsing new providers to offer TCC services. Starting July 1, 2024, new members needing this care will begin services with ICC or Idaho WInS rather than TCC.

Services

Targeted Care Coordination occurs through face-to-face or telephonic contact and is not intended to be duplicative of any other service. Targeted Care Coordination services vary in intensity, frequency, and duration in order to support the member's ability to access, coordinate, and utilize services and social resources that support the member in reaching the goals of their coordinated care plan. Targeted Care Coordination may be delivered as a community-based service or in the outpatient clinic setting.

Provider Requirements

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

- Holds at least a bachelor's level in a human services field, is practicing under Magellan's approved supervision policy, and has completed the TCC endorsement training prior to June 30, 2024.

OR

- Holds at least a bachelor's degree, is a Certified Case Manager (CCM) through the Commission for Case Manager Certification (***ccmcertification.org***) and has completed the required TCC endorsement training prior to June 30, 2024.

Authorization
Authorization not required.

Payment Methodology

CPT Code	Description	Unit
T1017	Targeted Care Coordination	Unit = 15 minutes

SSI/SSDI Outreach, Access, and Recovery

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.
- 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 SOARtraining@dhw.idaho.gov. Idaho SOAR Website

Authorization
No authorization required.

Payment Methodology

Code	Description	Unit

H0006	SSI/SSDI Application Assistance	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 condition. Services are delivered in a range of environments that are chosen by the member including the home, community, and/or agency settings. 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. Adult Peer Support Services may be delivered face-to-face or via telehealth and can be offered individually and/or in group settings.

A Certified Peer Support Specialist supports members who are experiencing mental health or co-occurring challenges, 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. Adult Peer Support 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 support specialist can support the member.
- Supporting the member in engaging in supportive services, resources, and/or treatment based on the member's needs and goals.
- 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 18 years of age or older.
- State funded benefits may also be available.
- A licensed professional 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.
- The CPSS will support the member in defining what is important to them related to their recovery, resiliency, and wellness.
- Providers must have procedures to evaluate outcomes for adult peer support services. Within 30 days of first engagement with the member, the CPSS will support the member in completing the **Peer Support Outcomes Measure (PSOM) in Availity Essentials.** Following the initial PSOM, members should then complete the PSOM every 90 days, and within 30 days prior to disenrollment/graduation from peer support services.
- 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.
- The member's recovery/wellness goal(s) should be self-directed, strengths-based, and chosen by the member. The CPSS will collaborate with the member to specify the CPSS's role in supporting the member and the frequency with which peer support services will be delivered.
- Documentation should demonstrate a strengths-based, recovery and resiliency focus and the CPSS's individualized support and benefit to the member.
- With the consent of the member, the CPSS collaborates with family members, service and treatment providers, other programs, and natural supports to assist the member's self-directed recovery/wellness.
- Adult Peer Support Services are coordinated with other mental health professionals and adjunct social service agencies that are engaged with the member, when appropriate.
- Adult Peer Support Services should adhere to the Magellan supervisory protocol.

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.
- Provide services within an agency in the Magellan of Idaho 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 and CBRS.

- Peer 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 peer support services.

Authorization

No authorization required. 416 units of Adult Peer Support Services 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	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.

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 youth or young adult member 21 years of age and younger who has a diagnosis of SED, mental health condition, or co-occurring conditions. Services are delivered in a range of environments that are chosen by the parent/caregiver including the home, community, and/or agency settings. 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. Family Support Services may be delivered face-to-face or via telehealth and can be offered individually or in group settings.

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/young adults 21 years of age or younger.
- State funded benefits may also be available.
- A licensed professional has determined that family support will assist in the parent/caregiver'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 family support to the parent/caregiver so there is shared understanding about the role of a certified family support partner and ensure the parent/caregiver voluntarily confirms the service is a good fit.
- The CFSP will support the parent/caregiver in defining what is important to them related to their family's recovery, resiliency, and wellness.
- Providers must have procedures to evaluate outcomes for family support services. Within 30 days of first engagement with the parent/caregiver, the CFSP will support the parent/caregiver in completing the **Family Support Outcomes Measure (FSOM) in Availity Essentials**. Following the initial FSOM, the parent/caregiver should then complete the FSOM every 90 days, and within 30 days of disenrollment/graduation from family support services.
- 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.

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 Magellan of Idaho network.

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 CBRS.
- Family support services are inherently individualized, flexible, and based on the strengths and needs of the family/caregiver.
- 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 peer/family support services.

Authorization

No authorization required. 416 units of Family Support Services 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 an Idaho-certified peer support specialist (CPSS) who has completed Idaho Youth Support Training. These services support members aged 12-17 who have a diagnosis of SED, a mental health condition, or co-occurring conditions. Services are delivered in a range of environments that are chosen by the member including the home, community, and/or agency settings. 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 natural supports in the community of their choice. Youth Support Services may be delivered face-to-face or via telehealth and can be offered individually or in group settings.

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 lived experience, helps youth navigate barriers and obstacles in their recovery journey, and supports youth in building natural supports in the community. Youth Peer Support services include but are not limited to:

- Supporting the youth member in defining what is important to them related to their recovery, resiliency, and wellness.
- Supporting the youth member in choosing self-directed recovery/wellness goal(s) and how the youth support provider can support the member.
- Supporting the youth member in engaging in supportive services, resources, and/or treatment based on the member's needs and goals.
- 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.
- State funded benefits may also be available.
- 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 youth support provider (YSP) will describe youth peer support to the member so there is shared understanding about the role of a youth support provider and ensure the member voluntarily confirms the service is a good fit.
- The YSP will support the member in defining what is important to them related to their recovery, resiliency, and wellness.
- Providers must have procedures to evaluate outcomes for youth peer support services. Within 30 days of first engagement with the member, the YSP will support the member in completing the **Peer Support Outcomes Measure (PSOM) in Availity Essentials**. Following the initial PSOM, members should then complete the PSOM every 90 days, and within 30 days of disenrollment/graduation from youth peer support services.
- Within 30 days of first engagement with the member, the YSP will support the member in defining a minimum of one recovery/wellness goal(s) and how the YSP will support the member.
- The member's recovery/wellness goal(s) should be self-directed, strengths-based, and chosen by the member. The YSP will collaborate with the member to specify the YSP's role in supporting the member and the frequency with which youth peer support services will be delivered.
- Documentation should demonstrate a strengths-based, recovery and resiliency focus and the YSP's individualized support and benefit to the member.
- 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 are coordinated with other mental health professionals and adjunct social service agencies that are engaged with the member, when appropriate.
- Youth Peer Support Services should adhere to the Magellan supervisory protocol.
- Youth peer support groups consist of 4 to 12 participants, and the minimum ratio is one facilitator to six participants. Groups exceeding six participants require two facilitators or shall be separate groups.

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.

- Complete Idaho Youth Support Training and receive the Youth Support Endorsement.
- Provide services within an agency in the Magellan of Idaho network.

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 and CBRS.
- 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.

Authorization

No authorization required. 416 units of Youth Peer Support Services 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	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.

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.

Services

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 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.

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.
    - At least 18 years of age.
    - At least a high school graduate or have a GED.
    - Have at least six months' full-time (1,040 hours) work or volunteer experience working with children experiencing SED and their families.
    - Have a CPR certification.
    - Have completed the required Respite Training provided by Magellan.
    - No less than 36 months older than the member to which they are rendering services.

Authorization

Authorization not required.

- Limited to 300 hours per calendar year.
- Services cannot exceed 72 hours of consecutive care (when not delivered in a community location) 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.
- State funded benefits may also be available.

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 face-to-face and may include telehealth. IOP-MH occurs at minimum three days per week, maintaining at least nine hours of service for adults and at least six hours of service for adolescents.

Required IOP components:

- 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)
    - Medication Management (can also be billed outside of the bundled rate)

- 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
- A physical exam completed within the first week of treatment
- Care Coordination/Transition Management/Discharge Planning
- For Eating Disorders:
    - Health assessment and monitoring
    - Dietary and nutrition services.

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
- Peer Support, Youth Support, or Family Support
- Recovery Coaching
- Medication Management
- Psych/Neuropsychological Testing.

IOP services do not include overnight 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.

Authorization

Authorization is not required.

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 (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 who require 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.

Member Eligibility

- Medicaid benefit.
- State funded benefits may also be available.

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.

Required PHP components:

- 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)

- Medication Management (can also be billed outside of the bundled rate)
- 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.

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, Peer Support or Family Support
- Recovery Coaching
- Medication Management
- Psychological/Neuropsychological Testing.

Partial Hospitalization Program services do not include overnight 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.

Authorization

Authorization is required.

Payment Methodology

Code	Description	Unit
H0035 or Rev code 0912 w/ H0035	Partial Hospitalization Program, all-inclusive payment three to five hours (half day)	Unit = per diem
H0035 or rev code 0913 w/ H0035	Partial Hospitalization Program, all-inclusive payment of six or more hours (full day)	Unit = per diem
H0035 or rev code 0912 w/ H0035	Partial Hospitalization Program - Eating Disorder, all-inclusive payment three to five hours (half day)	Unit = per diem
H0035 or rev code 0913 w/ H0035	Partial Hospitalization Program - Eating Disorder, all-inclusive payment of six 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, or cognitive problems are so severe that residential care is required. Services are provided by physician or non-physician practitioners in a separate, stand-alone entity.

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.
- State funded benefits may also be available for youth up to age 18.

Services

Covered services and interventions may include the following:

- Behaviorally focused skill 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

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.
- Meet all licensing and certification requirements for the states in which they are located.

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.

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. Residential 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, 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.
- State funded benefits may also be available for youth up to their 18th birthday.

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.

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.

Payment Methodology

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

Homes for Adult Residential Treatment (HART)

Coming soon

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.
- State funded benefits may also be available for:
  - 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).

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 member's 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 years' 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

- A Notification 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.
- State funded benefits may also be available. 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.
- State funded benefits may also be available.

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 Division of Occupational and Professional Licenses and IDAPA; and/or practicing under a supervisory protocol.

Authorization

No authorization 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

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 face-to-face 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).

*Magellan will phase in 24/7 MRT coverage statewide:

July 1, 2024 – Dec. 31, 2024	MRTs will be available Monday through Friday 8 a.m. - 6 p.m. MT or 7 a.m. - 5 p.m. PST in North Idaho.
Jan. 1 – June 30, 2025	MRTs will be available 8 a.m. - 11 p.m. MT or 7 a.m. - 10 p.m. PST in North Idaho, 7 days/week.
Starting July 1, 2025	MRTs will be 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 Division of Occupational and Professional Licenses; 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

Code	Description	Unit
90839	Psychotherapy for Crisis	Unit = initial 60 minutes
90840	Psychotherapy for Crisis	Unit = additional 30 minutes
H0030	Crisis Response Telephonic	Unit = Per call
H2011	Crisis Intervention	Unit = 15 minutes
H2011	Crisis Intervention – Mobile Response Team	Unit = Monthly

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. The IDHW Centers of Excellence MRT Competency Center monitors fidelity to the MRT standards.

Adult Crisis Centers

Coming soon

Youth Crisis Centers

Coming soon

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 recommendations for an array of services 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 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.
- State funded benefits may also be available for youth up to age 18.

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 Availity Essentials**, guides the person-centered service plan development and additional specific treatment plans.
- 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

Services may be provided by one of 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 involved in the youth's care and providing other services to the youth.

Training and Fidelity Monitoring

The Division of Behavioral Health, Centers of Excellence, Transformation Collaborative Outcome Management (TCOM) Competency Center is a team of certified Subject Matter Experts (SMEs) who collaborate, create, provide, and share expertise, best practices, and support for clinicians using TCOM tools. Team services:

- Provide certification training for CANS and Crisis Assessment Tool (CAT).
- Organize and facilitate collaboratives that promote interaction among community partners and shared responsibility for future strategy, enhancement, and sustainability.
- Coach, mentor, train, fidelity monitor, and provide technical assistance, certifications, and analysis of standards/guidelines to support administrative code, data analysis, and outcomes.

For further information, access this link to the TCOM Competency Center.

Authorization

Authorization is not required.

Payment Methodology

Code	Description	Unit
H0031	CANS Assessment for adolescent under the age of 19	Unit = per session

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.
- State funded benefits may also be available.

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 have the current Infant Mental Health endorsement (IMH-E®) in infant and toddler behavioral health care from the Idaho Association for Infant Mental Health (aimearlyidaho.org), or who have received the training hours required to sit for this examination, and who are qualified to diagnose as part of their clinical licensure.

Authorization

No authorization 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.
- State funded benefits may also be available for youth up to age 18.

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 age 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 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 skill 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.

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.

Authorization

Authorization is required.

Payment Methodology

Code	Description	Unit
H0036	Intensive Home and Community Based Service - FFT, MDFT 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 4-5 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.

Member Eligibility

- Medicaid benefit.
- State funded benefits may also be available.

Services

- Assessment and Treatment Planning
- At least 2 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 or TCC/CFT
- Respite
- Youth Support or Family Support
- Recovery Coaching
- Psych/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.

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.
- State funded benefits may also be available for youth up to age 18.

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 required.

Payment Methodology

CPT 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).
- State funded benefits may also be available for youth up to their 18th birthday.

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 include reasons for a child's behavior, behavior contracts, positive feedback, and approaches 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. The second and third phases focus on developing a behavioral contract and role-playing skills learned in group sessions. 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 one to two hours
- Multi-family therapy
    - No more than eight families
    - Six consecutive two-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 Division of Occupational and Professional Licenses 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), Center of Excellence (COE) 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 COE *Principles of Agreement to Maintain PLL Certification*. Link to DBH CoE PLL Competency Center.

- Providers must be trained and licensed by the Savanah Family Institute (SFI) or by SFI's trained partners with the Idaho COE. The COE will cover licensing fees for providers.

Authorization

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

Payment Methodology

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

Training

- The IDHW CoE will provide implementation support and guidance, PLL certification training, PLL consultation and overall program support.
- 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 CoE 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.

All youth involved in the Youth Empowerment Services (YES) system of care should have access to a CFT – 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.
- State funded benefits may also be available.

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).

Authorization

Authorization is not required.

Payment Methodology*

Code	Description	Unit
G9007	Child and Family Team (CFT) Interdisciplinary Team Meeting, scheduled and facilitated by a Targeted Care Coordinator, Wraparound Coordinator, or Intensive Care Coordinator.	Unit = 15 minutes

*This service should not be billed by the Targeted Care Coordinator (TCC) or Wraparound Coordinator.

Wraparound Intensive Services (WInS)

Description

Wraparound Intensive Services (WInS) is a form of High-Fidelity Wraparound (HFW) that is a structured fidelity-based care coordination planning process which is an evidence-based modality of Intensive Care Coordination (ICC). Wraparound planning involves multiple systems and is intended to assist youth and families who may be experiencing high levels of need or are at risk of requiring more intensive services, including out-of-home placement. WInS is strengths-based, culturally responsive, family-driven, youth-guided, has structured framework, and is implemented through a Child and Family Team (CFT) facilitated by a high-fidelity trained Wraparound Coordinator. While building relationships of trust and understanding, the team will work together to create a system of supports that helps the family move forward with confidence.

Participants of the CFT include the youth, family, guardian(s), providers, and both formal and informal members of the youth's community. The CFT assesses for needs and strengths with the CANS, completes a treatment plan based on assessed needs and strengths, monitors the plan and outcomes, creates and implements a crisis and safety plan, and plans for services needed upon discharge from WInS. The Wraparound Coordinator collaborates and coordinates with a case manager to ensure services are not duplicative and are delivered conflict-free.

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 or Targeted Case Coordination (TCC).

WInS may be appropriate for youth with intensive needs, including one or more of the following criteria:

- Has qualifying CANS score.
- Is at substantial risk of out-of-home placement due to mental health needs.
- Has experienced three or more foster care placements within 24 months for reasons related to mental health needs.
- Is involved with multiple child-serving systems related to their mental health needs.
- Is under age 12 and has been hospitalized for reasons related to mental health needs within the last six months.
- Is under age 12, has been detained within the last six months, and has unmet mental health needs.
- Has experienced more than one hospitalization for mental health needs within the last 12 months.
- Is currently in an out-of-home placement due to mental health needs and could be discharged safely to their home or community within 90 days with appropriate services and supports in place.

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.
- State funded benefits may also be available for youth up to their 18th birthday.

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 3-6 months after transition from the formal planning process.

Services are provided face-to-face in the home, community, office, or school settings, or via telehealth, taking into account youth and family preference. Wraparound puts the child or youth and family at the center. Support from a Child and Family Team (CFT) of professionals and natural supports, and the family's ideas and perspectives about what they need and what will be helpful, drives all the work in Wraparound. The young person and their family members work with a Wraparound Coordinator to build their CFT, which can include the family's friends and people from the wider community, as well as providers of services and supports. With the help of the CFT, the family and young person take the lead in deciding team vision and goals, and in developing creative and individualized services and supports that will help them achieve the goals and vision. Team members work together to put the plan into action, monitor how well it is working, and change it as needed. Discharge occurs when the team mission is complete, the identified goals and outcomes are complete, or families choose to discontinue.

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 the foundational 10 module web-based training in the Idaho WInS Model of High Fidelity Wraparound (HFW) to begin accepting clients. In order to meet fidelity to the WInS model, the coordinator must complete the training in High Fidelity Wraparound by the DBH Center of Excellence (CoE) Idaho WInS Competency Center: WInS Competency Center.
- Complete required DBH CoE Transformation Collaborative Outcome Management (TCOM) Competency Center CANS trainings with a score of 70% or higher: TCOM Competency Center.
- 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.

All members of the multidisciplinary Wraparound team must be oriented to the principles and delivery of the WInS model prior to the initiation of services. Within the teams:

- Formal supports include trained professionals providing a service. Examples include doctors, therapists, and behavioral aides.
- Informal and natural supports include individuals who are part of the youth and family's community and social network. Examples include extended family members, neighbors, colleagues, sports coaches, and religious leaders.

Authorization

Notice of Admission is required.

Payment Methodology

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

Fidelity and Quality Monitoring

Magellan monitors and reports on the performance of the WInS providers through Quality record reviews. The WInS (Wraparound) Competency Center conducts quality management of Wraparound practice through a coaching model, fidelity monitoring four times per year, and annual quality service reviews, which include record reviews and interviews with youth and families.

Behavior Modification and Consultation (BMC)

Description

Behavior modification and consultation (BMC) is the design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior, competencies, and confidence. These interventions are based on scientific research and the use of direct observation, measurement, and functional analysis. Behavioral strategies are used to teach the youth alternative skills to manage targeted behaviors across various environments, such as problem-solving skills, anger management, and other social skills. All treatment, care, and support services are outcome-based and must be provided in a context that is youth-centered, family-focused, strengths-based, culturally responsive, and responsive to each youth's individual psychosocial, developmental, and treatment care 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.
- State funded benefits may also be available for youth up to their 18th birthday.

Services

BMC services include:

- Behavior modification functional behavioral assessment;
- Behavior modification treatment plan; and
- Implementation of the behavior modification intervention.

Behavior modification providers may provide this service at any time and any setting appropriate to meet the youth's needs. Services cannot be provided via telehealth. BMC services can be provided individually, in a group, with the family (with or without the youth

present), or in a multi-family group (without the youth present). For successful outcomes, modified behaviors must be reinforced by the youth's parent/guardian(s), family, and other natural supports.

Youth should not be actively engaged in Skills Building/Community Based Rehabilitative Services (CBRS) while receiving BMC services.

Youth may also receive Child Habilitation Intervention Services (CHIS) and Behavior Modification and Consultation (BMC) services through Medicaid's Children's Developmental Disabilities Program if the goals are unique and there is coordination between providers.

Provider Requirements

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

- Psychologist Board-Certified Behavior Analyst (BCBA) - Completes functional behavior assessments and advanced assessments, writes behavior modification treatment plans, provides direct implementation of the behavior modification treatment plan, provides direct implementation of interventions, and supervision of Board-Certified Assistant Behavior Analyst (BCaBAs), Registered Behavior Technician (RBTs), and Behavior Technician (BTs).
- Board-Certified Assistant Behavior Analyst (BCaBA) - Assists with functional behavioral assessments and in writing the behavior modification treatment plans, provides direct implementation of interventions, and supervision of BTs.
- Registered Behavior Technician (RBT), Behavior Technician (BT) and Behavior Technician (Psychologist Service Extender) - Provides direct implementation of interventions.

Authorization

An authorization is required for a BMC assessment, treatment review, and continued stay reviews.

For authorization of the behavioral assessment, the following must be submitted for review:

- Completed CDA and CANS.
- Justification for referral for a functional behavioral assessment.

Once approved for an assessment, the provider must submit the following for treatment review:

- A treatment plan based on behavior and/or skills-based assessments.
- Results of the behavior and/or skills-based assessments rendered by the qualified supervisor.

With each continued stay review for continued services:

- Updated treatment plan and progress reports.

Payment Methodology - *TBD*

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.
- State funded benefits may also be available.

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 Division of Occupational and Professional Licenses and IDAPA.
- Providers need to be contracted with Magellan to provide this service.

Authorization

Authorization not 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).

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.
- State funded benefits may also be available.

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.

Authorization
No authorization required.

Payment Methodology

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

Mileage Reimbursement

Description
Used when some clinical services may be provided in the member's home. In addition to the member's home, mileage reimbursement is available for other locations such as school, another office, etc.

Member Eligibility
- Not a Medicaid benefit.
- State funded benefits may also be available.

Services
Mileage reimbursement is available for the provider to return to their office after meeting with the member in the home or alternative location.

Providers cannot claim the mileage reimbursement code at a different location on the same day for the same member.

Mileage reimbursement is not available for member transportation.

Mileage reimbursement is only reimbursable in conjunction with the following services: 90791, 90792, 90846, 90847, 90832, 90833, 90834, 90836, 90837, 90838, H1011, H0031, H0036, H2033, S5150 and T1017.

Provider Requirements
Services may be provided by one of the following professionals operating within the scope of their practice:
- Licensed behavioral health clinicians.
- Providers practicing under Magellan's supervisory protocol.

Authorization
No authorization required.

Payment Methodology

Code	Description	Unit
T2002	Mileage Reimbursement	Unit = 1 mile

Telehealth/Virtual Care

Description
A method of delivering behavioral health services using interactive telecommunications when the member and the behavioral health provider are not in the same physical location. Telecommunications is the combination of audio and live, interactive video or can be live audio-only, as permitted by regulation.

Member Eligibility
- Medicaid benefit.
- State funded benefits may also be available.

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 www.MagellanofIdaho.com/ For Providers / 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.
- Are licensed in the state in which the member resides at the time of service or are working under the supervision of a provider licensed in the state in which the member resides 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.

Authorization
Authorization not required.

Payment Methodology

Code	Description	Unit
Q3014	Telehealth Originating Site Facility Fee	
T1014	Telehealth Transmission	Unit = 1 minute transmission cost

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.
- State funded benefits may also be available.

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. Additionally, naltrexone and naloxone treatment reimbursement is allowable when appropriate.

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 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 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 (provision of the services by a Medicare-enrolled opioid treatment program).

*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

SUD TREATMENT

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

	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 adults and adolescents 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 adults and youth. 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 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.
ASAM Level 3.5	Clinically managed high-intensity residential services intended for adults or youth 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 managed high-intensity inpatient or residential treatment services for adults and youth 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 high-intensity services for adults and youth 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 see if a member has a SUD and help providers determine the best way to treat it.

Member Eligibility

- Medicaid benefit.
- State funded benefits may also be available.

Services

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

- Dimension 1 – Intoxication, Withdrawal and Addiction Medications
- Dimension 2 – Biomedical conditions
- Dimension 3 – Psychiatric and Cognitive conditions
- Dimension 4 – Substance Use Related Risks
- Dimension 5 – Recovery Environment Interactions
- Dimension 6 – Person-Centered Considerations

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

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, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), Northwest Indian Alcohol/ Drug Certification Board (NWIADCB), the Idaho Department of Health and Welfare Division of Behavioral Health (DBH per IDAPA); and practicing under supervisory protocol.
- Paraprofessionals (defined as individuals who are not independently licensed) 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., CADC).
- 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.
- State-approved certification/designation entities are IBADCC, NWIADCB, DBH per IDAPA.

Authorization
No authorization 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 SUD.

Member Eligibility
- Medicaid benefit.
- State funded benefits may also be available.

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, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), Northwest Indian Alcohol/ Drug Certification Board (NWIADCB), the Idaho Department of Health and Welfare Division of Behavioral Health (DBH per IDAPA); and practicing under supervisory protocol.
- Paraprofessionals (defined as individuals who are not independently licensed) 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., CADC).

- 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.
- State-approved certification/designation entities are IBADCC, NWIADCB, DBH per IDAPA.

Authorization
No authorization 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 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.
- State funded benefits may also be available.

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 methodology is 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.

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, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), Northwest Indian Alcohol/ Drug Certification Board (NWIADCB), the Idaho Department of Health and Welfare Division of Behavioral Health (DBH per IDAPA); and practicing under supervisory protocol.
- Paraprofessionals (defined as individuals who are not independently licensed) 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., Certified Alcohol Drug Counselor [CADC]).
- 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.
- State-approved certification/designation entities are IBADCC, NWIADCB, DBH per IDAPA.

Authorization

No authorization 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.

Member Eligibility

- Medicaid benefit.
- State funded benefits may also be available.

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 face-to-face and may include telehealth. IOP-SUD programs maintain nine to 19 hours of service weekly for adults and six to 19 hours of service for adolescents.

Required IOP-SUD Components:

- 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)
    - Medication Management (can also be billed outside of the bundled rate)

- 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
- A physical exam completed within the first week of treatment
- Care Coordination/Transition Management/Discharge Planning.

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

- Separate Case Management or TCC/CFT
- Respite
- Peer Support, Youth Support or Family Support
- Recovery Coaching
- Psych/Neuropsychological Testing.

IOP services do not include overnight 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, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), and Northwest Indian Alcohol/Drug Certification Board (NWIADCB); and practicing under supervisory protocol.
- Paraprofessionals (defined as individuals who are not independently licensed) providing outpatient substance use disorder 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., CADC).
- 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.
- State-approved certification/designation entities are IBADCC and NWIADCB per IDAPA 16.07.17.

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

Code	Description	Unit
H0015 or Rev code 0906 w/ H0015	Intensive Outpatient Program, Substance Use Disorder ASAM 2.1 (treatment program that operates at least three hours/day and at least three days/week and is based on an individualized treatment plan), 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 - 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.

Member Eligibility

- Medicaid benefit.

- State funded benefits may also be available.

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.

Required PHP-SUD components:

- 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)
- Medication Management (can also be billed outside of the bundled rate)
- 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 three days (or one program day if SUD or eating disorder). 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.

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, Peer Support or Family Support
- Recovery Coaching
- Medication Management
- Psychological/Neuropsychological Testing.

Partial Hospitalization Program services do not include overnight 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, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), and Northwest Indian Alcohol/ Drug Certification Board (NWIADCB); and practicing under supervisory protocol.
- Paraprofessionals (defined as individuals who are not independently licensed) providing outpatient substance use disorder 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., CADC).
- 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.
- State-approved certification/designation entities are IBADCC and NWIADCB per IDAPA 16.07.17.

Authorization

Authorization is required.

Payment Methodology

Code	Description	Unit
H0035 or Rev code 0912 w/ H0035	Partial Hospitalization Program - Substance Use Disorder ASAM 2.5, all-inclusive payment three to five hours (half day)	Unit = per diem
H0035 or Rev code 0913 w/ H0035	Partial Hospitalization Program - Substance Use Disorder ASAM 2.5, all-inclusive payment of six 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.
- State funded benefits may be available.

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 may be provided at least five 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),
  - The Joint Commission (TJC), or
  - The Council on Accreditation (COA)
- 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.
- Residential treatment services may be provided in accredited Institutions for Mental Diseases (IMDs).

- IMDs providing SUD services are required to provide at least two forms of Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD) in order to receive Medicaid reimbursement.

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
H0043	Supported housing	Unit = Per Diem

Residential Treatment - Substance Use Disorder (Adult Only)

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, drugs and supplies, psychological testing, and room and board.

ASAM Level 3.5 is clinically managed high-intensity residential services intended for adults or youth 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 managed high-intensity inpatient or residential treatment for adults and youth 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 up:
    - Medicaid does not cover room and board services or custodial care.
    - If the facility is an IMD or a State Hospital, 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.
- State funded benefits may also be available. The limitations regarding length of stay do not apply.

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),
    - The Joint Commission (TJC), or
    - The Council on Accreditation (COA)
- 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.
- Residential treatment services may be provided in accredited Institutions for Mental Diseases (IMDs).
    - IMDs providing SUD services are required to provide at least two forms of Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD) in order to receive Medicaid reimbursement.

Authorization

Prior authorization is required.

Payment Methodology

Rev Code	Description	Unit
0192	ASAM 3.5	Unit = Per Diem
0193	ASAM 3.7	Unit = Per Diem

INPATIENT SUD

Inpatient SUD

ASAM Level 3.7/4.0

Description

ASAM Level 4.0 is medically managed high-intensity services for adults and youth 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.

ASAM Level 3.7 is medically managed high-intensity inpatient or residential treatment for adults and youth 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.
- State funded benefits do not cover SUD treatment in an inpatient setting, only residential settings.

Services

ASAM Level 4.0 and 3.7 provide medically managed high-intensity inpatient services, physician oversight, 24-hour nursing care, education, therapy, and counseling. 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.

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 with a psychiatric unit
- Psychiatric Hospitals
- Institutions for Mental Diseases (IMDs)
    - IMDs providing SUD services are required to provide at least two forms of Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD) in order to receive Medicaid reimbursement.

Certification/Accreditation

Facilities that provide ASAM Level 4.0 or 3.7, including 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

A notification 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.

RECOVERY SUPPORT SERVICES (RSS)

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.
- State funded benefits may also be available.

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, Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC), Northwest Indian Alcohol/ Drug Certification Board (NWIADCB), the Idaho Department of Health and Welfare Division of Behavioral Health (DBH per IDAPA); and practicing under supervisory protocol.
- Paraprofessionals (defined as individuals who are not independently licensed) 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., CADC).
- 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.

- State-approved certification/designation entities are IBADCC, NWIADCB, and DBH per IDAPA.

Authorization
No authorization 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.
- State funded benefits may also be available.

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 medically necessary by a licensed or certified healthcare professional enrolled with the IBHP.
- Provider Proficiency (ASAM, 2023): 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 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 face-to-face 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.
- State funded benefits may also be available.

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 member's 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 member's 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 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.

Authorization

Prior authorization is not required up to four hours per week.

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.

Case Management - Pregnant Women or Women with Dependent Children (PWWC)

Note: PWWC will not be available via the IBHP until July 2025

Description

Case management for pregnant women with SUD and women with SUD who have dependent children. This program also helps children who may have been affected by their mother's substance use. Participants receive:

- Childcare while women are receiving services and treatment.
- SUD treatment for the children.
- Case management services including referrals to primary medical care for women and children including prenatal care and immunizations.
- Transportation for the mother and her children to access all care.
- Gender-specific SUD treatment, including help with relationship issues, sexual and physical abuse, parenting.

Member Eligibility

- Not a Medicaid benefit.
- State funded benefits may be available.

Services
Specialized case management services provided to pregnant women and women with dependent children that address needs of pregnant and parenting women and their children.

Provider Requirements
- Provider must hold at least a bachelor's degree in a human service field.
- Providers must comply with the Federal Block Grant requirements for serving the PWWC population.
- Provider must be serving pregnant women and with dependent children.

Authorization
No authorization required.

Payment Methodology

Code	Description	Unit
H0006	Case Management for PWWC participants	Unit = 15 minutes

Medical Needs Benefit for PWWC

Description
Pregnant Women and Women with Children (PWWC) with SUD may need medical, dental, vision, or pharmacy services for themselves or their children.

Member Eligibility
- Not a Medicaid benefit.
- State funded benefits may be available.

Services
Funds may be used for the medical, pharmacological, dental, or vision needs for the mother, or her children not covered by other insurance or payer-group. The benefit does not cover over-the-counter medications or supplies.

Provider Requirements
N/A

Authorization
No authorization required.

Payment Methodology

Code	Description	Unit	Duration/Setting
H2016	PWWC Medical Needs Benefit	Unit = Per Diem	Limited to PWWC population

Child Care

Description
Members with SUD who have children can get free or low-cost childcare while they are in a treatment facility and at appointments.

Member Eligibility
- Not a Medicaid benefit.
- State funded benefits may be available.

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

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

Authorization
Authorization 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. Programs offering 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.
- State funded benefits may be available.

Services

These programs may be provided on an individual basis or in a group setting and can include activities that are culturally, spiritually, 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 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 age 18 and older who are living with a substance use or a co-occurring condition. 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 face-to-face 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.
- 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

- Member is 18 years of age or older.
- Member is living with a substance use disorder or co-occurring condition.
- A licensed professional 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.
- The recovery coach will support the member in defining what is important to them related to their recovery, resiliency, and wellness.
- Providers must have procedures to evaluate outcomes for recovery coaching services. Within 30 days of first engagement with the member, the recovery coach will support the member in completing the **Peer Support Outcomes Measure (PSOM) in Availity Essentials**. Following the initial PSOM, members should complete the PSOM every 90 days, and within 30 days of disenrollment/graduation from recovery coaching services.
- 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.
- 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.

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 Certified Peer Recovery Coach (CPRC), Provisional Certified Peer Recovery Coach (P-CPRC), Certified Recovery Coach (CRC), or Provisional Certified Recovery Coach (P-CRC) as defined by the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC).
- Provide services within an agency in the Magellan of Idaho 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 and CBRS.
- 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.

Authorization

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

Payment Methodology

Code	Service	Unit	Threshold
H0038	Recovery Coaching One-on-One	Unit = 15 minutes	416 units per member, per calendar year

H0038	Recovery Coaching Groups	Unit = 15 minutes	Including individual and groups

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

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 co-occurring mental health and substance use disorder 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.

Member Eligibility

- Not a Medicaid benefit.
- State funded benefits may also be available for eligible adults 18 years old and older.
    - Individuals enrolled in Medicaid may be eligible for services that are not covered under their Medicaid benefit plan.

Services

Guiding Principles:
Staffed Safe and Sober Housing and Enhanced Staffed Safe and Sober Housing are guided by the 10 principles as identified by the Substance Abuse and Mental Health Services Administration. 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; or
2. A housing coordinator who is off site but monitors house activities at minimum on a daily basis.
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/Narcan, Magellan supports the recommendation that each house maintains naloxone/Narcan 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 Narcan;
    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 Coach/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/Narcan, Magellan supports the recommendation that each house maintains naloxone/Narcan 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 Narcan;
    c. How to support the client; and
    d. When and how to engage EMS.

Provider Requirements

- Safe and Sober Housing 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.

Authorization

Authorization is required. The benefit is limited to 180 days per episode.

Payment Methodology

Code	Description	Unit
H0044	Adult Safe & Sober Housing	Unit = Per diem (not including day of discharge)
H0044	Enhanced Adult Safe and Sober Housing	Unit = Per diem (not including day of discharge)
S5199	Basic Housing Essentials (ESSH)	Unit = 15 minutes (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)	

Program Fees

SSH providers may collect Program Fees. The fees may be imposed to cover the following expenses:

- 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.

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.
- State funded benefits may be available.

Services

Used to cover costs such as bedding, towels, and hygiene items.

Provider Requirements

N/A.

Authorization

Authorization is required.
Members are limited to $125.00 per treatment episode.

Payment Methodology

Code	Description	Unit
S5199	Basic Housing Essentials	Unit = 15 minutes

Transportation Flat Fee

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 beneficiaries can access Non-Emergency Medical Transportation (NEMT) provider network.
- State funded benefits may be available.

Services

Bus ticket, airfare, 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 required.

Payment Methodology

Code	Description
T2003	Transportation for SUD

Transportation 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 recovery/treatment-related appointments.

Member Eligibility

- Not a Medicaid benefit.
    - Medicaid beneficiaries can access Non-Emergency Medical Transportation (NEMT) provider network.
- State funded benefits may be available.

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. Transportation for a child is specific to the Pregnant Women or Women with Children (PWWC) Specialty network.

Provider Requirements
Transportation provider must be in the Medicaid Non-Emergency Medical Transportation (NEMT) provider network.

Authorization
No authorization required.

Payment Methodology

Code	Description
T2002	Transportation Pick-Up for SUD

Transportation of a Child

Description
Transportation for a child is specific to the Pregnant Women or Women with Children (PWWC) Substance Use Disorder benefit. Children whose parents are receiving PWWC services and who also need behavioral health services and supports, can get free or low-cost travel to a treatment facility and treatment-related appointments.

Member Eligibility
- Not a Medicaid benefit.
    - Medicaid beneficiaries can access Non-Emergency Medical Transportation (NEMT) provider network.
- State funded benefits may be available.

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 Non-Emergency Medical Transportation (NEMT) provider network.

Authorization
No authorization required.

Payment Methodology

Code	Description
A0080	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.
- State funded benefits may be available.

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 Non-Emergency Medical Transportation (NEMT) provider network.

Authorization

No authorization required.

Payment Methodology

Code	Description
A0080	Transportation for SUD