Sentara® Health Plans

Medicaid

Therapeutic Day Treatment (TDT) for Youth

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Effective Date	1/2018
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Coverage Policy	BH 20
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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.

Purpose:

This policy addresses Therapeutic Day Treatment (TDT) for Youth.

Service Requirements:

In addition to the "Requirements for All Services" section of Chapter IV, the following required activities apply to TDT:

- The program must operate a minimum of two hours per day and may offer flexible program hours (e.g., school based, after school, or during the summer). A minimum of two or more therapeutic activities shall occur per day. This may include individual or group therapeutic interventions and activities.
- Prior to the start of services, a Comprehensive Needs Assessment, as defined in Appendix A, shall be conducted in-person by the LMHP, LMHP-S, LMHP-R, or LMHP-RP, documenting the youth's diagnosis and describing how service needs match the level of care criteria.
- An ISP developed within 30 calendar days of initiation of services that meets all requirements of an ISP as defined in 1 12 VAC30-50-130, 12VAC30-50-226 and the ISP Requirements section of Chapter IV.
- Individual, group and/or family counseling is a required component of this service and must be provided by a LMHP, LMHP-S, LMHP-R or LMHP-RP. Counseling may be provided by the TDT provider, another provider or by the local education agency behavioral health staff, as long as it is documented in the ISP and coordinated by the TDT provider. If the counseling is provided by a private provider, the private provider would bill as an outpatient psychiatric service separate from the TDT services. If the counseling is provided by the local education agency, then the local education agency would need to provide services according to the Local Education Agency DMAS Provider Manual. If this child is also receiving other Mental Health Services and counseling is a required component of that service, the counseling services shall be coordinated between service providers and documented in the child's ISP and would be billed by the servicing provider.

- Services must be therapeutic in nature and align with the youth's ISP.
- The ISP, including the individualized discharge plan contained in the ISP, should be reviewed every 3 months (defined as 90 calendar days) at a minimum, but as frequently as medically necessary.
- When a child transitions from school based TDT to non-school based TDT or from non-school based TDT to school based TDT, providers shall:
    - Review and update the Comprehensive Needs Assessment as described in the Comprehensive Needs Assessment of Chapter IV.
    - Update the ISP based on the activities being provided
- Family meetings and contacts, either in person or by telephone, occurs at least once per week to discuss treatment needs and progress. Contacts with parents/guardian include at a minimum the youth's progress, any diagnostic changes, any ISP changes, and discharge planning. The parent/guardian should be involved in any significant incidents during the school day and be informed of any changes associated with the ISP. Family meetings are not considered to be the same as family therapy.
- If the youth is prescribed medication related to their behavioral health needs, education about side effects, monitoring of compliance and referrals for routine physician follow up must be provided to the youth and parent/ guardian and documented in the Comprehensive Needs Assessment, the ISP and progress notes. A QMHP-C must remain within the boundaries of their level of expertise and may consult with the service provider's clinical director, consult with current prescribing physician and school personnel such as school nurse, coordinate referrals for medication evaluation, monitor compliance, and provide developmentally appropriate education to the youth regarding medication adherence and side effects. The QMHP must involve the parent/guardian to monitor the youth's medication compliance/adherence. Response to medication and education, as well as compliance must be documented.
- Services must include providing individual and group therapeutic interventions and activities based on specific TDT objectives identified in the ISP. Examples include, but are not limited to, planning and implementing individualized pro-social skills interventions; problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations.
- For school based TDT, services must include providing feedback to the youth and direct skills training in the classroom based on specific TDT objectives identified in the ISP.

- For school based TDT, services must include responding to and providing on-site crisis response during the school day and behavior management interventions throughout the school day; services should include a "de-briefing" with the youth and family to discuss the incident; how to recognize triggers, identify alternative coping mechanisms and providing feedback on the use of those alternative coping mechanisms. A crisis plan should be kept onsite and in the medical record and reviewed throughout treatment.

Description & Definitions:

Mental Health Services (formerly CMHRS) - Appendix H: Community Mental Health Rehabilitative Services (CMHRS) p. 9 (01/12/2023)

Therapeutic Day Treatment (TDT) provides medically necessary, individualized, and structured therapeutic interventions to youth with mental, emotional, or behavioral illnesses as evidenced by diagnoses that support and are consistent with the TDT service and whose symptoms are causing significant functional impairments in major life activities such that they need the structured treatment interventions offered by TDT. TDT treatment interventions are provided during the school day or to supplement the school day or year. The supporting diagnosis must be made by an LMHP practicing within the scope of his or her license. This service shall include assessment, assistance with medication management, interventions to build daily living skills or enhance social skills, and individual, group, and/or family counseling and care coordination. These services shall be provided for two or more hours per day.

Youth receiving TDT must have the functional capability to understand and benefit from the required activities and counseling of this service. These services are rehabilitative and are intended to improve the youth's functioning.

Successful service provision includes the active engagement of the service provider, any involved school, and the youth's parent/guardian. The service provider shall engage with the school and parent/guardian to reach the desired outcomes as outlined in the ISP. Ideally, if a school is involved, it will provide a secure space for service provision and liaison with the

service provider. The licensed practitioner shall determine the frequency of visits based on the individual needs of the youth. DMAS recommends that family involvement, to include family counseling, family meetings or family contacts, occurs at least weekly from the beginning of treatment unless contraindicated as documented in the ISP and Comprehensive Needs Assessment. The licensed practitioner shall document justification for less than weekly family involvement if weekly involvement is contraindicating to the youth's needs.

Youth receiving TDT should experience improvement on measurable objectives and goals documented in the ISP and ISP reviews that enable the youth to transition to a lower level of care. TDT is intended for youth who reside in the community with their parent(s)/guardian(s) in the family home or in a group home placement. TDT should provide stabilization during the school day or to supplement the school day or year, as medically necessary, for youth who are at risk to be placed in a higher level of care in order to address current symptoms, or who are transitioning from an acute or residential level of care to a home environment.

It is expected that the pattern of service provision may show more intensive services and more frequent contact with the youth and family initially, with gradually reduced intensity progressing toward discharge.

Mental Health (formerly CMHRS) – Appendix A: Definitions p. 1 (01/12/2023)

"Comprehensive Needs Assessment" means the face-to-face interaction, in which the provider obtains information from the individual, and parent or other family member or members, as appropriate, about the individual's mental health status. It includes documented history of the severity, intensity, and duration of mental health care problems and issues and shall contain all of the following elements: (i) the presenting issue/reason for referral, (ii) mental health history/hospitalizations, (iii) previous interventions by providers and timeframes and response to treatment, (iv) medical profile, (v) developmental history including history of abuse, if appropriate, (vi) educational/vocational status, (vii) current living situation and family history and relationships, (viii) legal status, (ix) drug and alcohol profile, (x) resources and strengths, (xi) mental status exam and profile, (xii) diagnosis, (xiii) professional summary and clinical formulation, (xiv) recommended care and treatment goals, and (xv) The dated signature of the LMHP, LMHP-supervisee, LMHP-resident, or LMHP-RP.

"At Risk of Hospitalization" means one or more of the following: (i) within the two weeks before the Comprehensive Needs Assessment, the individual shall be screened by an LMHP, LMHP-R, LMHP-S or LMHP-RP for escalating behaviors that have put either the individual or others at immediate risk of physical injury such that crisis services, hospitalization or other high intensity interventions are or have been warranted; (ii) the parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement; (iii) a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in 12VAC35-105-20, or LMHP-R, LMHP-S, or LMHP-RP and who is neither an employee of nor consultant to the intensive in-home (IIH) services or therapeutic day treatment (TDT) provider, has recommended an out-of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident; (iv) the individual has a history of unsuccessful services (either mobile crisis response, community stabilization, outpatient psychotherapy, outpatient substance use disorder services, or mental health skill building) within the past 30 calendar days; (v) the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who, within the past thirty calendar days, is either: (a) transitioning out of residential treatment services, either psychiatric residential treatment facility (PRTF) or therapeutic group home TGH), (b) transitioning out of acute psychiatric hospitalization, or (c) transitioning between foster homes, mental health case management, mobile crisis response, community stabilization, outpatient psychotherapy, or outpatient substance use disorder services.

"At Risk of Out-of-Home Placement" means placement in one or more of the following: (i) Therapeutic Group Home; (ii) regular foster home if the individual is currently residing with his biological family and, due to his behavior problems, is at risk of being placed in the custody of the local department of social services; (iii) treatment foster care if the individual is currently residing with his biological family or a regular foster care family and, due to the individual's behavioral problems, is at risk of removal to a higher level of care; (iv) PRTF; (v) emergency shelter for the individual only due either to his mental health or behavior or both; (vi) psychiatric hospitalization; or (vii) juvenile justice system or incarceration.

"Failed Services" or "Unsuccessful Services" means, as measured by ongoing behavioral, mental, or physical distress, that the service or services did not treat or resolve the individual's mental health or behavioral issues.

Criteria:

Youth must meet **all of the following** to include the Diagnostic, Clinical Necessity, and Level of Care criteria.

- Diagnostic Criteria with **ALL of the following**:
  - Youth qualifying for this service shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. The diagnosis must be the primary clinical issue addressed with the service targeted for treatment. The diagnosis must support the mental, behavioral or emotional illness attributed to the recent significant functional impairments in major life activities.
- Clinical Necessity Criteria with **2 or more of the following**:
  - Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are **at risk of hospitalization or out of-home placement** as defined in the definitions section because of conflicts with family or community
  - Exhibit such inappropriate behavior that **documented, repeated** interventions by the mental health, social services or judicial system are or have been necessary
  - Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior
- Level of Care criteria **– Youth shall meet at least 1 or more of the following**:
  - The youth must require year-round treatment in order to sustain behavior or emotional gains
  - The youth's behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms **without one or more of the following**
    - TDT programming during the school day
    - TDT programming to supplement the school day or school year
  - The youth would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning
  - The youth must have **all of the** following:
    - Have deficits in social skills, peer relations or dealing with authority
    - Are hyperactive
    - Have poor impulse control
    - Are extremely depressed or marginally connected with reality
  - The youth is placed or pending placement in a preschool enrichment and/or early intervention program but the youth's emotional/behavioral problems are so severe that it is documented that they cannot function or be admitted in these programs without TDT services
- Service authorizations shall meet the following components related to Procedures Regarding Service Authorization of Mental Health Services by meeting **1 or more of the following**:
  - Initial service authorization requests with all of the following:
    - Clearly document how the individual's behaviors, within the last 30 calendar days, demonstrate that each of the medical necessity criteria for the service have been met
    - Clearly document how the individual's behaviors, within the last 30 calendar days, support the need for the amount of service units and the span of dates requested
    - Demonstrate individualized and comprehensive treatment planning and initial conceptualization of goals
  - Continued authorization requests with all of the following:
    - Clearly document how the individual's behaviors, within the last 30 calendar days, demonstrate that each of the medical necessity criteria for the service have been met
    - Clearly document how the individual's behaviors, within the last 30 calendar days, support the need for the amount of service units and the span of dates requested
    - Demonstrate individualized and comprehensive treatment planning and initial conceptualization of goals
    - Demonstrate individualized and comprehensive treatment planning
    - Documentation of the individual's current status and the individual's progress, or lack of progress toward goals and objectives in the ISP
    - Documentation of discharge planning.

In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply:

- Therapeutic group activities are limited to no more than 10 youth.
- Medicaid will only reimburse for allowed service activities as defined in the ISP.
- Activities that are not allowed / reimbursed:
    - Inactive time or time spent waiting to respond to a behavioral situation
    - Transportation
    - Time spent in documentation of youth and family contacts, collateral contacts, and clinical interventions.
    - Time required for academic instruction when no treatment activity that align with the goals and objectives in the youth's ISP is taking place.
    - Time spent monitoring behavior during the classroom when no treatment activity is occurring.
- Services must not duplicate those services provided by the school, including interventions identified on the school's IEP for the member.
- TDT may not be authorized or billed concurrently with Assertive Community Treatment, Mental Health Intensive Outpatient or Mental Health Partial Hospitalization Program services. Short-term service authorization overlaps are allowable as approved by the FFS Contractor or MCO during transitions from one service to another for care coordination and continuity of care. TDT may not be billed concurrently with Community Stabilization or Residential Crisis Stabilization Unit Services.

Discharge Guidelines:

Medicaid reimbursement is not available when other less intensive services may achieve stabilization.

Reimbursement shall not be made for this level of care if **any of the following** applies:

- The youth no longer meets the diagnostic, clinical necessity, or level of care criteria
- The level of functioning has improved with respect to the goals outlined in the ISP, and the youth can reasonably be expected to maintain these gains at a lower level of treatment
- When the youth has achieved baseline functioning (his or her level of functioning has not improved despite the length of time in treatment and interventions attempted) and his or her needs can be met in a less intensive service

If there is a lapse in service greater than 31 consecutive calendar days, the provider shall discharge the youth.

Recommendations:

Successful service provision includes the active engagement of the service provider, any involved school, and the member's parent/guardian. The service provider shall engage with the school and parent/guardian to reach the desired outcomes as outlined in the ISP. Ideally, if a school is involved, it will provide a secure space for service provision and liaison with the service provider. The licensed practitioner shall determine the frequency of visits based on the individual needs of the member. DMAS recommends that family involvement, to include family counseling, family meetings or family contacts, occurs at least weekly from the beginning of treatment unless contraindicated as documented in the ISP and Comprehensive Needs Assessment. The licensed practitioner shall document justification for less than weekly family involvement if weekly involvement is contraindicating to the member's needs.

Members receiving TDT should experience improvement on measurable objectives and goals documented in the ISP and ISP reviews that enable the member to transition to a lower level of care. TDT is intended for youth who reside in the community with their parent(s)/guardian(s) in the family home or in a group home placement. TDT should provide stabilization during the school day or to supplement the school day or year, as medically necessary, for youth who are at risk to be placed in a higher level of care in order to address current symptoms, or who are transitioning from an acute or residential level of care to a home environment.

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Coding:

Medically necessary with criteria:

Coding	Description
H0032	Mental health service plan development by nonphysician
H2016	Comprehensive community support services, per diem

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

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- 2021: June, October
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- 2019: October

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- 2019: June
- 2018: December

Effective Date:

- January 2018

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

Behavioral health professionals are involved in the decision-making process for behavioral healthcare services.

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

SHP behavioral health 20, BH, therapeutic day treatment, psychotherapeutic interventions, evaluation, medication education, medication management, interpersonal skills, behavior management, skill-building,

outcome evaluation, development delay, SHP Therapeutic Day Treatment (TDT) for Children and Adolescents