GUIDELINE STATEMENT

This guideline outlines the management and best practices using treatment of Home Care Training to Home Care Client (HCTC), also known as Therapeutic Foster Home, which adheres to the Arizona Vision Twelve Principles for children up to age 18 and to the nine Guiding Principles for Recovery Oriented Adult Behavioral Health Services and System for individuals 18 and over.

PURPOSE

CRS Behavioral Health, Home Care Training to Home Care Client (HCTC) Practice Guidelines represents the criteria for providing care to individuals who need this level of care. Care and treatment should be provided in a manner that is adherent to and consistent with the following guideline.

DEFINITIONS

Arizona Vision: The ‘Arizona Vision’ for children is built on twelve principles to which ADHS and AHCCCS are both obligated and committed to. The Arizona Vision states: “In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child’s family’s cultural heritage.”

AAC: Arizona Administrative Code

Arizona Twelve Principles:

1. Collaboration with the child and family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting
7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family’s unique cultural heritage
11. Independence
12. Connection to natural supports

**AMPM**: AHCCCS Medical Policy Manual

**ART**: Adult Recovery Team. A group of individuals, that following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems work in collaboration and are actively involved in a person's assessment, Service planning and service delivery. At a minimum, the team consists of the person, his/her guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include members of the enrolled person's family, physical health, mental health or social service providers, representatives or other agencies serving the person, professionals representing various areas of expertise related to the person's needs, designated presentatives or other persons identified by the enrolled person.

**Child and Adolescent Service Intensity Instrument (CASII)**: Is a standardized tool administered to children age 6-18 years of age. The purpose and motivation behind the implementation of the CASII is to utilize objective, quantifiable criteria for determination of service intensity in providing guidance for assignment of case managers to children identified with “high or complex needs” in a consistent manner on a statewide basis. The use of this tool will also provide data to Child & Family Teams (CFTs) to better inform service planning that is individualized to each child and family’s needs.

**Child Family Team (CFT)**: The Child and Family Team (CFT) is a defined group of people that includes, at a minimum, the child and his/her family, a behavioral health representative, and any individuals important in the child's life and who are identified and invited to participate by the child and family. This may include for example, teachers, extended family, members, friends, family support partners, healthcare providers, coaches, community resource providers, representatives from religious affiliations, agent from other service systems like Division of Child Safety (DCS) or the Division of Developmental Disabilities (DDD), etc. The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by which individuals are needed to develop an effective ISP, and can therefore expand and contract as necessary to be successful on behalf of the child.

**DCS**: Division of Child Safety, formerly known as Child Protective Service.

**DDD**: Division of Developmental Disability
Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems:

1. Respect
2. Persons in recovery choose services and are included in program decisions and program development efforts
3. Focus on individual as a whole person, while including and/or developing natural supports
4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure
5. Integration, collaboration, and participation with the community of one’s choice
6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust
7. Persons in recovery define their own success
8. Strengths-based, flexible, responsive services reflective of an individual’s cultural preferences
9. Hope is the foundation for the journey towards recovery

Home Care to Home Care Training to Home Care Client (HCTC or Therapeutic Foster Home): A facility licensed per A.A.C. 20 and Title XIX certified by ADHS/ALS/OBHL that provides a structured treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services. Home Care Training to Home Care Client (HCTC) services are provided by a behavioral health therapeutic home to a person residing in their home in order to implement the in-home portion of the person’s behavioral health service plan. HCTC services assist and support a person in achieving their service plan goals and objectives. It also helps the person remain in the community setting, thereby avoiding residential, inpatient or institutional care. These services include supervision and the provision of behavioral health support services such as personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training, and development, transportation of the person to therapy or visitations and/or the participation in treatment and discharge planning.

Integrated Individual Service Plan (IISP): A complete written description of all covered behavioral and medical health services and other informal supports that have been identified through the assessment process that will assist the person to meet his/her specified goals to improve function. Assumes recent evaluation has been completed and reviewed and includes member’s strengths, weaknesses, member, and family’s goals, cultural considerations, identified barriers to success of achievement of goals, and is family centric. There is a plan for measuring and monitoring progress. Interventions targeted to assist progress toward goals are listed. The IISP is documented in the comprehensive clinical record and provided to all agencies involved in providing services identified
on the IISP. When needed or appropriate, input from other organizations such as CMDP, DDD, Indian Health Services/TRBHA, or DCS should occur.

**SCOPE OF SERVICES**

**A. HCTC Services Provided**

1. Supervision and the provision of behavioral health support services such as:
   a. personal care (including but not limited to prescribed behavioral interventions), psychosocial rehabilitation,
   b. skills training and development,
   c. transportation of the person to therapy or visitations and/or the participation in treatment and discharge planning,
   d. treatment to meet the individual’s basic physical and age-appropriate needs,
   e. all integrated medical needs will be addressed while in this setting.

**B. Individuals Eligible for HCTC Services**

1. Individuals who are experiencing a behavioral health issue that limits their Independence.
2. Individuals who have responded to outpatient treatment and community supports in the home of family or guardian.
3. Individuals who have been able to participate in all aspects of treatment.

**C. Expected Treatment Outcomes**

1. Goals for behavioral treatment are achievable in a reasonable period of time and cannot be met in a less restrictive or cost effective environment appropriate for member’s needs.
2. Goals are based on individual’s unique needs and tailored to the individual and family’s (guardian’s) choices where possible.
3. Goals allow the individual to improve functioning and ability to integrate into the community meeting the individual’s basic physical/medical and age-appropriate needs to enhance independence.
4. Active treatment with the services available at the HCTC can reasonably be expected to improve the member’s condition in order to achieve discharge from the HCTC at the earliest possible time and to facilitate his/her return to outpatient care and/or family living.

D. Alternatives to HCTC Treatment

1. Services may include but are not limited to the following:
   - Intensive Outpatient Services or wrap services in the home
   - Day Program,
   - Partial Hospitalization
   - Respite
   - Substance Abuse Outpatient Programs
   - Sexual Offense Outpatient Programs
   - Outpatient Trauma Therapy
   - Other BH wrap around services
   - Acute outpatient psychiatric follow up and medication management
   - Family or individual counseling and community support
   - Higher level of care such as a residential facility if medically necessary and needs won’t be met with the HCTC

E. Prior Authorization Requirement

1. Home Care Training for the Home Care Client (HCTC) services require treatment Approval prior to service delivery.

2. Determination of medical necessity will be made for expedited decisions within (3) three business days and standard decisions within 14 calendar days of the service request with a potential for extension of an additional 14 calendar days if additional documentation is needed to make the determination.

F. Documentation Requirement

1. Initial Case Review
   a. Clinical documentation of admission need and why now.
b. CASII recent assessment within 2 weeks prior to request.

c. Updated Integrated Individual Service Plan indicating goals for the member at HCTC placement and how progress will be measured to indicate when improvement towards goals will allow a less restrictive level of care. Use of instruments such as the Child and Adolescent Needs and Strengths (CANS) as an outcome measurement tool should be used.

d. Service Plan must include an integrated plan for all medical and behavioral problems.

e. Explain what treatments have been successful or not, and why, as well as when the treatments occurred.

f. Recent psychiatric evaluation reflecting current behaviors, functioning and diagnosis.

g. Current medications, psychiatrist, services to date.

h. Anticipated length of stay and specific discharge plan.

i. Names/contact information of CFT members include psychiatrist, PCP and key specialists involved in care.

j. Summary of recent CFT recommendations within last month prior to request Include the Strengths, Needs and Culture Discovery (SNCD).

k. Documentation of any court ordered treatment or legal involvement/decisions/mandates.

2. Concurrent Case Review

Re-authorizations Monthly: the provider is required to submit documents seven days prior to the expiration of the current authorization. The facility must notify the CRS Utilization Nurse regularly of date, time and call in number for CFT or other family meetings. The following information is needed for continued authorization determination:

   a. Monthly facility notes summarizing progress towards goals and any events, of SI, HI, SH, aggression and circumstances, triggers, frequency, and interventions taken to correct.

   b. Updated Service Plan, monthly progress towards goals.
c. Crisis Plan and Incident Reports, Psychiatry progress notes for treatment; member is to be seen at least monthly.
d. Discharge Plan including how barriers to discharge will be addressed and Child Family Team (CFT) summary note.

G. **Criteria for Admission**

Admission to Behavioral Health Short-Term Residential, without room and board is judged appropriate as indicated by **ALL** of the following:

1. **Behavior and Functioning**

   As a result of a DSM-V diagnosis, the child /adolescent has:
   a. a risk of harm to self or others or
   b. disturbance of mood, thought or behavior which renders the child or adolescent incapable of developmentally-appropriate self-care or self-regulation that clearly impairs functioning in a typical family setting; and
   c. persists in the absence of stressors, and impairs recovery from the presenting problem.

2. **Least Restrictive**

   Treatment should be at the least restrictive level of care consistent with the members need. HCTC services should not be instituted unless there is documentation of a failure to respond to, or professional judgment of an inability to be safely managed in a non-therapeutic community based placement.

3. **Discharge Criteria Have Been Developed**

   A written discharge plan will be put in place. The plan must outline specific discharge criteria such behaviorally measurable goals, and documented recommendations for aftercare treatment that includes involvement of the Child Family Team. The plan must comply with current standards of medically necessary covered behavioral health services, cost effectiveness, and least restrictive environment and is in conformance with federal and state clinical practice guidelines.
4. **Exclusion Criteria Must Not be Met**

HCTC admission is not used primarily and therefore clinically inappropriate, as one of the following:

a. An alternative to preventative detention, or as a mean to ensure community safety in an individual exhibiting conduct disordered behavior; or

b. The equivalent of safe housing, permanency placement, or an alternative to parents’/guardians’ or other agencies’ capacity to provide for the child/adolescent; or

c. A behavioral health intervention when other less restrictive alternatives are available and meet the child’s/adolescent’s treatment needs; or

H. **Continued Stay Criteria:**

Continued stay is indicated by all of the following:

1. **Behavior And Functioning must meet one of the following:**

   a. Emergence or continuance of recent, recurring, or intermittent episodes of risk of harm; or continued moderate functional impairment with disturbance of mood, thought or behavior which substantially impairs developmentally appropriate self-care or self-regulation; or

   b. Significant regression of the member’s condition is anticipated with supporting evidence without continuity at this level of care factoring in the resilience of member. Peer to peer may be required if not clearly demonstrated.; or

   c. The above criteria are not met, but efforts to secure a less restrictive placement suitable to the behavioral health needs of the member have been exhausted and none are available. Negotiation for rates for the appropriate level of care/services will be made with HCTC provider for services until appropriate placement found.

2. **Exclusion Criteria must not be met. HCTC admission is not used primarily, and therefore clinically inappropriately, as one of the following:**
a. An alternative to preventative detention, or as a means to ensure community safety in an individual exhibiting conduct disordered behavior; or
b. The equivalent of safe housing, permanency placement, or an alternative to parents’/guardians’ or other agencies’ capacity to provide for the child/adolescent; or
c. A behavioral health intervention when other less restrictive alternatives are available and meet the child’s/adolescent’s treatment needs; or
d. An intervention for runaway behavior.

3. Recovery Course and Expected Response to HCTC level of care. There is documented evidence that (ALL of the following):

   a. Active treatment, with direct supervision/oversight by professional behavioral health staff only available at this level of care is being provided by the HCTC family on a 24 hour basis, is reducing the severity of disturbances of mood, thought, or behavior, which were identified as reasons for admission; and

   b. The treatment is empowering the member to gain skills to successfully function in his/her family and/or community; and

   c. The CFT or ART is meeting at least monthly or more frequently, as Clinically indicated, to review progress, and has revised the service plan to respond to any lack of progress; and

   d. If member is a Child or Adolescent, the family or parents to whom the child will be transitioned after discharge are actively involved in treatment with the child and HCTC agency; and

   e. There is an expectation that continued treatment can reasonably be expected to improve or stabilize the member’s condition so that this type of service will no longer be needed.
4. Discharge Plan: There is a written plan for discharge with specific discharge criteria, written as behaviorally measurable goals, and with recommendations for aftercare treatment, that includes involvement of the CFT or ART. The plan complies with current standards for medically necessary covered behavioral health services, cost effectiveness, and least restrictive environment and is in conformance with federal and state clinical practice guidelines. This plan can be modified if the member’s needs change but should be started at time of admission to be clear on what goals member needs to achieve for their condition and situation.

   a. Clinical Status for Discharge

      i. Symptom or behavior relief is sufficient. This means primary ISP goals are met or are acceptable for treatment at the next level of care (key symptom reduction). Symptom status is acceptable when symptoms are stabilized although may not be totally resolved.

      ii. Patient can participate in needed treatment in alternative setting or is HCTC setting is not meeting member needs and alternative setting is needed.

      iii. No current expectation for further significant change in primary symptoms/behaviors outside of expected transition related anxiety and behaviors. Assumes a plan for transition includes intervention to decrease stresses and continue services will be in place. There is no evidence to indicate continued HCTC treatment will improve outcome over a lower level of care that is medically necessary and cost effective.

      iv. Provider and supports are sufficiently available at lower level of care.

I. Discharge

   1. Clinical Status for Discharge, ALL of the following.

      a. Symptom or behavior relief is sufficient. This means primary IISP goals are met or are acceptable for treatment at the next level of care (key symptom reduction), symptom status is acceptable when symptoms are stabilized although may not be totally resolved.
b. Patient can participate in needed treatment in alternative setting or the HCTC setting is not meeting member needs.

c. No current expectation for further significant change in primary symptoms/behaviors outside of expected transition related anxiety and behaviors. Assumes a plan for transition includes intervention to decrease stresses and continue services will be in place.

d. There is no evidence to indicate continued HCTC treatment will improve outcome over a lower level of care that is medically necessary and cost effective.

e. Provider and supports are sufficiently available at lower level of care.

2. Intervention:

   a. Patient and/or family/caregiver supports understands follow-up treatment and crisis plan.

   b. Coordination of care and transition planning in process. (Reconciliation of medications and follow up appointments made).

J. Code Specific Information

HCPCS Codes

S5109 HB–Home Care Training to Home Care Client (Adult) – Age 18-64 years
S5109 HC-Home Care Training to Home Care Client (Adult geriatric) – Age 65 years and older
S5109 HA-Home Care Training to Home Care Client (Child) – Age 0-17 years

K. Billing Unit: Per Diem

Billing Limitations for HCTC Services
a. Personal care services, skills training and development and home care training family services (family support) are provided by the behavioral health therapeutic home provider and are included in the HCTC rate. Counseling, evaluation, support, and rehabilitation services provided to the AHCCCS Behavioral Health Services member may be billed using the appropriate procedure code.

b. The HCTC procedure code does not include any professional services; therefore, professional services provided should be billed by the appropriate provider using the applicable CPT codes.

c. The HCTC procedure code does not include day program services, this service should be billed by the appropriate provider using the applicable procedure code.

d. Room and board services are to be billed separately. The State-funded HCPCS code for room and board is to be used for all persons except for state-placed children (i.e., ADES or AOC) whose room and board should be paid by the placing agency.

e. A licensed professional who supervises and trains the behavioral health therapeutic home provider may not bill for these functions. Employee supervision and training has been built into the procedure code rate.

f. Pre-training activities associated with the HCTC setting is included in the rate. This service may not be billed outside the HCTC procedure code rate by either the licensed professional or behavioral health therapeutic home provider.

g. Prescription drugs are not included in the rate and should be billed by appropriate providers using the applicable NDC procedure codes.

h. Over-the-counter drugs and non-customized medical supplies are included in the rate and should not be billed separately.

i. Emergency transportation provided to an AHCCCS Behavioral Health Services member is not included in the rate and should be billed separately by the appropriate provider using the applicable transportation procedure codes.

j. Non-emergency transportation is included in the rate and cannot be billed separately.
k. Any medical services provided to persons, excluding those medical services included in the AHCCCS BEHAVIORAL HEALTH SERVICES covered service array, as set forth in this guide should be billed to the member’s health plan.

l. HCTC services cannot be encountered/billed on the same day as Unskilled Respite Care (S5151).

m. Based on behavioral health recipient needs, Personal Care Services (T1019), Skills Training, and Development (H2014/H2014HQ), Home Care Training Family Services (S5110) and Psychosocial Rehabilitation Services (H2017) may be provided and billed on the same day that HCTC services are furnished. The clinical rationale for providing these additional services must be specifically documented in the Service Plan and Progress Note.

IV. REFERENCES


2. A.A.C. 9 Article 10 Behavioral Health Therapeutic Home

3. A.A.C .R6-5-5850 ADES licensed professional foster care home


5. AMPM 310-B BEHAVIORAL HEALTH SERVICES REVISION DATES: 10/01/11, 05/01/2011, 10/01/2010, 07/01/2010, 05/01/09, 06/01/07, 10/01/06, 05/01/06, 10/01/01, 10/01/99 INITIAL EFFECTIVE DATE: 10/01/1994. AHCCCS covers behavioral health services (mental health and/or substance abuse services) within certain limits for all members except those enrolled to receive family planning extension services only. The following outlines the service delivery system for behavioral health services.

