Vaya Partners

In-Home Therapy Services

H2022 HE U5
H2022 TS U5 – Encounters

Service

In-Home Therapy Services (IHTS) is a combination of evidence-based therapy services and coordination of care interventions provided in a home setting for members with complex clinical needs that traditional outpatient therapy services cannot adequately address. For some individuals in high-risk situations, such as families involved in domestic violence or child protective services, traditional outpatient services alone are not sufficient to address the member's needs and prevent future incidents.

This service is for children and adolescents in need of individual and family therapy services, as well as coordination of care due to complex psychosocial situations and/or multisystem involvement. These members are at risk for residential treatment or other forms of out-of-home placement, due to family systems issues in combination with mental health (MH) and/or substance use (SU) symptoms. These children/adolescents have moderate to severe symptoms in addition to multisystem involvement. The use of this service prevents the need for more restrictive levels of care and intensively engages families in treatment, which has been demonstrated to lead to successful outcomes.

These activities are provided through face-to-face interventions with schools, juvenile justice system, etc. – beyond the scope of traditional outpatient therapy (even when provided in the home). This promotes seamless service delivery and allows for flexibility in the intensity of coordination over the course of treatment with the ability to quickly address any issues that arise rather than having to wait for issues to become so severe that the individual needs a higher level of care.

Intended Outcomes

a. Prevention of crisis episodes
b. Reduction in symptomatology
c. Member and family/caregivers' engagement in the recovery process
d. Improved member functioning in the home, school, and community settings
e. Improved ability of the member and family or caregiver to identify and manage triggers, cues, and symptoms
f. Member's sustained improvement in developmentally appropriate functioning in specified life domains
g. Member's utilization of increased coping and social skills that mitigate life stresses resulting from the member's diagnostic and clinical needs
h. Reduction of symptoms and behaviors that interfere with the member's daily living, such as negative effects of the substance use disorder or dependence, psychiatric symptoms, or both
i. Decrease in delinquent behaviors when present
j. Increased use of available natural and social supports
k. Prevention of out of home placement
l. Improvement in Child and Adolescent Needs and Strengths (CANS) score

Service Exclusions

The following service may not occur during the same authorization period:

a. Intensive In-Home Services (IIHS)
b. Multisystemic Therapy (MST)

Copyright © 2026 Vaya Partners. All rights reserved.

c. Day Treatment
d. Individual, group, and family therapy (billed as separate services, as these interventions as part of IHTS service)
e. Substance Abuse Intensive Outpatient Program (SAIOP)
f. Child residential treatment services
g. Psychiatric Residential Treatment Facility (PRTF)
h. Substance abuse residential services

IHTS is not billed on dates when members are receiving inpatient hospitalization services, but IHTS staff may facilitate coordination of discharge plans if admission occurs. Since this service includes a case management component, providers must clearly outline on the member's care plan how they will collaborate with Tailored Care Management to ensure there is no duplication of services. The case management function of this service is to support the treatment being done within the program to ensure progress and decrease the need for a higher level of care.

Service Frequency and Intensity

An IHTS unit is a per diem event with a minimum of two hours combined therapy and coordination of care. Only one unit may be billed per week. To be able to bill for this service, the provider must have delivered a minimum of two hours of treatment during the week (Sunday to Saturday). Duration of this service is for up to six months, so the expected utilization is 24 units.

Provider Requirements

The provider delivering this service shall meet the following requirements:

1. Provider must meet qualification for participation in the NC Medicaid program, as applicable, and be enrolled in NCTracks.
2. Provider must be credentialed and enrolled as a network provider in Vaya Partners' Closed Provider Network, in good standing, and contracted to deliver the service.
3. For any member requiring nursing level assistance, N.C. Board of Nursing regulations and requirements must be followed for tasks that present health and safety risks to the member.
4. Provider must verify employee/independent contractor qualifications at the time employee is hired/contracted. Providers must provide verification of staff qualifications on at least an annual basis.
5. Provider must comply with all terms and conditions of its contract with Vaya Partners, other applicable written agreements, and all applicable federal, state, and local laws, rules, and regulations.

Staffing Requirements

The team structure can vary and allows some flexibility; however, it always consists of at least two staff. In some cases, the structure includes two fully licensed clinicians who provide both the therapy and coordination of care interventions. In other cases, a licensed therapist provides all therapy interventions and oversees coordination of care interventions provided by either a QP or an AP who has Family Partner training and qualifications. Typically, the need for coordination of care can be resolved within a few interactions.

The licensed therapist may have a caseload of up to 12 IHTS members. The licensed therapist may additionally provide outpatient therapy to members not enrolled in IHTS. IHTS members will step down into basic, office-based therapy services with the same licensed therapist after discharge from IHTS to ensure treatment continuity and engagement.

The organization providing IHTS must provide telephonic crisis response 24/7 but this may be provided by staff other than members of the IHTS team. The provider ensures that crisis response staff have access to the member's crisis plan developed with IHTS. Following a crisis event, crisis plans must be reviewed and modified if needed.
Clinicians must follow the standard credentialing process. QP/APs shall receive supervision as outlined in an individualized supervision plan.

Copyright © 2026 Vaya Partners. All rights reserved.

Licensed Professional (LP)
A fully licensed professional who has the knowledge, skills and abilities required by the population and age to be served. For services focused on substance use disorder interventions, the therapist must be either a certified clinical supervisor (CCS) or a licensed clinical addiction specialist (LCAS).

May also use Qualified Professional (QP) in addition to the LP
QP who has the knowledge, skills and abilities required by the population and age to be served to provide coordination of care and case coordination tasks

May also use Associate Professional (AP) in addition to the LP
AP who has been trained as a Family Partner and who has the knowledge, skills, and abilities required by the population and age to be served to provide coordination of care and coordination of care functions. Training as a Family Partner includes the following trainings, at minimum.

- Family Partner 101
- Motivational Interviewing
- Child and Family Teams 1
- Trauma Informed Care
- WRAP (Wellness Recovery Action Planning)

The LP is responsible for all therapy provision and may also perform the coordination functions. The QP and/or AP may perform only the coordination functions, although they may reinforce some of the skills and interventions being implemented through the therapy sessions.

The LP, QP and, AP must complete the following trainings:

- All mandatory state and employee training as required by North Carolina General Statutes.
- 1 hour of crisis response training
- Training on crisis plan development to be able to develop enhanced crisis plan for all youth under this definition
- A minimum of 24 hours of training, completed within the past 10 years, in therapy practices, clinical interventions and treatment modalities to the population being served
- For the selected evidence-based treatment modality, LP completes training as required for the treatment modality by the developer of the model or qualified trainer. For trauma-focused treatment, this includes participation in a yearlong learning collaborative.
- Annual follow-up training and ongoing continuing education as required for the chosen modality (a minimum of 10 hours annually in the chosen modality is required, unless best-practice training recommendations for the specific modality recommend more)

Service Delivery Requirements

a. Availability of 24-hour telephonic crisis response with agency staff who have access to the member's specific crisis plan.
b. Minimum 60% of therapy interventions include family/caregivers.
c. Minimum 85% of therapy services are in the home or community settings over the course of treatment (expectation is that this may be higher initially with titration over time)
d. 60% of total encounter time consists of therapy (vs. case management/case coordination activities).
e. CANS-MH assessment completed at admission, every 60 days, and at discharge
f. Service exclusions are adhered to (does not occur during the same authorization period)
    - Intensive In-Home Services (IIHS)
    - Multisystemic Therapy (MST)

Copyright © 2026 Vaya Partners. All rights reserved.

- Day Treatment
- Individual, group, and family therapy (billed as separate services, as these interventions as part of IHST service)
- Substance Abuse Intensive Outpatient Program (SAIOP)
- Child residential treatment services
- Psychiatric Residential Treatment Facility (PRTF)
- Substance abuse residential services.

g. Service is not to be billed on dates when members are receiving inpatient hospitalization services but may facilitate coordination of discharge plans if admission occurs.
h. Adherence to supervision plans

Member Eligibility Requirements

To be eligible for In-Home Therapy, the member (ages three to 21) must have NC Medicaid based on residence in a county located within Vaya Partners region and be enrolled in the State of North Carolina MH/IDD/SAS Health Plan waiver authorized pursuant to section 1915(b) of the Social Security Act, and meet **ALL** the following criteria:

a. A mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), is present other than a sole diagnosis of intellectual and developmental disability
b. Based on the current comprehensive clinical assessment (CCA), this service was indicated, and traditional office-based outpatient treatment services were considered or previously attempted, but were found to be inappropriate or not effective
c. The CCA identifies the need for linkage and/or coordination with other service systems or community resources to prevent family disruption or need for more intensive levels of care
d. The member's symptoms and behaviors at home, school, or in other community settings due to the member's mental health or substance use disorder condition, are moderate to severe in nature and require intensive, coordinated clinical interventions
e. Evidence of impaired functioning in at least two major life domains, which are significantly affecting the member's behavioral health, as evidenced by at least two of the following:
    1. Housing insecurity (problems with safety/stability)
    2. Education/school problems
    3. Physical health care linkage or access needs
    4. Involvement with one or more of the following:
        i. Department of Social Services (involvement due to allegations of abuse, neglect, etc. or involvement for prevention based on identification of at-risk factor for potential removal of children from the home; safety concerns ; reports that were unsubstantiated, but some concerns still identified or members in custody working towards family reunification)
        ii. Department of Juvenile Justice or other legal system (individuals actively on probation, on diversion contracts, being discharged from jail or youth detention or identified as at risk for involvement due to criminal activities)
        iii. Exceptional Children's Program (actively involved with Individualized Education Plan (IEP), 504 plan, or alternative school setting; individuals identified as in need of these school services that are not yet actively in place; individuals that may be able to be maintained in traditional settings with some additional support and coordination, such as behavior plans or early intervention)
    5. The member does not present with an imminent risk of out of home placement based on MH/SU diagnosis AND does not have a history of multiple crisis events within the last six months
    6. There is no evidence to support that alternative interventions would be equally or more effective, based on North Carolina community practice standards (Best Practice Guidelines of the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine)

Copyright © 2026 Vaya Partners. All rights reserved.

Utilization Management

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to eligible beneficiaries.

Prior Approval Requirements

No prior Authorization for IHTS is required unless when this service is stacked with another enhanced service. Initial authorization for services may not exceed six months. Re-authorization must be conducted every six months. The member must meet all criteria outlined in the "Member Eligibility Requirements" section specific above. Documentation required for an initial authorization includes a Service Authorization Request (SAR), Comprehensive Clinical Assessment, Person Centered Plan (PCP), Child and Adolescent Level of Care Utilization System (CALOCUS) for children ages 6-18 or Child and Adolescent Needs and Strengths (CANS) for children younger than 6 years of age. Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's PCP. Medical necessity is determined by North Carolina community practice standards, as verified by Vaya Partners, which will evaluate the request to determine if medical necessity supports more or less intensive services. Medically necessary services are authorized in the most cost-effective mode, as long as the treatment that is made available is similarly efficacious as services requested by the beneficiary's physician, therapist, or other licensed practitioner. Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment.

Continued Stay Criteria

The CANS and CALOCUS tools will be used to guide the determination of whether an IHTS member continues to meet the entrance criteria above. The service should be time limited, estimated at no more than six months.

The member is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the member's Person-Centered Plan or care plan; or the member continues to be at risk for out-of-home placement, based on current clinical assessment, history, and the tenuous nature of the functional gains.

AND

One of the following applies:

a. The member has achieved current service plan goals, and additional goals are indicated as evidenced by documented symptoms;
b. The member is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the service plan;
c. The member is making some progress, but the specific interventions in the service plan need to be modified so that greater gains, which are consistent with the member's premorbid level of functioning, are possible; or
d. The member fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the service plan. The member's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

This service shall be covered when the service is medically necessary and:

a. The procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member's needs;
b. The procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide;
c. The procedure, product, or service is furnished in a manner not primarily intended for the convenience of the

Copyright © 2026 Vaya Partners. All rights reserved.

member, the member's caretaker, or the provider; and

d. The member meets and continues to meet the eligibility requirements for this service, and treatment goals have not yet been achieved. Services and interventions must be reviewed for effectiveness, and interventions should be modified, if necessary, so that the individual makes greater progress.

Transition or Discharge Criteria

The criteria for transition or discharge of the member from IHTS:

a. The member has made significant progress toward rehabilitation goals and discharge to basic, office-based therapy services with the same licensed therapist is indicated.
b. The member requires a more intensive level of care or service.
c. The member or legally responsible person no longer wishes for the service to continue.

EPSDT SPECIAL PROVISION

Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

- That is unsafe, ineffective, or experimental or investigational
- That is not medical in nature or not generally recognized as an accepted method of medical practice or treatment

EPSDT and Prior Approval Requirements

If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

Important additional information about EPSDT and prior approval is found in the NC Tracks Provider Claims and Billing Assistance Guide and on the EPSDT provider page.

Service limitations on scope, amount, duration, frequency, location of service and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problem.

Copyright © 2026 Vaya Partners. All rights reserved.

Documentation Requirements

These services shall be properly and contemporaneously documented in accordance with this section and the DMH/DD/SAS Records Management and Documentation Manual 45-2 (RMDM) prior to seeking reimbursement from Vaya Partners.

Regardless of the service type, significant events in an individual's life that require additional activities or interventions shall be documented over and above the minimum frequency requirements.

Providers shall make all documentation supporting claims for services reimbursed by Vaya Partners available to Vaya Partners, NCDHHS and CMS upon request.

- A full service note that meets the requirements per APSM 45-2 Records Management and Documentation Manual is required for all dates of service. The note must include the activities performed and the agencies contacted, if applicable.
- Documentation required for this service should be maintained in the provider's medical record for the individual and a full-service note is required for all dates of service. This should include a note of the activities preformed, amount of time spent, agencies contacted, if applicable, and signature and credentials of the individual providing the service.
- If the services are delivered telephonically or through telehealth methods, the documentation must clearly support why this is the most appropriate service delivery method.
- A service order signed by a master's level behavioral health professional fully licensed in the state of North Carolina with at least two years of post-master's degree experience with the population served
- Providers shall make all documentation supporting claims for IHTS reimbursed by Vaya Partners available to Vaya Partners and NCDHHS upon request.

Claims-Related Information

Providers shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins issued by the NC Division of Heath Benefits (DHB), NC Department of Health and Human Services (NCDHHS) Clinical Coverage Policies, this service definition, Vaya Partners' fee schedule and other requirements and any other relevant documents for specific coverage and reimbursement for Medicaid.

1. **Claim Type:** Professional (CMS-1500/837P transaction) billed through Vaya Partners.
2. **International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS):** Provider(s) shall report the ICD-10-CM and Procedural Coding to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description.
3. **Codes and Modifiers:** Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
4. **Billing Units:** Providers bill this service on a unit basis. Only one unit may be billed per week. To be able to bill for this service, the provider must have provided a minimum of two hours of treatment during the week (Sunday to Saturday). The average consumer will receive this service for up to six months, so the expected utilization is 24 units. The service is time limited, estimated at no more than six months.
5. **Place of Service:** This service is provided in any location. IHTS providers shall deliver services in various environments, such as homes, schools, court, homeless shelters, libraries, street locations and other community settings. IHTS also includes telephonic contact with the member and their family or caregivers, as well as collateral contact with people who assist the member in meeting their rehabilitation goals specified in the service plan. IHTS

Copyright © 2026 Vaya Partners. All rights reserved.

includes participation and ongoing clinical involvement with the Child and Family Team and meetings for the planning, development, implementation, and revision of the care plan.

6. **Prior Authorization:** No prior authorization required unless stacked with other services.
7. NC Tracks Enrollment: Providers must be enrolled through NC Tracks and ensure valid NPIs, taxonomies, sites, zip code (+4) and all other provider demographic information provided to Vaya Partners matches the information in NC Tracks to bill and be reimbursed for this service.
8. **Coordination of Benefits:** Providers must file with primary payor(s) prior to submission of claims for payment to Vaya Partners, if applicable.
9. **Reimbursement:** Vaya Partners reimburses providers for clean claims for services rendered in accordance with this Service Definition.

Copyright © 2026 Vaya Partners. All rights reserved.