

Clinical Policy: Intensive In-Home Services for Youth

Reference Number: NH.CP.BH.400

Last Review Date: 4/2026

Effective Date: 7/1/2026

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Statement

This policy describes coverage criteria and provider requirements for Intensive In-Home Services for members under age 21 (through age 20 years, 364 days), consistent with the EPSDT benefit, delivered in home and community settings.

Purpose

To ensure consistency in the application of services for members who require Intensive In-Home Services for Youth.

Scope

This policy applies to the delivery of HCPS code H0040 for Intensive In-Home Services for members under age 21.

Description

The Plan considers the use of intensive in-home services for youth to be medically necessary when the Plan's clinical criteria are met, and it is a covered service for the member or is required Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for a member aged twenty-one or younger on the date of service.

Intensive in-home services are a flexible, community-based mental health service for youth and families, delivered in the home or other natural settings. Services include daily wrap around support provided by a multi-disciplinary team to proactively reduce crisis situations, prevent emergency department visits, and lower inpatient hospital readmissions.

Policy/Criteria

I. For members aged 5-20, services may be covered when needed to correct or ameliorate physical or behavioral health condition, including improving functioning or preventing deterioration. Documentation must describe needs/impairment, why this level of care is appropriate, measurable goals, and how services address the condition; Medical Director review may be required.

It is the policy of New Hampshire Healthy Families that intensive in-home services for youth are medically necessary when meeting all the following:

Applicable criteria must be met in item 1 and item 2 or is a required EPSDT service.

Medical necessity criteria for intensive in-home services for youth:

ALL criteria must be met in items (1) through (5):

- (1) Member is under age 21 on the date of service; AND

(2) Comprehensive behavioral health assessment indicates service is needed to address problem-solving, limit-setting, safety planning, and communication; advance therapeutic goals; improve interaction patterns; and strengthen the caregiver's ability to maintain the member at home and prevent higher levels of care; AND

(3) Member resides in a family home environment (e.g., foster, adoptive, birth, kinship) and parent/guardian/caregiver agrees to continued care; AND

(4) Required consent is obtained.

2. ALL criteria must be met in item (1) and item (2):

(1) Member and parent/guardian/caregiver actively participate in treatment as required by the treatment plan and to the extent possible given the member's condition; AND

(2) Member's condition continues to warrant intensive in-home service, and criterion is met in either item (a) or item (b):

(a) Progress toward identified treatment plan goal(s) is evident and has been documented based upon the objectives defined for each goal, but the goal(s) has not been achieved, OR

(b) Progress has not been made, and the treatment team have identified and implemented changes to the treatment plan to support the goal(s), OR

II. It is the policy of New Hampshire Healthy Families that intensive in-home services for youth may be appropriate for discontinuation and/or transfer to alternative or less intensive levels of care when meeting any of the following:

(1) Initial service criteria are no longer met and/or member meets criteria for a less- or more-intensive level of care, OR

(2) Treatment plan goals and objectives have been substantially met, and continued services are not necessary to prevent the member's behavioral health condition from worsening, OR

(3) Member and parent/guardian/caregiver are not engaged in treatment, and despite multiple documented outreach efforts, the lack of engagement suggests withdrawn consent or renders treatment at this level ineffective or unsafe, OR

(4) Required consent for treatment is withdrawn, OR

2. Medical director review is required when medical necessity criteria (item 1 above) are not met, or individual consideration is necessary for EPSDT services.

3. Services may be delivered in-person or via telehealth in accordance with NH Medicaid telehealth requirements. In-person services are preferred, but telehealth may be utilized when necessary to ensure timely access and continuity of care.

Limitations and Exclusions

The Plan considers ANY service listed in items 1 through 6 NOT medically necessary:

1. Intensive in-home services for youth when the Plan's medical necessity criteria are not met.

2. Member exhibits suicidal or homicidal ideation at the time of the request.

3. Member is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of request and is not ready for discharge to a family home environment or community setting with community-based supports.

4. Service setting presents a significant safety risk to the service provider, alternative community settings are not likely to reduce the risk, and no other safe venue is available or appropriate for this service.

5. Member is in an independent living situation and is not in the family's home or returning to a family setting.

6. Member has medical conditions or impairments that would prevent the member from benefiting from the service.

Prior Authorization Requirements

- No prior authorization is required for Participating Providers.
- Prior authorization is required for Non-Participating Providers.

For eligible members, documentation must support that requested services are medically necessary to correct or ameliorate a condition and must meet applicable medical necessity criteria and program requirements. The Health Plan may conduct prospective, concurrent, or retrospective clinical reviews, including audits, to determine medical necessity and compliance with documentation requirements. Services that are not supported by sufficient documentation and/or are determined not medically necessary may be denied, adjusted, or subject to recovery/recoupment in accordance with applicable law, regulation, and the provider contract.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers are responsible for complying with applicable administrative review, documentation, and coverage requirements for the services described in the Clinical Criteria section and Limitations and Exclusions section of this clinical policy, even if an applicable code appropriately describing the service is not included in the policy’s Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

HCPCS Code Description: H0040 Assertive community treatment program, per diem. Code covered for intensive in-home services for youth when medically necessary.

Plan note: Used for youth mental health emergency diversion program. While the Intensive In-Home Services for Youth policy applies to members aged 5 through 20, New Hampshire Healthy Families remains committed to ensuring comprehensive EPSDT coverage for all Medicaid-enrolled children under age 21. For children under age 5 who may require intensive behavioral health support, alternative EPSDT-covered services—such as early childhood mental health programs or other developmentally appropriate interventions—are available to meet their needs and ensure there are no gaps in care.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed.	2/26	2/26
Policy Revised	4/26	4/26

References

[Efficacy of Home-Based and Inpatient Treatment for Children and Adolescents in Psychiatric Crisis: A Systematic Review Protocol. PLoS One. 2025 Mar;20\(3\):e0318792. doi:10.1371/journal.pone.0318792. PMID: 40063892. Graf D, Sigrist C, Boege I, Cavelti M, Koenig J, Kaess M.](#)

[Effectiveness of Home Treatment in Children and Adolescents with Psychiatric Disorders: Systematic Review and Meta-Analysis. BMC Med. 2024 Jun 13;22\(1\):241. doi:10.1186/s12916-024-03448-2. PMID: 38867231. Keiller E, Masood S, Wong BH, Avent C, Bediako K, Bird RM, Boege I, Casanovas M, Dobler VB, James M, Kiernan J, Martinez-Herves M, Ngo TVT, Pascual-Sanchez A, Pilecka I, Plener PL, Prillinger K, Sabbah Lim I, Saour T, Singh N, Skouta E, Steffen M, Tolmac J, Velani H, Woolhouse R, Zundel T, Ougrin D.](#)

<https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment>

[The Mental Health Parity and Addiction Equity Act of 2008 \(MHPAEA\). The Center for Consumer Information & Insurance Oversight. Centers for Medicare and Medicaid Services \(CMS\).](#)

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be

subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/Enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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