

PHP_3.01 Behavioral Health Treatment			
Original Policy Date:	November 1, 2025	Effective Date:	June 1, 2026
Section:	3.0 Mental Health	Page:	Page 1 of 12

State Guidelines

Applicable Medi-Cal guidelines as of the publication of this policy (**this guideline supersedes the criteria in the Policy Statement section below**):

- I. Department of Managed Health Care (DMHC) All Plan Letter (APL) Guideline:
 - N/A
- II. Department of Health Care Services (DHCS) Provider Manual Guideline:
 - N/A
- III. Department of Health Care Services (DHCS) All Plan Letter (APL) Guideline:
 - [APL 23-010](#) – Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21

Below is an excerpt of the guideline language. Please refer to the specific All Plan Letter in the link above for the complete guideline.

Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 Background:

In accordance with federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, Medi-Cal provides coverage for all Medically Necessary Behavioral Health Treatment (BHT) services for eligible beneficiaries under 21 years of age. This includes children diagnosed with autism spectrum disorder (ASD) and children for whom a licensed physician, surgeon, or psychologist determines that BHT services for the treatment of ASD are Medically Necessary, regardless of diagnosis.^{1,2}

BHT services include applied behavioral analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction. The goal is to promote, to the maximum extent practicable, the functioning of a beneficiary, including those with or without a diagnosis of ASD. Examples of BHT services include behavioral interventions, cognitive behavioral intervention, comprehensive behavioral treatment, language training, modeling, natural teaching strategies, parent/guardian training, peer training, pivotal response training, schedules, scripting, self-management, social skills package, and story-based interventions.

Policy:

For the EPSDT population, state and federal law define a service as “Medically Necessary” if the service is necessary to correct or ameliorate defects and physical and/or mental illnesses and conditions.^{3,4}

Medical necessity decisions are individualized. Therefore, MCPs are prohibited from imposing service limitations on any EPSDT benefit other than medical necessity.

MCPs must comply with mental health parity requirements when providing BHT services. Treatment limitations for BHT services may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits.

I. Criteria for BHT Services for Members Under the Age of 21

When considering a Member's need for BHT services under Medicaid, the MCP must ensure the Member:

- 1) Has a recommendation from a licensed physician, surgeon, or psychologist that evidence-based BHT services are Medically Necessary and covered under Medicaid;
- 2) Is medically stable; and
- 3) Does not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities.

II. Covered Services

BHT services must be:

- 1) Medically Necessary and covered under Medicaid;
- 2) Provided and supervised in accordance with an MCP-approved behavioral treatment plan that is developed by a BHT service Provider who meets the requirements in California's Medicaid State Plan; and,
- 3) Provided by a Qualified Autism Service Provider, Qualified Autism Service Professional, or Qualified Autism Service Paraprofessional who meets the requirements contained in California's Medicaid State Plan.⁵

III. Non-Covered Services

Medi-Cal does not cover the following as BHT services under the EPSDT benefit:

- 1) Services rendered when continued clinical benefit is not expected, unless the services are determined to be Medically Necessary.
- 2) Provision or coordination of respite, day care, recreational services, educational services, or reimbursement of a parent, legal guardian, or legally responsible person (hereinafter, "Guardian") for costs associated with participation under the behavioral treatment plan.
- 3) Treatment where the sole purpose is vocationally- or recreationally-based.
- 4) Custodial care. For purposes of BHT services, custodial care:
 - a. Is provided primarily to maintain the Member's or anyone else's safety; and,
 - b. Could be provided by persons without professional skills or training.
- 5) Services, supplies, or procedures performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
- 6) Services rendered by a parent or legal custodian.
- 7) Services that are not evidence-based behavioral intervention practices.

MCPs are not contractually responsible for educationally necessary BHT services covered by a Local Educational Agency (LEA) and provided pursuant to a Member's Individualized Family Service Plan (IFSP), Individualized Education Program (IEP), or Individualized Health and Support Plan (IHSP). However, if Medically Necessary and covered under Medicaid, the MCP must provide supplementary BHT services, and must provide BHT services to address gaps in service caused when the LEA discontinues the provision of BHT services (e.g., during a public health emergency [PHE]).⁶ Lastly, if medically necessary BHT services are otherwise still needed, but the need is not documented in an IEP or IFSP/IHSP, then the MCP may coordinate any needed BHT services in a school-linked setting.

IV. Behavioral Treatment Plan

- BHT services must be provided, observed, and directed under an MCP-approved behavioral treatment plan.

- The behavioral treatment plan must be person-centered and based on individualized, measurable goals and objectives over a specific timeline for the specific Member being treated.
- The behavioral treatment plan must identify the Medically Necessary services covered by Medicaid to be provided in each community setting in which treatment is medically indicated, including on-site at school or during remote school sessions.
- Medically Necessary BHT services provided under the MCP-approved behavioral treatment plan must be provided by qualified Providers in accordance with California's Medicaid State Plan.
- In cases where the MCP-approved behavioral treatment plan includes BHT services provided during school hours, the MCP must ensure effective coordination with the LEA, as necessary.
- The Provider of BHT services must review, revise, and/or modify no less than once every six months the behavioral treatment plan.
- If services are no longer Medically Necessary under the EPSDT medical necessity standard, then the behavioral treatment plan must be modified or discontinued.³
- Decreasing the amount and duration of services is prohibited if the therapies are Medically Necessary.
- MCPs must permit the Member's Guardian(s) to be involved in the development, revision, and modification of the behavioral health treatment plan, in order to promote Guardian participation in treatment.

The approved behavioral treatment plan must also meet the following criteria:

- 1) Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
- 2) Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
- 3) Identify measurable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
- 4) Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
- 5) Include the Member's current level of need (baseline, expected behaviors the Guardian will demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal as met, not met, or modified (include explanation).
- 6) Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the Member.
- 7) Clearly identify the service type, number of hours of direct service(s), observation and direction, Guardian training, support, and participation needed to achieve the goals and objectives, the frequency at which the Member's progress is measured and reported, transition plan, crisis plan, and each individual Provider who is responsible for delivering services.
- 8) Include care coordination that involves the Guardian, school, state disability programs, and other programs and institutions, as applicable.
- 9) Consider the Member's age, school attendance requirements, and other daily activities when determining the number of hours of Medically Necessary direct service and supervision. However, MCPs must not reduce the number of Medically Necessary BHT hours that a Member is determined to need by the hours the Member spends at school or participating in other activities.

- 10) Deliver BHT services in a home or community-based setting, including clinics. BHT intervention services provided in schools, in the home, or other community settings, must be clinically indicated, Medically Necessary and delivered in the most appropriate setting for the direct benefit of the Member. BHT service hours delivered across settings, including during school, must be proportionate to the Member's medical need for BHT services in each setting.
- 11) Include an exit plan/criteria. However, only a determination that services are no longer Medically Necessary under the EPSDT standard can be used to reduce or eliminate services.³

V. Coordination of Care

MCPs have primary responsibility for ensuring that EPSDT members receive all Medically Necessary BHT services covered under Medicaid. MCPs must establish data and information sharing agreements as necessary to coordinate the provision of services with other entities that may have overlapping responsibility for the provision of BHT services, including but not limited to [Regional Centers](#) (RCs), LEAs, and County Mental Health Plans. When another entity has overlapping responsibility to provide BHT services to the Member, the MCP must:

- 1) Assess the medical needs of the Member for BHT services across community settings, according to the EPSDT standard;
- 2) Determine what BHT services (if any) are actively being provided by other entities;
- 3) Coordinate the provision of all services including Durable Medical Equipment and medication with the other entities to ensure that the MCP and the other entities are not providing duplicative services; and
- 4) Ensure that all of the Member's medical needs for BHT services are being met in a timely manner, regardless of payer, and based on the individual needs of the Member.

The MCP is the primary Provider of Medically Necessary BHT services for Members eligible for EPSDT. Whenever Members are unable to receive BHT services from school-based Providers or other entities with overlapping responsibility for the provision of BHT services, the MCP is responsible for covering gaps in Medically Necessary services covered under Medicaid for the Member. MCPs are required to provide case management and coordination of care to ensure that Members can access Medically Necessary BHT services. For example, when school is not in session, MCPs must cover Medically Necessary BHT services that were being provided by the LEA when school was in session.

Policy Statement

- N/A

Policy Guidelines

Initial Requests for Services require verification that the member is enrolled with a Local Regional Center.

Coding

See the [Codes table](#) for details.

Description

Medically necessary treatment or services for autism spectrum disorder or pervasive developmental disorder may include, but is not limited to, speech therapy, occupational therapy, and behavioral health treatment (BHT). BHT consists of professional services and treatment programs, including

applied behavior analysis (ABA) and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism spectrum disorder. This medical policy pertains to ABA in the outpatient setting only.

Applied Behavior Analysis

Applied behavior analysis is a discipline that applies human behavior principles in various settings, i.e., clinics, schools, homes, and communities, to diminish substantial deficits in a recipient's adaptive functioning or significant behavior problems due to autism spectrum disorder. This technique applies interventions to address three core areas of behavioral functioning:

1. Deficits in developmentally appropriate self-care include, but are not limited to:
 - Feeding
 - Grooming
 - Activities of daily living (e.g., dressing, preparing for school)
 - Preoccupation with one or more restricted, stereotyped patterns of behavior that are abnormal in intensity or focus
 - Inflexible adherence to specific, nonfunctional routines or rituals
 - Stereotyped, repetitive motor mannerisms
 - Persistent preoccupation with parts of objects
2. Impairments in social adaptive skills include, but are not limited to:
 - Delay in or lack of spoken language
 - Inability to sustain adequate conversation with others
 - Impairment in non-verbal behaviors in social interaction
 - Failure to develop peer relationships
 - Lack of spontaneous seeking to share emotions in relationships
 - Lack of social or emotional reciprocity
3. Prevention of harm to self or others (safety concerns) include, but are not limited to:
 - Aggression directed to self or others (e.g., hitting, biting)
 - Engaging in dangerous behaviors (e.g., eating nonfood items, running into the street, elopement)

Autism Spectrum Disorders

The diagnostic category of autism spectrum disorders refers to a group of developmental conditions that involve delayed or impaired communication and social skills, behaviors, and cognitive skills (learning). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR[®]) has established a category for autism spectrum disorders which allows for the accountability of variations in symptoms and behaviors.¹

Autism Spectrum Disorder is characterized by the following⁷:

- Difficulty with communication and interaction with other people
- Restricted interests and repetitive behavior
- Symptoms that affect their ability to function in school, work, and other areas of life

Related Policies

- N/A

Benefit Application

Blue Shield of California Promise Health Plan is contracted with L.A. Care Health Plan for Los Angeles County and the Department of Health Care Services for San Diego County to provide Medi-Cal

health benefits to its Medi-Cal recipients. In order to provide the best health care services and practices, Blue Shield of California Promise Health Plan has an extensive network of Medi-Cal primary care providers and specialists. Recognizing the rich diversity of its membership, our providers are given training and educational materials to assist in understanding the health needs of their patients as it could be affected by a member's cultural heritage.

The benefit designs associated with the Blue Shield of California Promise Medi-Cal plans are described in the Member Handbook (also called Evidence of Coverage).

Regulatory Status

California Law

This medical policy is based on the Cal. Health & Safety Code § 1374.73⁸ which requires health care service plans to provide coverage of behavioral health treatment for individuals with autism spectrum disorders.

Cal. Health & Safety Code § 1374.73 requires that behavioral health treatment meet all of the following criteria⁵:

- The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.
- The treatment is provided under a treatment plan prescribed by a qualified autism service provider and is administered by one of the following:
 - A qualified autism service provider.
 - A qualified autism service professional supervised by the qualified autism service provider.
 - A qualified autism service paraprofessional supervised by a qualified autism service provider or qualified autism service professional.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
 - Describes the patient's behavioral health impairments or developmental challenges that are to be treated.
 - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
 - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
 - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

A qualified autism service provider is defined as either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission

for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.

- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

A qualified autism service professional is defined as an individual who meets all of the following criteria:

- A. Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.
- B. Is supervised by a qualified autism service provider.
- C. Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.
- D. Is either of the following:
 - (i) Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
 - (ii) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.
- E.
 - (i) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
 - (ii) If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.
- F. Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

A qualified autism service paraprofessional is defined as an unlicensed and uncertified individual who meets all of the following criteria:

- Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service provider.
- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
- Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

Additionally, a health insurer may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing.

NOTE: A board-certified behavioral analyst (BCBA) could prescribe ABA treatment for autism spectrum disorder or pervasive developmental disorder.

Health Equity Statement

Blue Shield of California Promise Health Plan's mission is to transform its health care delivery system into one that is worthy of families and friends. Blue Shield of California Promise Health Plan seeks to advance health equity in support of achieving Blue Shield of California Promise Health Plan's mission.

Blue Shield of California Promise Health Plan ensures all Covered Services are available and accessible to all members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

Rationale

Blue Shield of California Promise Health Plan will provide coverage for medically necessary outpatient Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) services for individuals when the BHT/ABA services are ordered and deemed medically necessary based on the specific applicability and criteria outlined by Health and Safety code 1374.73 and the Medi-Cal state guidelines as outlined in the Blue Shield of California Promise Medical Policy.

References

1. American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.).
2. Department of Healthcare Services All Plan Letter. APL 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APL. Accessed September 24, 2025 from <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.
3. 42 USC Section 1396d(r); EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents, JUNE 2014 at pp. 23-24. Accessed September 24, 2025 from [A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents](#).
4. Welfare and Institutions Code (WIC) Section 14059.5(b)(1). Accessed September 24, 2025 from <https://leginfo.legislature.ca.gov/>.
5. California's Medicaid State Plan, Limitations on Attachment 3.1-A, 13c – Preventive Services, BHT, and Attachment 3.1-A, Supplement 6. Accessed on September 24, 2025 from [State Plan Section 3](#).
6. IFSP and IEP services; Individuals with Disabilities Education Act, 20 USC 1400 et seq. (See definition at 20 USC Section 1401). Accessed on September 24, 2025 from [Subchapter I - Individuals with Disabilities Education Act](#).
7. National Institute of Mental Health (NIMH). Autism Spectrum Disorder. 2024. Accessed September 24, 2025, from <https://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd>
8. California Health and Safety Code Section 1374.73. 2012. Amended by Stats. 2023, Ch. 635, Sec. 1. (SB 805) Effective January 1, 2024. Accessed September 24, 2025, from

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.73&lawCode=HSC

9. Department of Healthcare Services All Plan Letter. All Plan Letter [APL 23-010](#): Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, or any superseding APL. Accessed September 24, 2025 from <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.

Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
 - Documentation of the type and degree of behaviors needing treatment (including frequency of baseline behaviors)
 - Functional assessment
 - Clinical findings (i.e., pertinent symptoms and duration)
 - Comorbidities
 - Activity and functional limitations
 - Family history, if applicable
 - Past and present diagnostic testing and results
- Proposed/current treatment plan including but not limited to the anticipated response to treatment, goals (date of introduction, estimated date of mastery) and other types of treatment that have been tried (with results) or considered but excluded
- For continuation, documented progress/improvement (if applicable) but not having yet met goals; why gains cannot be maintained with a lower level of care; and that treatment has not worsened issues
- Care coordination that involves the Guardian, school, state disability programs, and other programs and institutions, as applicable
- Clear identification of the service type, number of hours of direct service(s), observation and direction, Guardian training, support, and participation needed to achieve the goals and objectives, the frequency at which the Member's progress is measured and reported, transition plan/criteria, crisis plan, and each individual Provider who is responsible for delivering services
- Copy of the most current individualized education program (IEP)/intervention support program (ISP) (if applicable)
- Documentation of enrollment with local Regional Center
- Discharge summary from earlier treatment (if applicable/available)
- Other pertinent multidisciplinary notes/reports: (i.e., psychological or psychiatric evaluation, physical therapy, speech therapy, occupational therapy, multidisciplinary pain management), when applicable

Post Service (in addition to the above, please include the following):

- Results/reports of tests performed
- Procedure report(s)
- All multidisciplinary treatment notes documenting dates performed and hours spent

Coding

The list of codes in this Medical Policy is intended as a general reference and may not cover all codes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy.

Type	Code	Description
CPT®	0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.
	0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.
	97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
	97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes
	97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes
	97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes
	97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes
	97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
	97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
	97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes
HCPCS	G9012	Other specified case management service not elsewhere classified
	H0031	Mental health assessment, by nonphysician
	H0032	Mental health service plan development by nonphysician
	H0046	Mental health services, not otherwise specified
	H2014	Skills training and development, per 15 minutes
	H2019	Therapeutic behavioral services, per 15 minutes
	S5108	Home care training to home care client, per 15 minutes

Type	Code	Description
	S5110	Home care training, family; per 15 minutes
	S5111	Home care training, family; per session

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
11/01/2025	New policy.
02/01/2026	Policy revision without position change.
03/01/2026	Administrative update.
06/01/2026	Administrative update. Definitions of Decision Determinations section updated.

Definitions of Decision Determinations

Healthcare Services: For the purpose of this Medical Policy, Healthcare Services means procedures, treatments, supplies, devices, and equipment.

Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Criteria Determining Experimental/Investigational Status

Below is an excerpt of the language taken from California Children's Services Numbered Letter 05-1020.*

*Department of Healthcare Services Numbered Letter 05-1020. Accessed April 21, 2026, from <https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-05-1020-Experimental-and-Investigational-Services.pdf>

Policy

- A. The California Children's Services (CCS) Program and the Genetically Handicapped Persons Program (GHPP) will not provide coverage for experimental services unless specifically authorized by law.
- B. The CCS Program and GHPP may provide coverage for an investigational service if:
 1. It is approved by the FDA under any Investigational New Drug (IND) Application; or
 2. It is authorized for use under the State of California's Right to Try Act; and
 3. Its use is consistent with its FDA-approved IND Application or the State of California's Right to Try Act;
- C. Additional criteria that will be considered in the adjudication process include:

1. Conventional therapy will not adequately treat the intended patient's condition;
2. Conventional therapy will not prevent progressive disability or premature death;
3. The provider of the proposed service has a record of safety and success with it or equivalent to that of other providers of the investigational services;
4. Other criteria (e.g., cost and availability) may be considered in the adjudication of a given request in cases in which more than one investigational service is available;
5. There is reasonable expectation that the investigational service will significantly prolong the patient's life or will maintain or restore a range of physical and social function suited to activities of daily living; and
6. The service is not being performed as part of a research study protocol. For a beneficiary with cancer who participates in a clinical trial for cancer, California Health and Safety Code (HSC) § 1370.6 requires that all routine patient care costs related to the clinical trial be covered if the beneficiary's CCS-paneled treating physician recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the enrollee. The coverage does not include investigational services that have not been approved by the FDA and that are associated with the clinical trial.

Feedback

Blue Shield of California Promise Health Plan is interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration. Our medical policies are available to view or download at www.blueshieldca.com/en/bsp/providers.

For medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Questions regarding the applicability of this policy should be directed to the Blue Shield of California Promise Health Plan Prior Authorization Department at (800) 468-9935, or the Complex Case Management Department at (855) 699-5557 (TTY 711) for San Diego County and (800) 605-2556 (TTY 711) for Los Angeles County or visit the provider portal at www.blueshieldca.com/en/bsp/providers.

Disclaimer: Blue Shield of California Promise Health Plan may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as member health services contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member health services contracts may differ in their benefits. Blue Shield of California Promise Health Plan reserves the right to review and update policies as appropriate.