Clinical Policy: Community-based Wraparound Service in Lieu of Services

Reference Number: FL.CP.BH.17
Date of Last Revision: 02/26

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy describes the clinical criteria on which to review requests for Community-based Wraparound Services (CBWA) In Lieu of Services for Sunshine Health's Managed Medical Assistance (MMA), HIV/AIDS, Serious Mental Illness (SMI), Children's Medical Services (CMS), and Child Welfare (CW) members. The goal is to provide intensive behavioral health wrap around services when medically necessary, as an alternative to Therapeutic Group Care (TGC) or Statewide Inpatient Psychiatric Program (SIPP) and to define criteria and limitations established for the use of CBWA services.

Policy/Criteria

I. It is the policy of Sunshine Health that Community-based Wraparound Service in Lieu of Services is considered **medically necessary** when all of the following criteria are met:
- A. Member has a Serious Emotional Disturbance (SED) qualifying diagnosis and could benefit from CBWA services as a diversion to higher levels of residential care or shorten the length of stay in higher levels of residential care;
- B. Treatment at a lower level of care has been given serious consideration and there is adequate evidence to indicate that the member's condition and functional level cannot improve with a less intensive service;
- C. Score in at least the moderate impairment range on behavior and functional rating scale with behaviors that are not considered to be a temporary response to a stressful situation.
- D. The treating provider must submit the following information and documentation with any request for Community-based Wraparound Services in Lieu of Services:
  1. Medical information and documentation to support I.A through I.C. above;
  2. Documentation that the member has consented to the In Lieu of Service as an alternative to a covered state benefit.

Redetermination
Prior to the expiration of the initial authorization period, the requesting practitioner must submit information on the member's status to Sunshine Health's utilization management department for a review to determine if subsequent approval is medically necessary using *Criteria I.A. through I.C.* as stated in this policy.

II. It is the policy of Sunshine Health that **discharge** from Community-based Wraparound Service in Lieu of Services is appropriate when one or more of the following criteria are met:
- A. Member is no longer at risk for TGC, SIPP, or out of home placement;
- B. Goals have been met.

III. It is the policy of Sunshine Health that Community-based Wraparound Service in Lieu of Services are **not medically necessary** when one or more of the following indications are met:

A. Member is ≥ 21 years of age;
B. Member is not at risk for a more intensive, restrictive, and costly behavioral health placement;
C. Services are combined with any other type of Targeted Case Management service on the same day, including Mental Health Targeted Case Management, Child Health Services Targeted Case Management, or Targeted Case Management for Children At-Risk of Abuse or Neglect;
D. Member is receiving case management services under a home and community-based service waiver;
E. The member's clinical problem is primarily social, financial, and/or medical in nature and there is an absence of a primary behavioral health diagnosis;
F. Member is simultaneously receiving similar therapeutic services of equal or greater intensity via another resource.

Note: Coverage that exceeds the benefit limit is excluded.

Background

Health plans have the option to offer "in lieu of services" (ILOS), which are alternate services or settings to those required by the state Medicaid plan. These services can be offered when the alternate service or setting is medically appropriate but is more cost effective than the Medicaid alternative; services are optional-members have the right to choose; and providers are contracted with the health plan.[4,10]

Community-based Wraparound Services (CBWA) is an intensive level of community-based services intended to prevent Therapeutic Group Care (TGC) and Statewide Inpatient Psychiatric Care (SIPP). The wraparound service delivery model is built around family team planning. Wraparound services include frequent assessment and treatment plan progress reviews, and treatment team meetings must include the full complement of professionals working with the family. Meeting frequency of member and family teams is guided by the family's needs and level of risk. Included in the wraparound services are intensive targeted case management, in-home intervention, crisis intervention, parenting, peer support, psychiatric services, and behavior analytical services.[2,6]

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 2025, 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 should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
H2022	Community-based wrap-around services, per diem

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		06/18
Archer system correction; no content review or revision		05/19
Annual review; no changes		06/20
Integration review; added SMI and FLCMS; adjusted provider type specification; removed discharge criteria "member no longer meets continued stay criteria" added "Member no longer at risk for TGC, SIPP, or out of home placement"		09/20
Policy update; LOB update-removed Comprehensive		09/21
Policy update; added designated vendor for clinical decision		01/22
Annual review; changed FLCMS to CMS; defined acronym CBWA		02/23
Transitioned policy to new state specific template, references updated and sent to market for approval; policy number changed from FL.UM.53.00 to FL.CP.BH.17.	01/24	
Annual review; no criteria changes-minor grammatical changes	02/24	
Annual review; Added note under description that services are available to members with HIV. Minor rewording with no impact on criteria. Background updated. References reviewed and updated. Reviewed by FL BH team.	02/25	
Annual review. Note following description removed; HIV/AIDS added to description section. II.C. removed. Rewording to III. to change limitations/exclusions to not medically necessary criteria for clarity. III.D. changed to a note. Added HCPCS code H2022. References reviewed and updated.	02/26	

References

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2. Agency for Health Care Administration (AHCA). Road to Recovery-Wraparound process. https://ahca.myflorida.com/content/download/11038/file/Wraparound_Brochure.pdf. Accessed January 23, 2026.
3. Agency for Health Care Administration (AHCA). Suitability assessments and access to residential treatment for children in the dependency system: out of home treatment services for children in managed care. Residential mental health treatment in Florida. https://ahca.myflorida.com/content/download/5039/file/Regional_SIPP_care_coordination_training_120815.pdf. Published December 8, 2015. Accessed January 23, 2026.

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9. Silva DJ, Petrilla CM, Matteson D, Mannion S, Huggins SL. Increasing resilience in youth and families: YAP's wraparound advocate service model. *Child & Youth Services.* 2020 41(1):51 to 82. https://doi.org/10.1080/0145935X.2019.1610870
10. National Conference of State Legislatures (NCSL). Leveraging in lieu of services in Medicaid managed care. https://www.ncsl.org/health/leveraging-in-lieu-of-services-in-medicaid-managed-care. Updated December 20, 2023. Accessed January 23, 2026.

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, 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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

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.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.