Clinical Policy: Child First Services

Reference Number: NC.CP.MP.502
Date of Last Revision: 02/2026

Coding Implications
Revision Log

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

Description

Note: Child First Services are not considered to be a Standard Plan covered service under NC Medicaid. As such, they may be covered only for children eligible for *EPSDT services* when determined to be the most clinically appropriate and cost-effective option to address the specific clinical circumstances of the child.

Child First Services is an intensive, early childhood, two-generation, home visiting intervention that works with the most vulnerable young children (prenatal through age five years) and their families. The goal is to heal and protect children from trauma and adversity. Child First works to identify children at the earliest possible time to both prevent and decrease emotional and behavioral problems, developmental and learning problems, and abuse and neglect. This innovative, home-based early childhood intervention is embedded in a system of care framework that is designed to decrease the incidence of developmental and learning problems, and abuse and neglect among the vulnerable young children and families. Child First is recognized as an evidence-based model by several national programs and clearinghouses under the federal Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), the California Evidence-based Clearinghouse, the Coalition for Evidence-based Policy, National Registry for Evidence-based Programs and Practices (NREPP), Colorado Blueprints, and the UK-based Early Intervention Foundation.

Population
Infants and young children with behavioral/emotional, developmental/learning problems, and/or abuse and neglect **AND** at risk for such conditions due to adverse life circumstances – including parental mental illness, substance use, maladaptive parenting practices, interpersonal violence, homelessness, incarceration, and/or extreme poverty – in which there is considerable risk to the health and development of the child.

Eligibility Criteria

I. It is the policy of Carolina Complete Health that EPSDT Child First Services must meet criteria for coverage as follows: **Must meet A or B; *And* C *And* D *And* E**:

A. Children aged 0-5 years who have received a comprehensive developmental evaluation by an appropriately skilled clinician and have been determined to have:
   1. A cognitive or communication developmental delay that impacts or is related to their social well-being **OR**
   2. Social emotional delay; **OR**
   3. A DSM-5 diagnosis of a neurodevelopmental disorder. **OR**

B. Children aged 0-5 who meet the DSM 5 criteria (or subsequent editions of this referenced manual) as diagnosed by an appropriately licensed behavioral health clinician in a Comprehensive Clinical Assessment (master's level or higher) for **one or more** of the following:
   1. Depressive Disorders
   2. Anxiety Disorders
   3. Obsessive-Compulsive and related disorders
   4. Trauma and Stressor Related Disorders
   5. Feeding and Eating Disorders
   6. Elimination Disorders
   7. Sleep Wake disorders
   8. Disruptive, Impulse-Control and Conduct Disorders.

- ***Note:*** *For children referred for a trauma related disorder, there should be documentation of a referral from the DSS or other official 3rd party report of trauma (legal system, juvenile justice, school)* ***AND;***

C. An evaluation by a developmental/behavioral pediatrician, child psychiatrist, or CDSA (if available, for children under the age of 3) should be completed for all children who appear to have a cognitive, communication or developmental disorder to determine most appropriate service as well as ability to engage appropriately with dyadic child-parent psychotherapy. This evaluation should be completed prior to requesting or receiving this service, **AND;**

D. 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). Alternative services that should be considered where available include but are not limited to the following:
   1. Child-parent psychotherapy as stand-alone services
   2. Trauma-focused Cognitive Behavioral Therapy (CBT) for children aged 3 and over
   3. CDSA Services available as a part of an Individualized Family Service Plan
   4. Other appropriate services for early childhood treatment including but not limited PPP, Incredible Years, Nurse Family Partnership(NFP) and Strengthening Families, **AND;**

E. In addition to the coverage criteria above, consideration will be given to the following contextual information:
   1. Child has experienced adverse life circumstances or has been exposed to potentially traumatic events (e.g., physical and/or emotional abuse and/or neglect, sexual abuse, exposure to community and/or interpersonal violence, acute or prolonged separation from primary caregiver, neonatal abstinence syndrome (NAS), housing or food insecurity, poor health and nutrition with frequent emergency visits or hospitalization, and extreme poverty.
   2. Evidence that the child is being negatively impacted by the behavioral health and/or substance abuse issues of the primary caregiver, adults, or other inhabitants in the home.

3. Inadequate parenting skills with the inability of the caregiver(s) in the home to be sensitive to and respond to the infant/child's signals.
4. DSS involvement, CMAR involvement, CDSA referral.
5. Environmental or other factors placing the child at risk for major life disruption or out of home placement such as eviction, homelessness, expulsion from day care or other early childhood programming, hospitalization of parent or child, and/or removal to foster care.

II. Continued Stay Criteria - 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 **and any one** of the following apply:

A. Member has achieved initial Person-Centered Plan goals, and these services are needed to meet additional goals.
B. Member is making satisfactory progress toward meeting goals.
C. Member is making some progress, but the Person-Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the Member's premorbid level of functioning, are possible or can be achieved.
D. Member is not making progress; the Person-Centered Plan must be modified to identify more effective interventions **OR**
E. Member is regressing; the Person-Centered Plan must be modified to identify more effective interventions.
F. Member would not be equally served by standard outpatient services, such as outpatient therapy, trauma-focused CBT, or child-parent psychotherapy standalone.

III. Discharge Criteria

A. The Member has achieved goals and is no longer in need of Child First services;
B. The Member's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;
C. The Member is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
D. The Member or legally responsible person no longer wishes to receive Child First services; **or**
E. The Member, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

IV. Expected Outcomes:

By the end of treatment, outcomes may include but are not limited to:

A. Decrease in child emotional behavioral challenges
B. Improvement in child's social skills and social competence
C. Improvement in child's language development
D. Strengthening of the parent child relationship
E. Decrease in identified mental health issues (i.e., maternal depression, PTSD, and parenting stress), that negatively impact the child.

Background

I. Mental Health Services

Child First is based on the principle that families want the absolute best for their children. Consistent, responsive, nurturing, parent-child relationships are the foundation for mental health, cognitive and language development, and physical health. Collaboration with community providers is essential to ensure that all family members receive comprehensive, coordinated services, and supports. Together, this promotes strong, healthy children and families. To help a child, the family must also be helped:

- **A.** Development of a responsive, nurturing parent-child relationship to buffer the child from high levels of stress and promote healthy functioning and resilience.
- **B.** Enhancing the parent's capacity to provide sensitive, age-appropriate care and protection with mutual pleasure in the parent-child relationship.
- **C.** Assisting parent in recognizing and addressing their behavioral or mental health issues, substance use issues, intimate partner violence, or basic needs that may be negatively impacting their ability to attend to the needs of the child.
- **D.** Planning and treatment based upon the values, culture, and strengths of the family.

II. Objectives -

The Child First evidence-based intervention is provided in the home by a team of a licensed, master's level Mental Health/Developmental Clinician and a bachelor's level Family Resource Partner. The intervention includes:

- **A.** Engagement of the family through building a respectful and trusting relationship.
- **B.** Stabilization of the family if they are experiencing immediate, severe challenges, like eviction.
- **C.** Comprehensive assessment of the child's health and development, important relationships, and parental strengths and challenges that directly impact a child's healthy growth and development.
- **D.** Development of a comprehensive, well-coordinated, family-driven plan of care (or treatment plan), in partnership with the family, which is highly individualized and based on family strengths, priorities, culture, and needs.
- **E.** Two-generation, trauma-informed Child-Parent Psychotherapy and parent guidance delivered to enhance the development of a secure, nurturing, protective relationship.
- **F.** Promotion of executive functioning capacity in both the parent and child, through play, interactive activities, and routines.
- **G.** Mental health assessment and consultation within the early care or school environment.
- **H.** Care coordination, including referrals and hands-on assistance, to connect all members of the family with community-based services and supports.

III. Development of Child and Family Plan of Care

- **A.** A family-driven plan of comprehensive, well-coordinated, therapeutic intervention, supports, and services is developed in partnership with the parents or caregivers. This

plan reflects the parents' goals, priorities, strengths, culture, and needs. This is an opportunity to build parental capacity to prioritize goals, develop stepwise strategies, and monitor the results, all enhancing parental executive functioning. It not only includes treatment goals and services for the identified child, but also includes resources for the parents and siblings as well. This plan serves as the Medicaid-compliant treatment plan.

IV. Parent-Child Mental Health Intervention

A. Psychotherapeutic intervention and parent guidance start early in the assessment process, especially when children have emotional and behavioral problems or have experienced trauma. A primary goal is to build parents' reflective capacity, to help them understand the meaning, feelings, and motivations which result in difficult child behavior. This process is different from learning a specific strategy to get rid of a "bad" behavior at a particular age. Instead, it equips parents with a method to address behaviors throughout the lives of their children, understanding that behavior is a communication that has meaning.

B. The Child First model fully integrates trauma-informed *Child-Parent Psychotherapy*. The home environment provides an opportunity to respond to identified problems as they arise in their natural setting, is much more convenient, and is without the stigma of going to a mental health facility. The parent-child dyadic, mental health intervention is an opportunity to intervene with two generations simultaneously, both the child and the parent. This is especially important when the parent has experienced trauma and suffers from depression or other mental health problems.

C. The intervention operates at multiple levels: Enhancing child safety, understanding normal developmental challenges and facilitating appropriate expectations, understanding unique child sensitivities and processing, understanding the impact of trauma on both child and parents, building child and parent emotional regulation, promoting a joyful and nurturing parent-child relationship, helping to reframe and develop new strategies to respond to the child's behavior, and exploring the relationship between parental feelings and history, and her/his response to the child. The goal is to build a healthy, secure parent-child attachment so that it serves both as a protective buffer to unavoidable stress and directly facilitates emotional, language, and cognitive growth as well as physical health.

V. Facilitation of Executive Functioning

A. The executive functioning capacity of parents and caregivers served by Child First is often severely compromised by the trauma they have experienced from childhood and thereafter and the lack of structure and scaffolding provided by their own parents. They frequently become emotionally dysregulated. They have difficulty with attention, planning, organization, memory, monitoring, and problem solving. The work of CF Clinicians directly improves both child and parental emotional regulation. Care Coordinators use the development and execution of the service plan to help build the parents' executive functioning capacities, so that they can thoughtfully plan, organize, problem solve, and succeed. There is additional focus on interactive, parent-child routines, games, and conversation. These skills enable parents to scaffold the

development of executive functioning in their own children, which is essential to their children's educational success.

VI. Consultation in Early Care and Education

A. As an integral component of the Child First intervention, the Mental Health Clinician works with the early care and education or school environment to provide consultation to the teacher or caregiver. This is especially critical when there are challenging behaviors within the classroom. The Clinician conducts observations, discusses past and current behavior with the teacher, and helps the teacher understand the meaning of the child's behavior. Together they develop strategies that can meet the child's individual needs and coordinate efforts between the early care setting or school and home.

VII. Care Coordination at the Service Level

A. The Family Resource Partner facilitates the coordination of services and the family's access to multiple resources throughout the community, based on the collaborative planning with the parents. S/he provides hands on assistance obtaining information and partnering with community providers, researching program appropriateness and availability, and making and facilitating referrals to provider agencies. S/he will also collaborate with any care coordination activities from the managed care company or other payers. The Family Resource Partner works with the parents to address barriers to service access, renewed problem solving, and revision of the planning for services in consultation with the Mental Health Clinician and the Child First Clinical Director/Supervisor. Eight areas of need are addressed, including:

1. Child**:** Child development & early care and education, child behavior & emotions, and child health, **and**
2. Family: Parent support, adult education, family health, adult mental health and substance abuse, and social services and concrete needs.

VIII. Utilization Management

A. Authorization by WellCare of North Carolina behavioral health utilization review department is required. For Medicaid, initial authorization is limited to a maximum of **three months**.

B. The provider shall conduct utilization review every **three months** and document it in the Person-Centered Plan and the service record.

IX. Targeted Length of Service:

A. Families are served for an average of **6-12 months**. In the event services continue past 12 months, subsequent services may be reauthorized in 3-month intervals. If it is anticipated that the child and family have experienced a crisis necessitating more frequent visits on an ongoing basis or additional caregivers (e.g., removal to foster care, transition to birth parent), the child may be transferred to the Tailored Plan, but the clinical team shall continue working with the child and caregivers in the Tailored Plan.

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 2021, 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 ®*	Description	Billing Unit
H2022 (HE)	Community-based wrap-around services, per diem	1 unit =1 month

Reviews, Revisions, and Approvals	Revision Date	Approval Date
CCH-specific policy developed for Child First Services		

References:

1. State of North Carolina Medicaid. EPSDT Service Definition: Child First Service. Published October 30, 2019. Reviewed February 11, 2025.

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.

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. This clinical policy is not intended to recommend treatment for members. Members 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 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 and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, 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.