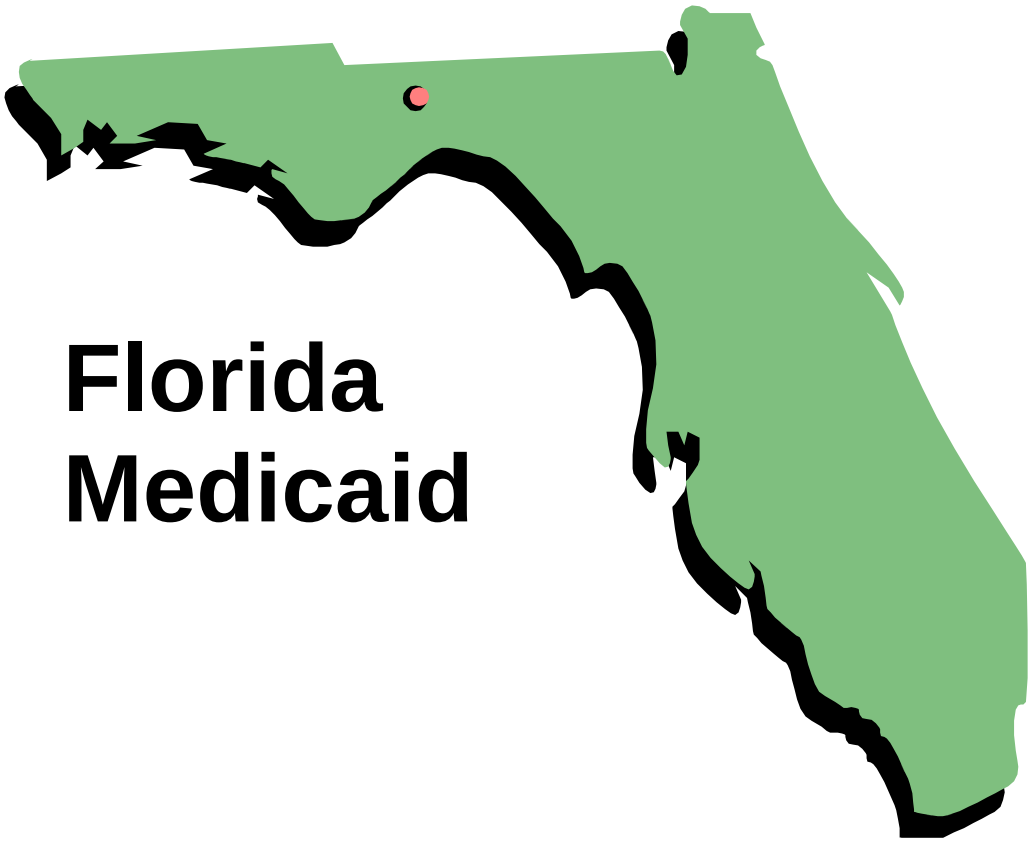

Florida Medicaid

BEHAVIORAL HEALTH OVERLAY SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration
March 2014

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

BEHAVIORAL HEALTH OVERLAY SERVICES COVERAGE AND LIMITATIONS HANDBOOK UPDATE LOG

How to Use the Update Log

Introduction

The update log provides a history of the handbook updates. Each Florida Medicaid handbook contains an update log.

Obtaining the Handbook Update

When a handbook is updated, the Medicaid provider will be notified. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Medicaid providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Services Contact Center at 1-800-289-7799.

Explanation of the Update Log

Providers can use the update log below to determine if updates to the handbook have been received.

Update describes the change that was made.

Effective Date is the date that the update is effective.

UPDATE	EFFECTIVE DATE
New Handbook	March 2014

BEHAVIORAL HEALTH OVERLAY SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
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Chapter and Topic **Page**

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter outlines the three types of Florida Medicaid policy handbooks that all enrolled providers must comply with in order to obtain reimbursement. This chapter also describes the format used for the handbooks and instructs the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid program.
- Coverage and limitations handbooks explain covered services, their limits, who is eligible to receive them, and any corresponding fee schedules. Fee schedules can be incorporated within the handbook or separately.
- Reimbursement handbooks describe how to complete and file claims for reimbursement from Medicaid.

The current Florida Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Federal and State Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act
- Title 42 of the Code of Federal Regulations
- Chapter 409, Florida Statutes
- Rule Division 59G, Florida Administrative Code

In This Chapter

This chapter contains:

Handbook Use

Purpose	The purpose of the Medicaid handbooks is to educate the Medicaid provider about the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters, or other documentation.
Provider	Term used to describe any entity, facility, person, or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	Term used to describe an individual enrolled in Florida Medicaid.
Provider General Handbook	Information that applies to all providers regarding the Florida Medicaid program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who renders more than one type of Medicaid service will have more than one coverage and limitations handbook with which they must comply.
Reimbursement Handbook	Most reimbursement handbooks are named for the type of claim form submitted.

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a way of displaying difficult, technical material.
Label	Labels are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Chapter Topics	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.
Note	Note is used to refer the reader to other important documents or policies contained outside of this handbook.
Page Numbers	Pages are numbered consecutively within each chapter throughout the handbook. The chapter number appears as the first digit before the page number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an "Update" and "Effective Date."
How Changes are Updated	The Medicaid handbooks will be updated as needed. Updates are classified as either a: • Replacement handbook – Major revisions resulting in a rewrite of the existing handbook, without any underlines and strikethroughs throughout the rulemaking process. • Revised handbook – Minor revisions resulting in modification of the existing handbook identified during the rulemaking process by underlines and strikethroughs.
Handbook Effective Date	The effective date of a handbook is the month and year that will appear on the final published handbook. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New information or information moved from one place to another within the handbook will be identified by an underline on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., <u>new information</u>).
Identifying Deleted Information	Deleted information will be identified by a line through the middle of the selected text on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., ~~deleted information~~).
Final Published Handbook	The adopted and published version of the handbook will not have underlines (indicating insertions) and text with strikethroughs (indicating deletions).

CHAPTER 1
QUALIFICATIONS, ENROLLMENT, AND REQUIREMENTS

Overview

Introduction

This chapter describes Florida Medicaid's behavioral health overlay services, the specific authority regulating these services, staff qualifications, and provider enrollment and requirements.

Legal Authority

Behavioral health overlay services are authorized by section 409.906, Florida Statutes (F.S.), and in Rule 59G-4.027, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

Purpose and Definitions

Medicaid Provider Handbooks

This handbook is intended for use by behavioral health overlay services providers that render services to eligible Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains information about specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid program.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. All of the Florida Medicaid provider handbooks are incorporated by reference in Rule Division 59G, F.A.C.

Aftercare Planning

The process of planning for a recipient's transition from the current level of care. This process begins during the assessment process when the recipient's needs and possible barriers to care are identified.

Clinical Services Supervisor

Maintains lead responsibility for the overall coordination and provision of behavioral health overlay services.

Purpose and Definitions, continued

Discharge Criteria	Measurable criteria established at the onset of treatment that identify a recipient's readiness to transition to a new level of care or out of care. Discharge criteria must be included on the recipient's individualized treatment plan and is separate and apart from the recipient's treatment plan goals and objectives.
Emotional Disturbance	A person under the age of 21 years who is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community. The emotional disturbance must not be considered to be a temporary response to a stressful situation.
Institution for Mental Disease	A hospital or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care to persons with behavioral diseases in accordance with 42 CFR 435.1010.
Other Responsible Persons	A relative, legal guardian, caretaker, or other individuals and natural supports who are known to the recipient and family and are active in providing care to the recipient. For services provided in the school, this may also include a child's classroom teacher or guidance counselor. Provision of services where the family or other responsible persons are involved must clearly be directed to meeting the identified treatment needs of the recipient. Services provided to family members or other responsible persons independent of meeting the identified needs of the recipient are not reimbursable by Medicaid.
Serious Emotional Disturbance	A person under the age of 21 years who is all of the following: • Diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. • Exhibits behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community, which behaviors are not considered to be a temporary response to a stressful situation.

Purpose and Definitions, continued

Shelter Status	The legal status that begins when a recipient under the age of 18 years is taken into the protective custody of the Department of Children and Families (DCF) and ceases when one of the following occurs: • Court grants custody to a parent. • After disposition of the petition for dependency. • Court orders the child to be released to a parent or placed in the temporary custody of a relative, a nonrelative, or DCF.
Staff Administrator	Responsible individual for the ongoing operations of behavioral health overlay services within the provider agency.
Treating Practitioner	A Medicaid-enrolled professional who authorizes services within the purview of the treating practitioner's credentials and state law on behalf of the Medicaid group provider (provider type 05).
Treatment Team	Key staff involved in planning and providing behavioral health overlay services to the recipient.

Staff Qualifications

General	Behavioral health overlay services staff must provide services within the scope of their professional licensure or certification, training, protocols, and competence. Providers must maintain staff records with background screening results, state mandated I-9 results, staff qualifications, verification of work experience, reference checks, and evidence of ongoing training. These records must additionally reflect adherence to human resources policies and procedures established by the provider.
Advanced Registered Nurse Practitioner (ARNP)	A licensed ARNP who works in collaboration with a physician according to protocol to provide diagnostic and interventional patient care. An ARNP must be authorized to provide these services in accordance with Chapter 464, F.S., and protocols filed with the Florida Board of Nursing.

Staff Qualifications, continued

Bachelor's Level Practitioner	A bachelor's level practitioner must meet all of the following criteria: • A bachelor's degree from an accredited university or college with a major in counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field. • Training in the treatment of behavioral health disorders, human growth and development, evaluations, assessments, treatment planning, basic counseling and behavior management interventions, case management, clinical record documentation, psychopharmacology, abuse regulations, and recipient rights. • Work under the supervision of a master's level practitioner.
Behavioral Health Overlay Counselor	A behavioral health overlay counselor must meet one of the following qualifications: • Master's level practitioner • Bachelor's level practitioner
Behavioral Health Technician	A behavioral health technician must: • Have a high school diploma or equivalent and in-service training in the treatment of mental health disorders, abuse regulations, recipient rights, crisis management interventions, and confidentiality. • Work under the supervision of a bachelor's level practitioner or higher. • Be certified as a behavioral health technician by the Florida Certification Board (FCB). Note: Information on initial and renewal certification requirements can be found on the FCB Web site at www.flcertificationboard.org.
Certified Addictions Professional (CAP)	A CAP must be certified by the FCB in accordance with Chapter 397, F.S. A bachelor's level CAP must have a bachelor's degree and be certified in accordance with Chapter 397, F.S. by the FCB. A master's level CAP must have a master's degree and be certified in accordance with Chapter 397, F.S. by the FCB.
Certified Associate Behavior Analyst	A certified associate behavior analyst must be a National Board Certified Associate Behavior Analyst or Florida Associate Behavior Analyst, who maintains active certification for a Florida Board Certified Associate Behavior Analyst.

Staff Qualifications, continued

Certified Behavior Analyst	A certified behavior analyst must be a National Board Certified or Florida Certified Behavior Analyst, who maintains active certification as required for a Florida Board Certified Behavior Analyst. A Board Certified Behavior Analyst may possess a master's degree (BCBA) or doctoral degree (BCBA-D).
Certified Psychiatric Rehabilitation Practitioner	A certified psychiatric rehabilitation practitioner must be certified by the Certification Commission for Psychiatric Rehabilitation, established by the United States Psychiatric Rehabilitation Association, and is working under the supervision of a bachelor's level practitioner or higher.
Certified Recovery Peer Specialist—Adult	A certified recovery peer specialist—adult must be certified by the FCB and work under the supervision of a bachelor's level practitioner, master's level CAP, or higher.
Certified Recovery Peer Specialist—Family	A certified recovery peer specialist—family must be certified by the FCB and work under the supervision of a bachelor's level practitioner, master's level CAP, or higher.
Certified Recovery Support Specialist	A certified recovery support specialist must be certified by the FCB and work under the supervision of a bachelor's level practitioner, master's level CAP, or higher.
Clinical Services Supervisor	A clinical services supervisor must have a minimum of a master's degree and at least two years of experience working with children who have emotional or serious emotional disturbances.
Clinical Social Worker	A clinical social worker must be licensed in accordance with Chapter 491, F.S.
Direct Care Staff	Direct care staff must be of age 18 years and older and have a high school diploma or General Educational Development certificate. Direct care staff must receive both pre- and in-service training on the delivery of behavioral health overlay services.

Staff Qualifications, continued

Licensed Practitioner of the Healing Arts (LPHA)	LPHAs include: • Clinical social workers licensed in accordance with Chapter 491, F.S. • Mental health counselors licensed in accordance with Chapter 491, F.S. • Marriage and family therapists licensed in accordance with Chapter 491, F.S. • Psychologists licensed in accordance with Chapter 490, F.S. • Clinical nurse specialists (CNS) with a subspecialty in child/adolescent psychiatric and mental health or psychiatric and mental health licensed in accordance with Chapter 496, F.S. • Psychiatric advanced registered nurse practitioners licensed in accordance with Chapter 464, F.S. • Psychiatric prescribing physician assistants licensed in accordance with Chapters 458 and 459, F.S.
Marriage and Family Therapist	A marriage and family therapist must be licensed in accordance with Chapter 491, F.S.
Master's Level Practitioner	A master's level practitioner must have a master's degree from an accredited university or college with a major in the field of counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field with one of the following: • Two years of professional experience in providing services to persons with behavioral health disorders. • Current supervision under an LPHA as described in this section. Master's level practitioners hired after July 1, 2014 with degrees other than social work, psychology, marriage and family therapy, or mental health counseling must have completed graduate level coursework in at least four of the following thirteen content areas: human growth and development; diagnosis and treatment of psychopathology; human sexuality; counseling theories and techniques; group theories and practice; dynamics of marriage and family systems; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; personality theories; social and cultural foundations; counseling in community settings; and substance use disorders.
Medical Assistant	A medical assistant must be registered or certified in accordance with Chapter 458, F.S.

Staff Qualifications, continued

Mental Health Counselor	A mental health counselor must be licensed in accordance with Chapter 491, F.S.
Physician Assistant	A physician assistant must be a graduate of an approved program or its equivalent or meets standards approved by the Florida Board of Medicine and must be certified to perform medical services in accordance with Chapters 458 and 459, F.S.
Psychiatric Advanced Registered Nurse Practitioner (ARNP)	A psychiatric ARNP must have education or training in psychiatry and be authorized to provide these services in accordance with Chapter 464, F.S., and protocols filed with the Florida Board of Nursing.
Psychiatric Clinical Nurse Specialist (CNS)	A psychiatric CNS must have a subspecialty in child/adolescent psychiatric and mental health or psychiatric and mental health and is licensed in accordance with Chapter 464, F.S., and must meet all of the following criteria: • A current and active license as a registered nurse in Florida • A master's degree or higher in nursing as a CNS • Provide proof of current certification in a specialty area as a CNS from one of the four certifying bodies: American Nursing Credentialing Center, American Association of Critical-Care Nurses, Oncology Nursing Certification Corporation, and National Board of Certification of Hospice and Palliative Nurses; or meet the requirements of Chapter 464, F.S. and has provided the required affidavit • A certificate issued by the Florida Board of Nursing as a CNS A registered nurse currently enrolled as an LPHA must be licensed as a CNS with a subspecialty of child/adolescent psychiatric and mental health or psychiatric and mental health by January 1, 2016.
Psychiatric Physician Assistant (PPA)	A PPA must be a licensed prescribing physician assistant as defined in Chapter 458 or 459, F.S., with a Psychiatric Certificate of Added Qualification. The PPA's supervising physician must be a provider type 25 or 26 that is linked to the community behavioral health group provider type 05.
Psychologist	A psychologist must be licensed in accordance with Chapter 490, F.S.
Registered Nurse (RN)	An RN must be licensed to practice professional nursing in accordance with Chapter 464, F.S.

Staff Qualifications, continued

Substance Abuse Counselor	A substance abuse counselor must have a bachelor's degree from an accredited university or college with a major in counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field. In addition, the counselor must have training in the treatment of substance use disorders to include signs and symptoms associated with abuse and dependence, human growth and development, evaluations and assessments, treatment planning, addictions counseling and behavior management interventions, twelve-step recovery, case management, clinical record documentation, pharmacology, abuse regulation; and patient rights and special circumstances, such as emergencies, suicide, and out-of-control behavior.
Substance Abuse Technician	A substance abuse technician must have a high school degree or equivalent, must be under the supervision of a bachelor's level practitioner or higher, and meet one of the following criteria: • In-service training in the treatment of substance use disorders • Five years of experience working directly with recipients experiencing substance use disorders in a treatment setting The substance abuse technician must be able to function as a member of a recipient's multidisciplinary team, provide therapeutic support and recognize the signs and symptoms associated with abuse and dependence. The substance abuse technician must be familiar with substance use rules and regulations, confidentiality, twelve-step recovery concepts, clinical record documentation requirements, and patient rights; and be able to respond to special circumstances, such as emergencies, suicide, and out-of-control behavior.
Treating Practitioner	Treating practitioners include: • Physician • Psychiatrist • Psychiatric ARNP • PPA • LPHA • Master's level CAP (for the authorization of substance use treatment only)

Enrollment

Introduction

The enrollment criteria listed in this section apply to the following providers:

- Behavioral health overlay services (provider type 05)
- Treating physicians (provider types 25 and 26)
- Treating practitioners (provider type 07)

Note: Enrollment forms may be obtained from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com, select Public Information for Providers, then Provider Support, and then Enrollment, or by calling Provider Enrollment at 1-800-289-7799 and selecting Option 4.

Criteria

To enroll as a Medicaid provider agency of behavioral health overlay services, a provider must meet all of the following criteria:

- Be enrolled as a Medicaid community mental health services provider.
- Be licensed by the Department of Children and Families or their designee under Chapter 65C-14, F.A.C.
- Be under contract with the Department of Children and Families, Child Welfare and Community-Based Care organization.
- Have successfully completed the behavioral health overlay services provider agency self-certification process.

Provider Agency Certification Process

The provider must submit a Provider Agency Self-Certification to:

AHCA, Medicaid Services
Behavioral Health Unit
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308

The provider's executive director must sign the certification By signing the certification, the executive director is giving assurances that the provider conducted a review of the service location or site for which the certification is being requested and that the site meets the certification criteria (see Certification Criteria for Behavioral Health Overlay Services in this section for a description of the requirements).

Based on the provider's assurances, Medicaid will send a letter to the provider that grants certification for billing behavioral health overlay services at the service location or site.

Note: See the appendices for the Provider Agency Self-Certification.

Enrollment, continued

Certification Criteria	To be self-certified to provide behavioral health overlay services, a provider must comply with policy standards in the following areas: • Services to be provided • Crisis intervention and support • Quality assurance program • Required policies and procedures • Clinical record and documentation requirement
Services to be Provided	The provider must offer the following on-site clinical and support services: • Individual, family, and group therapy • Individualized behavior management services (including design, consultation, and supervision), when indicated • Therapeutic support services • Discharge and aftercare planning (including identification of behavioral health services needed for successful discharge from behavioral health overlay services and transition into the appropriate level of care)
Crisis Intervention and Support	The provider must demonstrate that crisis intervention and support are available 24 hours per day, 7 days per week. Crisis services include facilitating access to acute care settings or other behavioral health emergency management.
Quality Assurance Program	The provider must have a quality assurance program that evaluates the effectiveness and outcomes of all the behavioral health services it provides. The quality assurance policies and procedures must include: • Monitoring behavioral health treatment planning, implementation, and outcomes. • Ongoing review of behavioral health staff performance. • Reviewing behavioral health medication administration and monitoring. • Treatment teams that are responsible for organizing the delivery of behavioral health overlay services. • Interfacing with primary caregivers. • Implementing and documenting pre-service and ongoing staff training agendas that improve and support the delivery of behavioral health overlay services.

Enrollment, continued

Required Policies and Procedures

The provider agency must have policies and procedures in place that address the following:

- An internal review process of the recipient's eligibility for behavioral health overlay services.
- Thorough screening, evaluation, and diagnosis of symptoms, risks, functional status, and co-morbidity.
- Therapeutic crisis intervention, including the use of time out, in compliance with the rules of the Department of Children and Families. The policies and procedures must address transfer to a restrictive level of care if a recipient displays self-injurious behavior or is a danger to others and cannot be safely managed. The use of mechanical or chemical restraint is not allowed.
- Medical management of recipients who require psychotropic medical intervention.
- An organizational chart and staff qualifications and responsibilities.
- Treatment teams that are responsible for organizing the delivery of behavioral health overlay services.
- A clinical supervision protocol that assures timely monitoring of services and modification of treatment as needed.
- Weekly clinical individual or group supervision protocol for behavioral health overlay services counselors with a licensed practitioner of the healing arts that requires the documentation of the date, start and end times, and the clinical topic discussed for each supervision session.
- Integration of behavioral health overlay services into the daily activities of recipients.
- Best practice guidelines for the clinical management of specific types of emotional and behavioral problems encountered within the recipient population.
- Formal aftercare planning that supports development of independent living skills when developmentally appropriate.

Staff Requirements

The provider agency must employ or contract with all of the following:

- A staff administrator
- A psychiatrist
- A clinical services supervisor
- A behavior analyst (if behavior management services are offered)

The counselor-to-recipient ratio must not exceed one counselor to 20 recipients.

Enrollment, continued

Treating Practitioner	A treating practitioner must be independently enrolled in the Florida Medicaid program per provider type.
Treating Physician	A treating physician must enroll as a provider type 25 or 26 and must also be linked to a community behavioral health group (provider type 05).
Psychiatric Advanced Registered Nurse Practitioner (ARNP)	A psychiatric ARNP must have education or training in psychiatry and be authorized to provide these services in accordance with Chapter 464, F.S., and protocols filed with the Florida Board of Nursing. An ARNP must enroll as a provider type 07 and must also be linked to a group provider type 05.
Psychiatric Physician Assistant (PPA)	A PPA must be a licensed prescribing physician assistant as defined in Chapter 458 or 459, F.S., with a Psychiatric Certificate of Added Qualification. The PPA's supervising physician must be a provider type 25 or 26 that is linked to the community behavioral health group provider type 05.
Licensed Practitioner of the Healing Arts (LPHA)	A treating LPHA must enroll as a provider type 07 and must also be linked to a group provider type 05 for services rendered in the capacity of a treating practitioner in order to be qualified.
Certified Addictions Professional (CAP)	A CAP with a master's degree must enroll as provider type 07 and must also be linked to a community behavioral health group (provider type 05) in order to authorize services for treatment for substance use disorders.
Multiple Service Locations within the Same Medicaid-Designated Area	Behavioral health overlay services agency providers who render services at more than one service address within the same Medicaid-designated area are required to submit an Application for New Location Code to identify each separate physical address where services are provided. The Application for New Location Code is an attachment to the Florida Medicaid Provider Enrollment Application. Providers must use the code assigned to the location when billing for services provided at that location. Additional service sites are subject to an on-site review by the local Medicaid area office or its designee.

Enrollment, continued

Multiple Service Locations in Different Medicaid-Designated Areas	Behavioral health overlay agency providers who render services at more than one service address in different Medicaid-designated areas are required to submit a separate Florida Medicaid Provider Enrollment Application for each Medicaid-designated area. Providers must use the code assigned to the location when billing for services provided at that location. Additional service sites are subject to an on-site review by the local Medicaid area office or its designee.
Subcontracting	Florida Medicaid allows a provider to contract with an individual practitioner, but not with another agency for service delivery. As of July 1, 2014, providers are required to retain all contracts with subcontracted staff for no less than five years from the termination date of the contract. Providers must maintain subcontractor records with background screening results, staff qualifications, and verification of work experience. These records must additionally reflect adherence to human resources policies and procedures established by the provider related to subcontracting.

Requirements

Providers Contracted with Medicaid Health Plans	The service-specific Medicaid coverage and limitations handbooks provide the minimum requirements for all providers. This includes providers who contract with Florida Medicaid health plans (e.g., provider service networks and health maintenance organizations). Providers shall comply with all of the requirements outlined in this handbook, unless otherwise specified in their contract with the health plan. The provision of services to recipients enrolled in a Medicaid health plan shall not be subject to more stringent criteria or limits than specified in this handbook.

CHAPTER 2
COVERED, LIMITED, AND EXCLUDED SERVICES

Overview

Introduction

This chapter provides service coverage, limitations, and exclusions information. It also describes who can provide and receive series, as well as any applicable service requirements.

In This Chapter

This chapter contains:

General Coverage Information

Medical Necessity

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.

Rule 59G-1.010 (166), Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:

"[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

General Coverage Information, continued

Medical Necessity, continued	"(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services, does not, in itself, make such care, goods or services medically necessary or a covered service."
Exceptions to the Limits (Special Services) Process	As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, Title 42 of the United States Code 1396d(a). Services requested for recipients under the age of 21 years in excess of limitations described within this handbook or associated fee schedule may be approved, if medically necessary, through the prior authorization process described in the Medicaid Provider General Handbook.
Description	Behavioral health overlay services include mental health, substance abuse, and supportive services designed to meet the behavioral health treatment needs of recipients in the care of Medicaid enrolled, certified agencies under contract with the Department of Children and Families, Child Welfare and Community-Based Care organization. The intent of behavioral health overlay services is the maximum reduction of the recipient's disability and restoration to the best possible functional level in order to avoid a more intensive level of care. Services must be diagnostically relevant and medically necessary. Services must be included in an individualized treatment plan that has been approved by a treating practitioner. Behavioral health overlay services include the following components: • Therapy • Behavior management • Therapeutic support
Who Can Receive	To receive behavioral health overlay services a recipient must be: • Enrolled in a Medicaid behavioral health overlay services program. • Certified as meeting the clinical criteria listed below.

General Coverage Information, continued

Eligibility Criteria

The recipient must meet the diagnostic eligibility criterion described in Section A and also meet at least one of the risk factors in Section B.

Section A: Diagnostic Criterion

The recipient is under the age of 21 years and has an emotional disturbance or a serious emotional disturbance.

Section B: Risk Factors

The recipient must be at risk due to one of the following factors in the last 12 months:

- Has exhibited suicidal gestures or attempts, or self-injurious behavior or current ideation related to suicidal or self-injurious behavior, and is not currently in need of acute care.
- Has exhibited physical aggression or violent behavior toward people, animals, or property; this risk may also be evidenced by current threats of such aggression.
- Has run away from home or placements or threatened to run away on one or more occasions.
- Has had an occurrence of sexual aggression.
- Has experienced trauma.

The recipient's risk factor(s) must be documented and detailed on the Certification of Eligibility and reflected in the recipient's treatment plan.

Note: See the appendices for the Certification of Eligibility.

General Requirement

Providers must request reimbursement only for services that are provided by individuals employed by, under contract with, or who are compensated monetarily by the provider.

Assessment Requirement

Prior to the development of a treatment plan the provider must give the recipient an assessment of mental health status, substance use concerns, functional capacity, strengths, and service needs or must have one on file that has been conducted in the last six months. The purpose of the assessment is to gather information to be used in the formulation of a diagnosis and development of a plan of care that includes the discharge criteria.

General Coverage Information, continued

Treatment Plan Requirements	The recipient must have an individualized treatment plan developed in compliance with the Community Behavioral Health Services Coverage and Limitation Handbook policy. If the individualized treatment plan contains a behavior management component, the behavior analyst must review and sign the component. The behavior management plan must be consistent with treatment goals and objectives.
Treatment Plan Review Requirements	The recipient's treatment plan must be reviewed by the provider in compliance with the Community Behavioral Health Services Coverage and Limitations Handbook policy.
Recipient Clinical Record	Providers must maintain a clinical record for each recipient treated that contains all of the following: • Consent for treatment that is signed by the recipient or the recipient's legal guardian. An explanation must be provided for signatures omitted in situations of exception. • An evaluation or assessment that, at a minimum, contains the components of a brief behavioral health status examination conducted by a physician, psychiatrist, a licensed practitioner of the healing arts (LPHA), or master's level certified addictions professional (CAP) for diagnostic and treatment planning purposes. For new admissions, the evaluation or assessment by an LPHA for treatment planning purposes must have been completed within the past six months. • Copies of relevant assessments, reports and tests. • Service notes (progress toward treatment plans and goals). • Documentation of service eligibility, if applicable. • Current treatment plans (within the last six months), reviews, and addenda. • Copies of all certification forms (e.g., comprehensive behavioral health assessment). • The practitioner's orders and results of diagnostic and laboratory tests. • Documentation of medication assessment, prescription, and management. Note: For information about electronic records, see the Florida Medicaid Provider General Handbook.

General Coverage Information, continued

General Service Documentation Requirements

Providers must maintain documentation to support each service for which Medicaid reimbursement is requested; clearly distinguish and reference each separate service billed; and be authenticated with the dated signature of the individual who rendered the service. The date of a claim should be the same as the date the service was rendered.

Service documentation must contain all of the following in the recipient's clinical record:

- Recipient's name
- Date the service was rendered
- Start and end times
- Identification of the setting in which the service was rendered
- Identification of the specific problem, behavior, or skill deficit for which the service is being provided
- Identification of the service rendered
- Updates regarding the recipient's progress toward meeting treatment-related goals and objectives addressed during the provision of a service
- Dated signature of the individual who rendered the service
- Printed or stamped name identifying the signature of the individual who rendered the service and the credentials (e.g., licensed clinical social worker) or functional title (e.g., treating practitioner)

Note: For information about electronic signatures, see the Florida Medicaid Provider General Handbook.

Compliance and Quality of Care Reviews

Provider's compliance with service eligibility determination procedures, service authorization policy, staffing requirements, and service documentation requirements can be reviewed periodically by AHCA or its designee. Providers that violate these requirements are subject to recoupments, fines, or termination in accordance with Chapter 409.913, F.S.

Quality of care reviews are done periodically in conjunction with the compliance review.

Documentation Requirements for Daily Progress Notes

A daily progress note must be completed and signed by a qualified practitioner for each day that behavioral health overlay service is billed.

Documentation of Case Coordination

Documentation must reflect coordination and linkages with the recipient's family, recipient's school, community services, child welfare caseworker, Department of Juvenile Justice Probation officers, and primary medical care providers in accordance with the recipient's treatment and permanency plan.

General Coverage Information, continued

Aftercare Planning	The recipient and the treating staff should collaborate to develop the recipient's individualized formal aftercare plan. A formal aftercare plan should include community resources, activities, services, and supports that will be utilized to help the recipient sustain gains achieved during treatment.
Discharge Criteria	The recipient and the treating staff should collaborate to develop the individualized, measurable discharge criteria. The recipient's progress toward meeting the discharge criteria should be addressed throughout the course of treatment as part of the treatment plan review.

Therapy—Individual and Family

Who Can Provide Services	Individual and family therapy services must be provided by one of the following qualified practitioners: • Physician • Psychiatrist • Psychiatric physician assistant (PPA) • Psychiatric advanced registered nurse practitioner (ARNP) • LPHA • Master's level CAP • Master's level practitioner
Covered Services	Individual and family therapy services include the provision of insight-oriented, cognitive-behavioral, or supportive therapy to an individual or family. Individual and family therapy can involve the recipient, the recipient's family (without the recipient present), or a combination of therapy with the recipient and the recipient's family.

Therapy—Group

Who Can Provide Services	Group therapy services must be provided by one of the following qualified practitioners: • Physician • Psychiatrist • PPA • Psychiatric ARNP • LPHA • Master's level CAP • Master's level practitioner • CAP • Bachelor's level practitioner
Covered Services	Group therapy services include the provision of cognitive-behavioral or supportive therapy interventions to individuals or families and consultation with family or other responsible persons for sharing of clinical information. Also included is educating, counseling, or advising families or other responsible person on how to assist the recipient.
Group Size Limit	The group size must not exceed 15 participants.

Behavior Management

Who Can Provide Services	Behavior management services must be provided by a certified behavior analyst, or certified assistant behavior analyst, or by one of the following licensed practitioners who has three years of behavior analysis experience and a minimum of 10 hours of documented training every year dedicated to behavior analysis: • Clinical social worker • Mental health counselor • Marriage and family therapist • Psychologist

Behavior Management, continued

Covered Services

Behavior management services include the following:

- Assessing behavioral problems, and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the recipient's behaviors and the interactions that motivate, maintain, or improve behavior.
- Developing an individual behavior plan with measurable goals and objectives.
- Training caregivers and other involved person in the implementation of the behavior plan.
- Monitoring the recipient and caregiver progress and revising the plan as needed.
- Coordinating services on the treatment plan with the treatment team.

Therapeutic Support

Who Can Provide Services

Therapeutic support services must be provided by one of the following qualified professionals:

- Physician
- Psychiatrist
- PPA
- Psychiatric ARNP
- LPHA
- Master's level CAP
- Master's level practitioner
- Bachelor's level practitioner
- Certified behavior analyst
- Certified assistant behavior analyst
- Certified recovery peer specialist
- Certified psychiatric rehabilitation practitioner
- Certified recovery support specialist
- Certified behavioral health technician
- Direct care staff

Therapeutic Support, continued

Covered Services

Therapeutic support services are direct care contacts that must be related to the recipient's treatment plan goals and objectives and must include one or more of the following services, as medically necessary:

- One-to-one supervision and intervention with the recipient during therapeutic activities in accordance with the recipient's treatment plan.
- Skill training of the recipient for restoration of those basic living and social skills necessary to function in the recipient's own environment.
- Assistance to the recipient in implementing the behavioral goals identified through assessments, therapy, and development of the treatment plan.

Therapeutic Home Assignments

Therapeutic home assignments are overnight stays the recipient spends with the biological, adoptive or extended family, or in a potential placement in order to practice the generalized skills learned in treatment to the recipient's home or other natural settings. Therapeutic home assignments may include time spent away overnight with friends, school, or club activities.

Therapeutic home assignments are planned in conjunction with the recipient's treatment goals and objectives. Therapeutic home assignments must be prior authorized and must be prescribed on the recipient's treatment plan.
The provider agency must be accessible and must maintain a level of communication with the recipient during therapeutic home assignments.

Telephone communication can be utilized to maintain on-going communication with the recipient during therapeutic home assignments.

Excluded Services

Service Exclusions

Medicaid does not reimburse for behavioral health overlay services for treatment of a cognitive deficit severe enough to prohibit the service from being of benefit to the recipient.

Behavioral Health Overlay Services Exclusions

The following are services and supports not reimbursed under behavioral health overlay services:

- Services provided to a recipient on the day of admission into a statewide inpatient psychiatric program. However, community behavioral health services are reimbursable on the day of discharge.
- Case management services.
- Partial hospitalization.
- Services rendered to individuals residing in an institution for mental diseases.
- Services rendered to institutionalized individuals, as defined in 42 CFR 435.1009.
- Room and board expenditures.
- Travel time.
- Education services.
- Activities performed to maintain and review records for facility utilization, continuous quality improvement, recipient eligibility status processing, and staff training purposes.
- Activities (other than record reviews, services with family member or other interested person that benefit the recipient, or services performed using telemedicine) that are not performed face-to-face with the recipient.
- Services rendered by a recipient's relative.
- Services rendered by unpaid interns or volunteers.
- Services paid for by another funding source.
- Escorting or transporting a recipient to and from a service site.

CHAPTER 3
REIMBURSEMENT AND FEE SCHEDULE

Overview

Introduction

This chapter describes reimbursement and fee schedule information for behavioral health overlay services.

In This Chapter

This chapter contains:

Reimbursement Information

Procedure Codes

The procedure codes and fee schedule listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) Level II, which is a part of a nationally standardized code set. Level II of the HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes. HCPCS Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter (A–V) followed by four numeric digits. Please refer to the current HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert© code book is copyrighted by Ingenix, Inc. All rights reserved.

Effective Date of Certification

Medicaid will reimburse for behavioral health overlay services up to 72 hours prior to the Certificate of Eligibility being signed by a licensed practitioner.

Provider Agency Staff Linked to a Community Behavioral Health Group

The following provider agency staff must be reimbursed through the community behavioral health group (provider type 05) Medicaid number:

- Treating physician
- Psychiatric advanced registered nurse practitioner
- Psychiatric physician assistant
- Licensed practitioner of the healing arts

Reimbursement Information, continued

Units of Service	A unit of service is the number of times a procedure is performed. The definition of unit varies by service. For services defined in 15-minute increments, the total units of service for the day must be entered on the claim form. If multiple units are provided on the same day, the actual time spent must be totaled. If the minutes total ends in a 7 or less, round down to the nearest 15-minute increment. If the minutes total ends in 8 or more, round up to the nearest 15-minute increment. For example, 37 minutes is billed as two units of service while, 38 minutes is billed as three units of services. The provider may not round up each service episode to the nearest 15-minute increment before summing the total. Note: For more information on entering units of service on the claim, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.
Therapeutic Home Assignment Reimbursement	Medicaid reimburses up to 10 therapeutic home assignments per calendar quarter (three months). During the last three months of placement, and if the therapeutic home assignments are in accordance with the recipient's aftercare plan, Medicaid can reimburse for up to 20 therapeutic home assignments. The therapeutic home assignments must be authorized in the recipient's treatment plan.
Service Limits	Medicaid will reimburse for behavioral health overlay services for up to 365 days per recipient, per state fiscal year (July 1 through June 30). Medicaid will not reimburse for the same procedure code twice in one day.

Reimbursement Information, continued

Community Behavioral Health Services that can be Reimbursed in Conjunction with Behavioral Health Overlay Services

The following community behavioral health services are reimbursable in conjunction with behavioral health overlay services. The services must be delivered in accordance with the Community Behavioral Health Services Coverage and Limitations Handbook.

Service		Procedure Code	Modifier (if required)
Psychiatric assessment by a medical doctor or doctor of osteopathic medicine		H2000	HP
Psychiatric assessment by a psychiatric ARNP or psychiatric PA		H2000	HO
Review of records		H2000	
Brief mental health status examination		H2010	HO
Behavioral health day services—substance abuse		H2012	HF
In-depth assessment—new patient	Mental health	H0031	HO
	Substance abuse	H0001	HO
In-depth assessment—established patient	Mental health	H0031	TS
	Substance abuse	H0001	TS
Bio-psychosocial evaluation	Mental health	H0031	HN
	Substance abuse	H0001	HN
Psychological testing		H2019	
Limited functional assessment	Mental health	H0031	
	Substance abuse	H0001	
Comprehensive behavioral health assessment		H0031	
Treatment plan development	Mental health	H0032	
	Substance abuse	T1007	
Treatment plan review	Mental health	H0032	TS
	Substance abuse	T1007	TS
Medication management		T1015	
Brief individual medical psychotherapy	Mental health	H2010	HE
	Substance abuse	H2010	HF
Group medical therapy		H2010	HQ
Behavioral health screening	Mental health	T1023	HE
	Substance abuse	T1023	HF
Medical or clinic service	Mental health	T1015	HE
	Substance abuse	T1015	HF
Verbal interaction	Mental health	H0046	
	Substance abuse	H0047	
Methadone administration		H0020	

Reimbursement Information, continued

Reimbursement Restrictions

The following Medicaid community behavioral health services cannot be reimbursed for recipients of behavioral health overlay services:

Service	Procedure Code	Modifier (if required)
Services Limited to Recipients Under the Age of 21 Years		
Therapeutic behavioral on-site—therapy	H2019	HO
Therapeutic behavioral on-site—behavior management	H2019	HM
Therapeutic behavioral on-site—therapeutic support	H2019	HN
Behavioral health day—mental health	H2012	
Behavioral health day—substance abuse	H2012	HF
Individual or family therapy	H2019	HR
Specialized therapeutic foster care Level I	S5145	
Specialized therapeutic foster care Level II	S5145	HE
Specialized therapeutic foster care crisis	S5145	HK
Therapeutic group care	H0019	
Psychosocial rehabilitative*	H2017	
Clubhouse*	H2030	

*These services may be reimbursed when provided as a part of a public school program or summer activities program.

Mental health targeted case management cannot be billed in conjunction with behavioral health overlay services.

How to Read the Fee Schedule

Introduction

Procedure codes allowed for behavioral health overlay services are listed in the Procedures Codes and Fee Schedule in the appendices.

The Procedures Codes and Fee Schedule includes the following information:

- Description of covered service
- Covered procedure code
- Modifiers
- Maximum fee per code
- Reimbursement and service limitations

Description of Service

Describes the service to be reimbursed.

How to Read the Fee Schedule, continued

Procedure Code	The code in the Procedure Codes and Fee Schedule, found in the appendices, that corresponds to behavioral health overlay services.
Modifier	For certain types of services, a two-digit modifier must be entered on the claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.
Maximum Fee	Maximum amount that Medicaid will reimburse for the procedure code, per unit of service.
Reimbursement and Service Limitations	Reimbursement and service limitations that pertain to the specific procedure code. Service limits are per recipient, per state fiscal year (July 1 through June 30). Medicaid will not reimburse for the same procedure code twice in one day.

APPENDIX A

PROCEDURE CODES AND FEE SCHEDULE

PROCEDURE CODES AND FEE SCHEDULE

These procedure codes are to be used for dates of service April 1, 2014 and after.

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement and Service Limitations
Behavioral health overlay services	H2020	HA		$32.75 per day	Medicaid will not reimburse for behavioral health overlay services when a recipient is absent because he or she is in a Department of Juvenile Justice detention center placement. Medicaid will not reimburse a provider for behavioral health overlay services if the provider has been paid for the provision of the same type of services by another purchasing entity.

APPENDIX B

CERTIFICATION OF ELIGIBILITY

CERTIFICATION OF ELIGIBILITY

This is to certify that:

Date: _____

Recipient's Name: _____ Medicaid No: _____

has been screened and meets the following clinical eligibility criteria to receive behavioral health overlay services.

Recipient is placed in: _____
(Name of provider/site)

a Medicaid enrolled residential program that has been certified (or self-certified) to provide behavioral health overlay services and meets the clinical criteria as listed below.

The recipient meets the eligibility criterion described in Section A and one of the five risk factors in Section B.

Section A: Diagnostic Criterion. The recipient is:

❑ Under the age of 21 years and has an emotional disturbance or a serious emotional disturbance.

_____
(Specify diagnosis)

Section B: Risk Factors. The recipient is at risk due to one of the following in the last 12 months and such risk is documented and detailed (check one). Please attach relevant documentation to this certification.

❑ (1) Has exhibited suicidal gestures or attempts, or self-injurious behavior or current ideation related to suicidal or self-injurious behavior, and is not in need of acute care.

❑ (2) Has exhibited physical aggression or violent behavior toward persons, animals or property. This risk may also be evidenced by current threats of such aggression.

❑ (3) Has run away from home or placements or threatened to run away on one or more occasions.

❑ (4) Has had an occurrence of sexual aggression.

❑ (5) Has experienced trauma.

Certified by:

_____ _____
Counselor Date

_____ _____
Licensed Practitioner Date

Services will be reviewed and re-certified prior to: _____
(six months from the date of original certification)

To be placed in recipient's clinical record.

AHCA Form 5000-3522, Revised March 2014 (incorporated by reference in Rule 59G-4.027, F.A.C.)

APPENDIX C

PROVIDER AGENCY SELF-CERTIFICATION

PROVIDER AGENCY SELF-CERTIFICATION

Provider Agency Name: _____ Medicaid No.: _____

Provider Agency Address: _____

City: _____ Zip Code: _____ Phone No.: _____

County: _____ Circuit: _____ Area: _____

Name and Address of Site: _____

_____ Zip Code: _____

This is to certify that the above named provider agency has conducted a self-survey of the above named site and determined that the provider and site are in compliance with the certification criteria, presented in the Florida Medicaid Behavioral Overlay Health Services Coverage and Limitations Handbook, including the following:

1. Is an enrolled Medicaid community behavioral health services provider.
2. Is licensed by the Department of Children and Families under Chapter 65C-14, F.A.C.
3. Is under contract with the Department of Children and Families, Child Welfare and Community-Based Care organization.
4. Is able to comply with policy standards in the following areas:

    - Services to be provided
    - Crisis intervention and support
    - Quality assurance program
    - Required policies and procedures
    - Clinical record and documentation requirement

I certify that the above named provider and site is in compliance with Medicaid policies and procedures as put forth in the Florida Medicaid Behavioral Overlay Health Services Coverage and Limitations Handbook. I further certify that statements made in this document are accurate and correct to the best of my knowledge.

Executive Director's Name
(please print) _____

Executive Director's
Signature _____ Date _____

Send original form to:
AHCA, Medicaid Services
Behavioral Health Unit
2727 Mahan Drive, MS 20
Tallahassee, FL 32308

Provider should maintain a copy.

AHCA Form 5000-3523, Revised March 2014 (incorporated by reference in Rule 59G-4.027, F.A.C.)