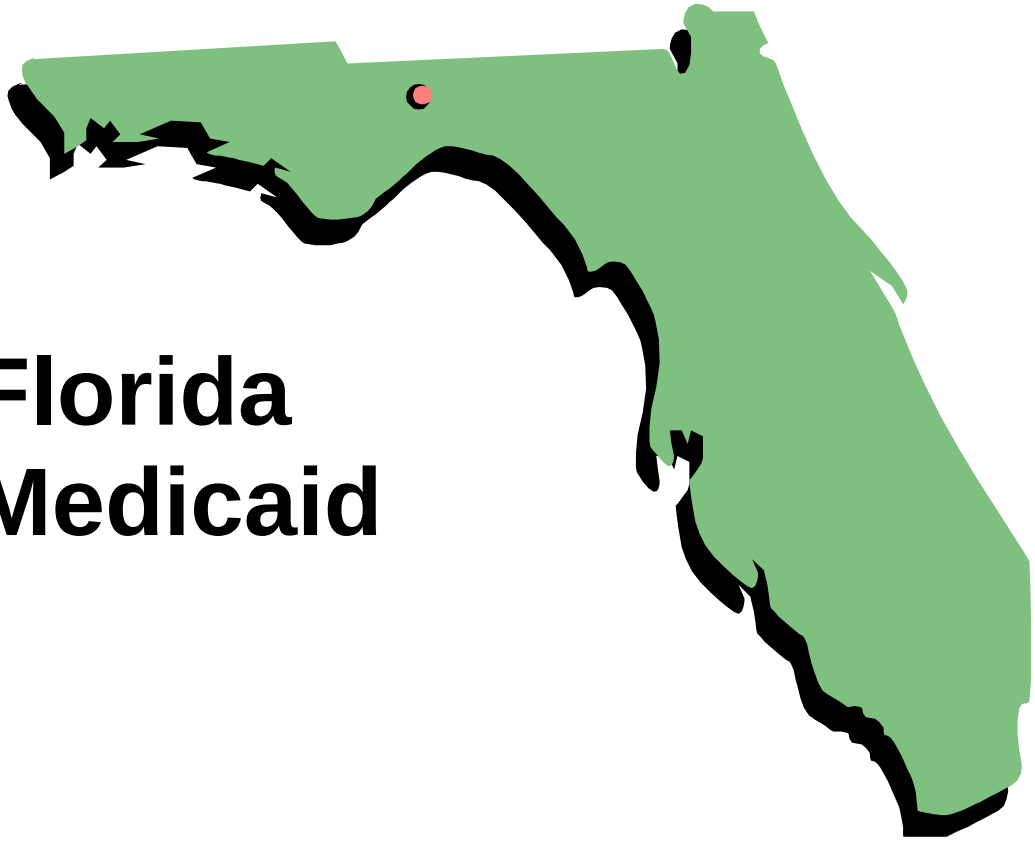

Florida Medicaid

COMMUNITY BEHAVIORAL HEALTH SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration
March 2014

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

COMMUNITY BEHAVIORAL HEALTH 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 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.

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
Revised Handbook	July 2000
Replacement Pages	July 2000
Replacement Pages	May 2002
Errata Replacement Pages and Pen and Ink Changes	June 2002
Revised Handbook	October 2004
Replacement Handbook	March 2014

COMMUNITY BEHAVIORAL HEALTH SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
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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 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 of the handbook represents a reader-friendly way of displaying 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."
Handbook Update Classifications	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 community behavioral health services, the specific authority regulating these services, staff qualifications, and provider enrollment and requirements.

Legal Authority

Community behavioral health services are authorized by section 409.906, Florida Statutes (F.S.), and in Rule 59G-4.050, 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 community behavioral health 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.

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.

Purpose and Definitions, continued

Bachelor's Level Infant Mental Health Practitioner	A bachelor's level practitioner who provides services to recipients under the age of 6 years.
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 are separate and apart from the recipient's treatment plan goals and objectives. 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.
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.
Hub Site	The telecommunication distance site in Florida at which the consulting physician, dentist or therapist is delivering telemedicine services.
Infant Mental Health Aides	A mental health aide who provides services to recipients under the age of 6 years.
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.

Purpose and Definitions, continued

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.
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.
Spoke Site	The provider office location in Florida where an approved service is being furnished through telemedicine.
Telemedicine	The practice of health care delivery using telecommunication equipment by the treating provider (at the spoke site) for the provision of approved covered services by the consulting provider (at the hub site) for the purpose of evaluation, diagnosis, or treatment.
Treating Practitioner	A Medicaid-enrolled professional who authorizes services within the purview of that 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 services to the recipient.

Staff Qualifications

General

Community behavioral health provider staff must provide services within the scope of 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.

Bachelor's Level Infant Mental Health Practitioner

A bachelor's level infant mental health practitioner must have completed 20 hours of documented training in the following areas, prior to working with this age population:

- Early childhood development
- Behavior observation
- Developmental screening
- Parent and child intervention and interaction
- Functional assessment
- Developmentally appropriate practice for serving infants
- Young children and their families
- Psychosocial assessment and diagnosis of young children
- Crisis intervention training

Bachelor's level practitioners who have had the above training through conferences, workshops, continuing education credits, or academic training are not required to repeat the training.

Bachelor's level infant mental health practitioners must be supervised by a master's level practitioner with two years of experience with recipients under the age of 6 years or by a licensed practitioner of the healing arts.

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 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.
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).

Staff Qualifications, continued

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 must 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 must 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 must work under the supervision of a bachelor's level practitioner, master's level CAP, or higher.
Clinical Social Worker	A clinical social worker must be licensed in accordance with Chapter 491, F.S.
Infant Mental Health Aides	Infant mental health aides must, at a minimum, have a high school diploma or equivalent with at least two years' experience with infants and toddlers, or hold a Child Development Aide certificate.
Licensed Practical Nurse	A licensed practical nurse must be licensed to practice practical nursing in accordance with Chapter 464, F.S.
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 physician assistants licensed in accordance with Chapters 458 and 459, F.S.

Staff Qualifications, continued

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 registered or certified in accordance with Chapter 458, F.S.
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.

Staff Qualifications, continued

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 be licensed in accordance with Chapter 464, F.S., and who 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 Nurses Credentialing Center, American Association of Critical-Care Nurses, Oncology Nursing Certification Corporation, and National Board for Certification of Hospice and Palliative Nurses; or meets 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.
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 regulations, patient rights, and special circumstances, such as emergencies, suicide, and out-of-control behavior.

Staff Qualifications, continued

Substance Abuse Technician	A substance abuse technician must have a high school degree or equivalent, must be working under the supervision of a bachelor's level practitioner or higher, and one of the following: • 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 qualifications listed in this section apply to the following providers:

- Community behavioral health 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.

Provider Qualifications

To enroll as a Medicaid community behavioral health services provider, providers must meet all of the following:

- Employ or have under contract a Medicaid-enrolled psychiatrist or a physician, who is linked with the Medicaid group provider.
- Achieve compliance on a community behavioral health services provider pre-enrollment certification review.
- Hold a regular (i.e., not probationary or interim) substance abuse license in accordance with Chapter 65D-30, F.A.C., for at least one of the following components, if substance abuse services are provided:
- Prevention
- Intervention
- Outpatient

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).

Services provided by the treating physician must be reimbursed through the community behavioral health group (provider type 05) provider Medicaid number, not the treating physician's (provider type 25 or 26) Medicaid provider number.

Psychiatric Advanced Registered Nurse Practitioner (ARNP)

A psychiatric ARNP must enroll as a provider type 07 and must also be linked to a group provider type 05. To enroll as a provider type 07, a psychiatric ARNP must submit a signed Practitioner Collaborative Agreement form with a physician (provider type 25 or 26) that is linked to the community behavioral health group (provider type 05). Community behavioral health services provided by a psychiatric ARNP must be reimbursed through the community behavioral health group (provider type 05) Medicaid number.

Enrollment, continued

Psychiatric Physician Assistant (PPA)	A PPA must enroll as a provider type 07 and must also be linked to a community behavioral health group (provider type 05). To enroll as provider type 07, a PPA must submit a signed Practitioner Collaborative Agreement form with a physician (provider type 25 or 26) that is linked to the community behavioral health group (provider type 05). Community behavioral health services provided by a PPA must be reimbursed through the community behavioral health group provider type 05 Medicaid number.
Licensed Practitioner of the Healing Arts (LPHA)	A treating LPHA must enroll as a provider type 07 and must also be linked to a community behavioral health group (provider type 05) for services rendered in the capacity of a treating practitioner in order to be qualified and reimbursed.
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.
Pre-Enrollment Provider Certification Review	Agencies or organizations seeking enrollment as community behavioral health providers must complete a provider pre-enrollment certification review with Medicaid or its designee, to assure compliance with state and federal guidelines.
Multiple Service Locations within the Same Medicaid-Designated Area	Community behavioral health 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 a new location code to identify each separate physical address where services are provided. The application for a 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	Community behavioral health services 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 services and any applicable service requirements.

In This Chapter

This chapter contains the following section topics:

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;

General Coverage Information, continued

Medical Necessity, continued

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; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

"(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 medical necessity 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, codified in Title 42 of the United States Code 1396d(a).

Services for recipients under the age of 21 years in excess of limitations described within this handbook or the associated fee schedule may be approved, if medically necessary, through the process described in the Florida Medicaid Provider General Handbook.

Description

Community behavioral health services include mental health and substance abuse services provided to recipients with mental health, substance use, and co-occurring mental health and substance use disorders for the maximum reduction of the recipient's disability and restoration to the best possible functional level.

General Requirement

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

General Coverage Information, continued

Assessment Requirement

Prior to the development of a treatment plan the provider must complete and provide to the recipient an assessment of mental health status, substance use concerns, functional capacity, strengths, and service needs or must have an assessment 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.

For recipients under the age of 6 years, a comprehensive behavioral health assessment completed within the past year, in accordance with the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook, may satisfy the current assessment requirement for services.

Recipient Clinical Record

Providers must maintain a clinical record for each recipient treated that contains all of the following documentation:

- 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:

- 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 section 409.913, F.S.

General Coverage Information, continued

Telemedicine

Services must be delivered from a facility that is enrolled in Medicaid as a community behavioral health services provider for Medicaid to reimburse for services delivered through telemedicine. Services that can be provided through telemedicine are listed in the Procedure Codes and Fee Schedule, found in the appendices.

The following interactions do not constitute reimbursable telemedicine services:

- Telephone conversations
- Video cell phone interactions
- E-mail messages
- Facsimile transmission
- "Store and forward" visits and consultations, which are transmitted after the recipient or psychiatrist is no longer available

Providers utilizing telemedicine must implement technical written policies and procedures for telemedicine systems that comply with the Health Insurance Portability and Accountability Act privacy regulations as well as applicable state and federal laws that pertain to patient privacy. Policies and procedures must also address the technical safeguards required by Title 45, Code of Federal Regulations, section 164.312, where applicable.

Assessment Services

Introduction

All assessment services must be billed with the correct procedure code and modifier found in the appendices. Assessment services include the following:

- Psychiatric evaluation
- Brief behavioral health status examination
- Psychiatric review of records
- In-depth assessment
- Bio-psychosocial evaluation
- Psychological testing
- Limited functional assessment

Assessment Documentation Requirements

In addition to meeting the general documentation requirements, a written report of evaluation and testing results for services listed in this section must be completed by the individual rendering the service.

Assessment Services, continued

Psychiatric Evaluation

A psychiatric evaluation is a comprehensive evaluation that investigates the recipient's clinical status.

The purpose of a psychiatric evaluation is to establish a therapeutic doctor–patient relationship, gather accurate data in order to formulate a diagnosis, and initiate an effective treatment plan.

A psychiatric evaluation must be conducted at the onset of illness. It can be utilized again if an extended hiatus occurs, a marked change in mental status occurs, or admission or readmission to an inpatient setting for a psychiatric illness is being considered or occurs.

Provision of a psychiatric evaluation is not considered necessary when the recipient has a previously established diagnosis of organic brain disorder (dementia), unless there has been a change in mental status requiring an evaluation to rule-out additional psychiatric or neurological processes that may be treatable.

Evaluation Components

A psychiatric evaluation must provide information on the following components:

- Presenting problems
- History of the presenting illness or problem
- Psychiatric history
- Physical history
- Trauma history
- Medication history
- Alcohol and other drug use history
- Relevant personal and family medical history
- Personal strengths
- Mental health status examination
- Summary of findings
- Diagnostic formulation
- Treatment recommendations or plan

Who Must Provide

A psychiatric evaluation must be provided by one of the following qualified treating practitioners:

- Treating physician
- Treating psychiatrist
- Psychiatric physician assistant (PPA)
- Psychiatric ARNP

Assessment Services, continued

Brief Behavioral Health Status Examination	A brief behavioral health status examination is a brief clinical, psychiatric, diagnostic, or evaluative interview to assess behavioral stability or treatment status. A brief behavioral health status examination must be completed prior to the development of the recipient's individualized treatment plan. A brief behavioral health status examination is not required when a psychiatric evaluation, bio-psychosocial assessment, or in-depth assessment has been completed by a physician, psychiatrist, LPHA, or a master's level CAP within six months prior to the development of recipient's treatment plan.
Examination Components	A brief behavioral health status examination must provide information on all of the following components: • Purpose of the exam • Mental health status • Summary of findings • Diagnostic formulation • Treatment recommendations or plan
Who Must Provide	A brief behavioral health status examination must be provided by one of the following qualified practitioners: • Physician • Psychiatrist • LPHA • Master's level CAP on the behalf of recipients with a primary diagnosis of a substance use disorder and no co-occurring mental health concerns

Assessment Services, continued

Psychiatric Review of Records	A psychiatric review of records includes a review of a recipient records, psychiatric reports, psychometric or projective tests, and clinical and psychological evaluation data for diagnostic use in evaluating and planning for recipient care. A written report must be done by the individual rendering the service and must be included in the recipient's clinical record. A psychiatric review of records does not include a review of the provider agency's own records except for psychological testing and other evaluations or evaluative data used explicitly to address documented diagnostic questions.
Who Must Provide	A psychiatric review of records must be provided by one of the following qualified practitioners: • Physician • Psychiatrist • PPA • Psychiatric ARNP
Specific Documentation Requirements	A psychiatric review of records may be documented in a report format or by a progress note in the recipient's clinical record. The sole use of checklists or fill in the blank forms is not allowed.
In-Depth Assessment	An in-depth assessment is a diagnostic tool for gathering information to establish or support a diagnosis, to provide the basis for the development of or modification to the treatment plan, and to develop the discharge criteria. The in-depth assessment must include an integrated summary as described here. Written documentation must be included in the recipient's clinical record to support the recipient's eligibility for this service.

Assessment Services, continued

Assessment Components

The in-depth assessment must provide detailed information on all the following components:

- Chief complaint—recipient's perception of problems, needs, or prominent symptoms.
- Personal history, including:
  - Identifying information
  - Medical
  - Alcohol and other drug use
  - Traumatic experiences
  - Legal involvement
  - Educational analysis
  - Resources and strengths.
- History of treatment (as applicable), including:
  - Psychiatric treatment to include previous and current psychotropic medications
  - Inpatient behavioral health treatment
  - Acute care treatment
  - Therapy and counseling
  - Mental health status examination
  - Desired services and goals from the recipient's viewpoint
  - Treatment recommendations or plan

For recipients under the age of 6 years, the in-depth assessment must include the following additional components:

- Presenting symptoms and behaviors
- Developmental and medical history: history of the mother's pregnancy and the recipient's delivery, past and current medical conditions, and developmental milestones
- Family psychosocial and medical history (can be as reported or based upon collateral information)
- Family functioning, cultural and communication patterns, and current environmental conditions and stressors
- Clinical interview with the primary caretaker and observation of the caregiver–infant or –child relationship and interactive patterns
- Provider's observation and assessment of the recipient, including affective, language, cognitive, motor, sensory, self-care, and social functioning

Assessment Services, continued

Who Can Receive

A new in-depth assessment can be provided to recipients who meet one of the following criteria:

- Recipients who are being admitted to treatment when it is documented that a psychosocial evaluation or bio-psychosocial evaluation was insufficient in providing a comprehensive basis for treatment planning.
- Recipients who have been identified as high-risk.
- Recipients, under the age of 6 years, who are exhibiting symptoms of an emotional or behavior nature that are atypical for the child's age and development.

An established patient in-depth assessment may be provided to recipients who meet one of the following criteria:

- Recipients for whom outpatient services, as initially prescribed, have been unsuccessful and whose clinical record documents a need for a more intensive level of treatment.
- Recipients who have been identified through the utilization management process as being high risk or high utilizers of behavioral health services.

Who Must Provide

The in-depth assessment and integrated summary must be provided by one of the following qualified practitioners:

- Physician
- Psychiatrist
- LPHA
- Master's level CAP
- Master's level practitioner

For recipients, under the age of 6 years, the in-depth assessment must be provided by one of the above professionals who has training and experience in infant, toddler, and early childhood development and the observation and assessment of young children.

Integrated Summary Specific Documentation Requirements

The integrated summary is developed after the in-depth assessment has been completed. The integrated summary is written to evaluate, integrate, and interpret from a broad perspective, the history and assessment information collected. The summary identifies and prioritizes the recipient's service needs, establishes a diagnosis, provides an evaluation of the efficacy of past interventions, and helps to establish discharge criteria.

The integrated summary must meet the assessment documentation standards defined in this handbook.

Assessment Services, continued

Bio-Psychosocial Evaluation

A bio-psychosocial evaluation describes the biological, psychological, and social factors that may have contributed to the recipient's need for services. The evaluation includes a brief mental status exam and preliminary service recommendations.

When it is consistent with the recipient's treatment needs, bio-psychosocial evaluations can be completed using telemedicine.

Evaluation Components

A bio-psychosocial evaluation must provide information on all the following components:

- Presenting problems
- Biological factors
- Psychological factors
- Social factors
- Mental health status examination
- Summary of findings
- Diagnostic impression
- Treatment recommendations or plan

Who Must Provide

A bio-psychosocial evaluation must be provided by one of the following qualified practitioners:

- Physician
- Psychiatrist
- LPHA
- Master's level CAP
- Master's level practitioner
- CAP
- Bachelor's level practitioner

Who Must Review

A bio-psychosocial evaluation completed by a bachelor's level practitioner must be reviewed, signed, and dated by a master's level practitioner, bachelor's level CAP, or a treating practioner prior to completion of the treatment planning process. The review must include clinical impressions, a provisional diagnosis, and a statement by the reviewer that indicates concurrence or alternative recommendations regarding treatment.

Assessment Services, continued

Psychological Testing	Psychological testing is the assessment, evaluation, and diagnosis of the recipient's mental status or psychological condition through the use of standardized testing methodologies.
Who Can Receive	Recipients are eligible to receive psychological testing only under one or more of the following circumstances: • At the onset of illness or suspected illness or when the recipient first presents for treatment. • If an extended hiatus in treatment or a marked change in status occurs, or if the recipient is being considered for admission or readmission to a psychiatric inpatient setting. • When there is difficulty determining a diagnosis or where there are differential diagnostic impressions. • When additional information is needed to evaluate or redirect treatment efforts.
Who Must Provide	Psychological testing must be provided by an individual practitioner within the scope of professional licensure, training, protocols, and competence.
Limited Functional Assessment	A limited functional assessment is restricted to administration of the Functional Assessment Rating Scale (FARS), and the Children's Functional Assessment Rating Scale (C-FARS), the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R), or any other functional assessment required by the Department of Children and Families (DCF). When it is consistent with the recipient's treatment needs, limited functional assessments can be completed using telemedicine.
Who Must Provide	The FARS and the C-FARS must be provided by an individual who is certified by DCF to administer the assessment. As of July 1, 2014, the American Society of Addiction Medicine Patient Placement Criteria must be provided by an individual who has completed provider agency training on how to use the instrument to make accurate level of care determinations.

Treatment Plan Development and Modification

Introduction

A treatment plan is an individualized, structured, and goal-oriented schedule of services with measurable objectives that promotes the maximum reduction of the recipient's disability and restoration to the best possible functional level. Treatment plan development and modification include:

- Treatment plan development
- Treatment plan review

Individualized recipient treatment plans must directly address the primary diagnosis(es) that is(are) consistent with the assessment.

A treatment plan should directly address additional diagnoses that are consistent with assessment and that are in the range of the provider's expertise. The provider must document efforts to coordinate services for diagnoses outside their expertise that, if treated, would assist meeting the recipient's goals.

Community behavioral health services must be prescribed on a treatment plan authorized by one of the group provider's treating practitioners.

Treatment Plan Development

The treatment plan must be jointly developed by the recipient and the treatment team. The treatment plan must be recipient-centered and consistent with the recipient's identified strengths, abilities, needs, and preferences.

The recipient's parent, guardian, or legal custodian should be included in the development of the recipient's individualized treatment plan, if the recipient is under the age of 18 years. Treatment planning for a recipient under the age of 18 years that does not include the recipient's parent, guardian, or legal custodian in a situation of exception requires a documented explanation.

Required Components of the Treatment Plan

The treatment plan must contain all of the following components:

- The recipient's diagnosis code(s) consistent with assessment(s)
- Goals that are individualized, strength-based, and appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the recipient
- Measurable objectives with target completion dates that are identified for each goal
- A list of the services to be provided (treatment plan development, treatment plan review, and evaluation or assessment services provided to establish a diagnosis and to gather information for the development of the treatment plan need not be listed)
- The amount, frequency, and duration of each service for the six month duration of the treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the recipient will receive a service "x to y times per week"

Treatment Plan Development and Modification, continued

Required Components of the Treatment Plan, continued

- Dated signature of the recipient
- Dated signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18 years)
- Signatures of the treatment team members who participated in development of the plan
- A signed and dated statement by the treating practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs
- Discharge criteria

Exceptions to the Requirement for Recipient's Signature

If the recipient's age or clinical condition precludes participation in the development and signing of the treatment plan, an explanation must be provided on the treatment plan.

Exceptions to the Requirement for Signature of Parent, Guardian, or Legal Custodian

There are exceptions to the requirement for a signature by the recipient's parent, guardian, or legal custodian. Documentation and justification of the exception must be provided in the recipient's clinical record. The following exceptions are:

- As allowed by Chapter 397, F.S., recipients under the age of 18 years seeking substance use services from a licensed service provider. Recipients ages 13 years and older, experiencing an emotional crisis in accordance with section 394.4784 (1), (2), F.S.
- Recipients in the custody of the Department of Juvenile Justice who have been court ordered into treatment or require emergency treatment such that delay in providing treatment would endanger the mental or physical well-being of the recipient. The signature of the parent, guardian, or legal custodian must be obtained as soon as possible after emergency treatment is administered.
- For recipients in the care and custody of the DCF (foster care or shelter status), the child's DCF or Community Based Care (CBC) caseworker must sign the treatment plan if it is not possible to obtain the parent's signature. The caseworker and foster parent should be encouraged to participate in the treatment planning. In cases where DCF is working toward reunification, the parent should be involved and must sign the treatment plan.

Treatment Plan Development and Modification, continued

Authorization and Effective Date of Treatment Plan	The treatment plan becomes effective on the date it is signed and dated by the treating practitioner. Medicaid will reimburse for services provided within 45 days prior to the signature of the treating practitioner.
Reimbursement Limitations	Medicaid reimburses for one treatment plan development per provider, per state fiscal year (July 1 through June 30). Medicaid reimburses for a maximum total of two treatment plans per recipient, per state fiscal year (July 1 through June 30).
Use of Addendum	An addendum may be used to make changes to the treatment plan, when significant changes have not occurred, in lieu of rewriting the entire plan. A treatment plan addendum can be used to add additional services or to modify services prescribed on the treatment plan. The addendum becomes part of the recipient's treatment plan. The addendum must be signed and dated by the treating practitioner and the recipient. Development of an addendum is not a reimbursable service.
Temporary Service Authorization	Anytime there is a temporary increase in prescribed services, the provider must report the increase using the Temporary Service Authorization, found in the appendices. The Temporary Service Authorization can be used to report the provision of crisis-oriented services that are not prescribed in the treatment plan. This form may also be used for documenting the need for services already provided when a recipient leaves treatment prior to completion of the treatment plan. When used for this purpose, the form must be completed within 45 days of intake and the recipient's file must reflect the recipient has been discharged from services. The Temporary Service Authorization must be completed, signed, and dated by a treating practitioner and placed in the recipient's clinical record. The Temporary Service Authorization cannot be used to add ongoing services to a recipient's treatment plan.

Treatment Plan Development and Modification, continued

Treatment Plan Review

The treatment plan review is a process conducted by the treatment team to ensure that treatment goals, objectives, and services continue to be appropriate to the recipient's needs and to assess the recipient's progress and continued need for services. The treatment plan review requires the participation of the recipient and the treatment team identified in the recipient's individualized treatment plan as responsible for addressing the treatment needs of the recipient.

Frequency of the Treatment Plan Review

A formal review of the treatment plan must be conducted at least every six months. The treatment plan may be reviewed more often than once every six months when significant changes occur.

Specific Documentation Requirements

Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any modifications or additions to the treatment plan must be documented based on the results of the review.

The treatment plan review must contain all of the following components:

- Current diagnosis code(s) and justification for any changes in diagnosis
- Recipient's progress toward meeting individualized goals and objectives
- Recipient's progress toward meeting individualized discharge criteria
- Updates to aftercare plan
- Findings
- Recommendations
- Dated signature of the recipient
- Dated signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18 years)
- Signatures of the treatment team members who participated in review of the plan
- A signed and dated statement by the treating practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs

If the treatment plan review process indicates that the goals and objectives have not been met, documentation must reflect the treatment team's re-assessment of services and justification if no changes are made.

The written documentation must be included in the recipient's clinical record upon completion of the treatment plan review activities.

Medical and Psychiatric Services

Introduction

These services include evaluation of the need for medication; evaluation of clinical effectiveness and side effects of medication; prescribing, dispensing, and administering of psychiatric medications; medication education and facilitating informed consent (including discussing side effects, risks, benefits, and alternatives with the recipient or other responsible persons); planning related to service delivery; and evaluating the status of the recipient's community functioning. Medication management cannot be provided in a group.

The following services are included under medical and psychiatric services:

- Medication management
- Brief individual medical psychotherapy
- Brief group medical therapy
- Behavioral health-related medical screening services
- Behavioral health-related services: verbal interactions
- Behavioral health-related services: alcohol and other drug testing specimen collection
- Medication assisted treatment

Medication Management

Medication management is the review of relevant laboratory test results, prior pharmacy interventions (e.g., medication dosages, blood levels if available, and treatment duration), and current medication usage. Medication management includes the discussion of indications and contraindications for treatment, risks, and management strategies with the recipient or other responsible persons.

Who Must Provide

Medication management must be provided by one of the following qualified practitioners:

- Physician
- Psychiatrist
- PA
- PPA
- Psychiatric ARNP

Brief Individual Medical Psychotherapy

Brief individual medical psychotherapy is treatment activity designed to reduce maladaptive behaviors related to the recipient's behavioral health disorder, to maximize behavioral self-control, or to restore normalized functioning and more appropriate interpersonal and social relationships. Brief medical psychotherapy includes insight-oriented, cognitive behavioral, or supportive therapy interventions.

Medical and Psychiatric Services, continued

Who Must Provide	Brief individual medical psychotherapy must be provided by one of the following qualified practitioners: • Physician • Psychiatrist • PA • PPA • Psychiatric ARNP
Brief Group Medical Therapy	Brief group medical therapy is a treatment activity designed to reduce maladaptive behaviors; maximize behavioral self-control; or to restore normalized functioning, reality orientation, and emotional adjustment. This service includes continuing medical diagnostic evaluation and drug management, when indicated, and can include insight oriented, cognitive behavioral, or supportive therapy.
Who Must Provide	Brief group medical therapy must be provided by one of the following qualified practitioners: • Physician • Psychiatrist • PPA • Psychiatric ARNP • Psychiatric nurse
Group Size Restrictions	Medicaid will reimburse for brief group medical therapy where the total group size equals 10 or fewer participants.
Behavioral Health-Related Medical Screening Service	A behavioral health-related medical screening service must include a face-to-face assessment of physical status, a brief history, and decision-making of low complexity. The assessment must include, at a minimum: • Vital signs. • Medication concerns to include side effects. • Brief mental health status assessment. • Plan for follow-up, if indicated.

Medical and Psychiatric Services, continued

Who Must Provide	Behavioral health-related medical screening services must be provided by one of the following qualified practitioners: • Physician • Psychiatrist • PPA • Physician assistant • Psychiatric ARNP • ARNP • Psychiatric nurse • Registered nurse
Behavioral Health-Related Medical Services: Verbal Interactions	This procedure code covers a verbal interaction (15-minute minimum) between a qualified medical professional and a recipient. This service must be directly related to the recipient's behavioral health disorder or to monitor side effects associated with medication.
Who Must Provide	For behavioral health-related medical services, verbal interactions must be provided by one of the following qualified practitioners: • Physician • Psychiatrist • PPA • Physician assistant • Psychiatric ARNP • ARNP • Psychiatric nurse • Registered nurse
Behavioral Health-Related Medical Services: Medical Procedures	The corresponding procedure code covers the following services: • Specimen collection (for the purposes of medication management) • Taking of vital signs • Administering injections This service must be directly related to the recipient's behavioral health disorder or to monitor side effects associated with psychotropic medication.

Medical and Psychiatric Services, continued

Who Must Provide

For behavioral health-related medical services, medical procedures must be provided by one of the following qualified practitioners:

- Physician
- Psychiatrist
- PPA
- Physician assistant
- Psychiatric ARNP
- ARNP
- Psychiatric nurse
- Registered nurse
- Licensed practical nurse
- Medical assistant

Behavioral Health-Related Medical Services: Alcohol and Other Drug Screening Specimen Collection

This procedure code covers specimen collection for the purposes of alcohol and other drug testing for the treatment of substance use disorders.

Who Must Provide

For behavioral health-related medical services, alcohol and other drug screening specimen collection must be provided by one of the following qualified practitioners:

- Physician
- Psychiatrist
- PPA
- Physician assistant
- Psychiatric ARNP
- ARNP
- Psychiatric nurse
- Registered nurse
- Licensed practical nurse
- Medical assistant
- LPHA
- Master’s level CAP
- Master’s level practitioner
- CAP
- Bachelor’s level practitioner
- Certified recovery peer specialist
- Certified psychiatric rehabilitation practitioner
- Certified recovery support specialist
- Certified behavioral health technician
- Substance abuse technician

Medical and Psychiatric Services, continued

Medication-Assisted Treatment

Services for medication-assisted treatment is reimbursed for opioid addiction treatment by a program licensed by the state and certified by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA), in accordance with state and federal regulations.

Recipients receiving methadone treatment can be prescribed take-home doses after 30 days of treatment, if it is clinically indicated. In order to qualify for take-home doses, it must be documented that a recipient is participating in a methadone maintenance regimen, in addition to meeting the conditions outlined in Rule 65D-30.014, F.A.C.

Who Must Provide

Medication-assisted treatment services must be provided under the supervision of a physician or a psychiatrist. Medication-assisted treatment must be provided by one of the following qualified practitioners:

- Physician
- Psychiatrist
- PPA
- Physician assistant
- Psychiatric ARNP
- ARNP
- Psychiatric nurse
- Registered nurse
- Licensed practical nurse
- Medical assistant

Behavioral Health Therapy Services

Introduction

Behavioral health therapy services include:

- Individual and family therapy
- Group therapy
- Behavioral health day services

Individual and Family Therapy

Individual and family therapy services include the provision of insight-oriented, cognitive behavioral or supportive therapy interventions to an individual recipient or a recipient's family.

Individual and family therapy may involve the recipient, the recipient's family without the recipient present, or a combination of therapy with the recipient and the recipient's family. The focus or primary beneficiary of individual and family therapy services must always be the recipient.

Behavioral Health Therapy Services, continued

Who Must Provide	Individual and family 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
Group Therapy	Group therapy services include the provision of cognitive behavioral or supportive therapy interventions to an individual recipient or the recipient's family. In addition to counseling, group therapy services to recipient families or other responsible persons include educating, the sharing of clinical information, and guidance on how to assist the recipient.
Who Must Provide	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
Group Size Restrictions	Medicaid will reimburse for group therapy where the total group size is equal to 15 or fewer participants.
Behavioral Health Day Services	These services are designed to enable recipients to function successfully in the community in the least restrictive environment and to restore or enhance ability for personal, social, and prevocational life management services. Behavioral health day services utilize an intensive therapeutic treatment approach to stabilize the symptoms of behavioral health disorders. These services should be used to provide transitional treatment after an acute episode or to reduce or eliminate the need for more intensive levels of care.

Behavioral Health Therapy Services, continued

Behavioral Health Day Services, continued

Behavioral health day services are appropriate early childhood therapeutic services provided to recipients ages 2 years through 5 years who are experiencing emotional problems and who meet the eligibility criteria described below. Services are designed to strengthen individual and family functioning, prevent more restrictive placement of recipients, and provide an integrated set of interventions to promote behavioral and emotional adjustments.

Services must be provided in a therapeutic milieu that allows for a broad range of therapeutic activities designed for the treatment of specific social, emotional, and behavioral problems. Services must be delivered in a coordinated manner and must be appropriate for the developmental age of the recipient. Services must be individualized and directly related to the treatment plan goals and the long-term goal of returning the recipient to regular day care, preschool, or the least restrictive environment possible.

Eligibility Criteria

In order to receive behavioral health day services a recipient must:

- Be age 2 years and older.
- Score in at least the moderate impairment range on a behavior and functional rating scale developed for this age group.

Components of Behavioral Health Day Services

Behavioral health day services are comprised of individual, group, or family therapy services, and therapeutic care services.

Individual and family therapy services include the provision of insight-oriented, cognitive behavioral or supportive therapy to an individual recipient or family.

Individual and family therapy may involve the recipient, the recipient's family without the recipient present, or a combination of therapy with the recipient and the recipient's family. The focus or primary beneficiary of individual and family therapy services must always be the recipient.

Group therapy services include the provision of cognitive behavioral, supportive therapy, or counseling to individuals or families, and consultation with family or other responsible persons for sharing of clinical information. Also included is education, counseling, or advising family or other responsible persons on how to assist the recipient. Group therapy services include the provision of cognitive behavioral, supportive therapy, or counseling to recipients and their families.

In addition to counseling, group therapy services to recipient families and other responsible persons include education, the sharing of clinical information, and guidance on how to assist recipients.

Behavioral Health Therapy Services, continued

Components of Behavioral Health Day Services, continued

Therapeutic care services assist the recipient in the development of the skills necessary for independent living and for symptom management. Progress toward treatment goals related to therapeutic care services should be assessed through observation.

Program Requirements for Recipients Ages 2 Years Through 5 Years

Behavioral health day services for recipients ages 2 years through 5 years must meet the following requirements:

- Services must be provided for a minimum of two to a maximum of four hours within the day. This need not be a continuous time period, but must be provided in one day. Therapeutic activities, as listed in the recipient's treatment plan, must be interwoven throughout the recipient's scheduled activities.
- The day treatment program must have a parent or caregiver component. At a minimum, there should be a monthly face-to-face contact with the parent or caregiver at the day treatment center or at the recipient's home.
- If the provider is unable to involve the parent or caregiver or meet the requirement for the face-to-face contact, a telephone contact is allowable, but is not reimbursable as part of day treatment. Written justification of why the face-to-face intervention could not occur must be provided in the recipient's clinical record.
- The group size during therapeutic activities must not exceed 10 recipients.
- The behavioral health day services staff-to-recipient ratio during therapeutic activities cannot exceed 1:5. Infant mental health aides may be used to meet these staffing requirements.

Written Certification for Behavioral Health Day Services for Recipients Ages 2 Years Through 5 Years

Prior to a recipient receiving behavioral health day services, a physician or a LPHA experienced in the diagnosis of mental disorders in young children must provide written certification that:

- Recipient meets the service eligibility criteria.
- Services can be expected to slow deterioration, or maintain or improve the recipient's condition and functional level.
- Recipient's condition or functional level cannot be improved in a less restrictive level of care.

Who Must Provide

Individual and family 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

Behavioral Health Therapy Services, continued

Who Must Provide, continued

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

Therapeutic care 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
- Certified recovery peer specialist
- Certified psychiatric rehabilitation practitioner
- Certified recovery support specialist
- Certified behavioral health technician

A psychiatrist, LPHA, or master's level CAP must be available to provide clinical consultation for both mental health and substance use day treatment services during all hours of operation.

The behavioral health day services program for recipients ages 2 years through 5 years must have, per group of 10, one of the following qualified professionals who has training and experience in infant, toddler, and early childhood development and the observation and assessment of young children:

- Physician
- Psychiatrist
- PPA
- Psychiatric ARNP
- LPHA
- Master's level CAP
- Master's level practitioner
- Bachelor's level infant mental health practitioner

Behavioral Health Therapy Services, continued

Specific Documentation Requirements	Documentation must include at least a daily progress note that addresses each service provided. For the behavioral health day services program for recipients ages 2 years through 5 years, documentation must include a weekly summary note of the specific therapeutic activities rendered that is signed by at least a master's level practitioner.

Community Support and Rehabilitative Services

Introduction	Community support and rehabilitative services include: • Psychosocial rehabilitation • Clubhouse These services encompass rehabilitation-focused, community-based psychosocial services. Community support and rehabilitative services are designed to assist recipients in strengthening or regaining interpersonal skills and in developing environmental supports necessary to function in their community.
Who Can Receive	Community support and rehabilitative services are appropriate for recipients exhibiting psychiatric, behavioral or cognitive symptoms, addictive behavior, or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, prevocational, and educational functioning.
Psychosocial Rehabilitation Services	Psychosocial rehabilitation services are intended to restore a recipient's skills and abilities essential for independent living. Activities include: development and maintenance of necessary daily living skills; food planning and preparation; money management; maintenance of the living environment; and training in appropriate use of community services. This service combines daily medication use, independent living and social skills training, housing services, prevocational and transitional employment rehabilitation training, social support, and network enhancement to recipients and their families.

Community Support and Rehabilitative Services, continued

Psychosocial Rehabilitation Services, continued	These services are designed to assist the recipient to eliminate or compensate for functional deficits and interpersonal and environmental barriers created by their disabilities, and to restore social skills for independent living and effective life management. This activity differs from counseling and therapy in that it concentrates less upon the amelioration of symptoms and more upon restoring functional capabilities. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment, focusing on maximum recovery and independence. It includes work readiness assessment, job development on behalf of the recipient, job matching, on the job training, and job support. Psychosocial rehabilitation services may be provided in a facility, home, or community setting.
Who Must Provide	Psychosocial rehabilitation 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 • CAP • Bachelor's level practitioner • Certified recovery peer specialist • Certified psychiatric rehabilitation practitioner • Certified recovery support specialist • Certified behavioral health technician • Substance abuse technician
Group Size Restrictions	Medicaid will reimburse for provision of psychosocial rehabilitation services, where the group size is equal to 12 or fewer.
Specific Documentation Requirements	Documentation must include at least a daily progress note that addresses each service provided.

Community Support and Rehabilitative Services, continued

Clubhouse Services

Clubhouse services are structured, community-based group services provided in a group rehabilitation service setting. These services include a range of social, educational, pre-vocational and transitional employment rehabilitation training in a group rehabilitation service setting utilizing behavioral, cognitive, or supportive interventions to improve a recipient's potential for establishing and maintaining social relationships and obtaining occupational or educational achievements.

A clubhouse group service is designed to strengthen and improve the recipient's interpersonal skills, and provide psychosocial therapy toward rehabilitation that emphasizes a holistic approach focusing on the recipient's strengths and abilities to promote recovery from mental illness. This service is primarily rehabilitative in nature, using a wellness model that offers a setting to restore independent living skills. These services are designed to assist the recipient in eliminating the functional, interpersonal, and environmental barriers created by their disabilities and to restore social skills for independent living and effective life management. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment focusing on maximum recovery and independence.

Who Can Receive

To be eligible for clubhouse services, recipients must:

- Have a mental health diagnosis.
- Be at least 16 years of age.

Who Must Provide

Clubhouse 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
- CAP
- Bachelor's level practitioner
- Certified recovery peer specialist
- Certified psychiatric rehabilitation practitioner
- Certified recovery support specialist
- Certified behavior health technician

Community Support and Rehabilitative Services, continued

Group Size Restrictions	Medicaid will reimburse for provision of clubhouse services up to 12 participants per staff member.
Specific Documentation Requirements	Documentation must include at least a daily progress note that addresses each service provided.

Therapeutic Behavioral On-Site Services for Recipients Under the Age of 21 Years

Introduction

Therapeutic behavioral on-site services are intended to prevent recipients who have complex needs from requiring placement in a more intensive, restrictive behavioral health setting. These services are coordinated through individualized treatment teams and are designed to assist recipients and their families.

The treatment team must include the recipient and recipient's family, guardian, caregivers, other persons who provide natural, informal support to the family system, and the professionals involved in providing services. The recipient-specific plan for therapeutic behavioral on-site services must be based on a thorough assessment, with input from the recipient and recipient's family, to identify needs, strengths, and desired service outcomes. When indicated by the assessment and agreed to by the family, the plan must reflect referral to, and coordination with, other agencies and resources.

It is recognized that involvement of the family in the treatment of the recipient is necessary and appropriate. Provision of therapeutic behavioral on-site services with the family must clearly be directed toward meeting the recipient's identified treatment needs. Services provided to the recipient's family, independent of meeting the recipient's identified needs, are not reimbursable by Medicaid.

If the assessment indicates a need for intensive, clinical therapeutic behavioral on-site services, and the family agrees to these services, the following services are reimbursable under Medicaid:

- Therapeutic behavioral on-site—therapy services
- Therapeutic behavioral on-site—behavior management services
- Therapeutic behavioral on-site—therapeutic support services

Therapeutic behavioral on-site services are intended to maintain the recipient in the home (permanent or foster). Services are limited to recipients under the age of 21 years meeting specific eligibility criteria.

Therapeutic Behavioral On-Site Services for Recipients Under the Age of 21 Years, continued

Eligibility Criteria

In order to receive therapeutic behavioral on-site services, a recipient must meet one of the following eligibility critera:

- Under the age of 2 years and meets one of the following criteria:
  - Exhibiting symptoms of an emotional or behavioral nature that are atypical for the recipient's age and development that interferes with social interaction and relationship development.
  - Failure to thrive (due to emotional or psychosocial causes, not solely medical issues).
- Ages 2 years through 5 years and meets both of the following criteria:
  - Exhibiting symptoms of an emotional or behavioral nature that are atypical for the recipient's age and development.
  - Score in at least the moderate impairment range on a behavior and functional rating scale developed for the specific age group.
- Ages 6 years through 17 years and meets one of the following criteria:
- Have an emotional disturbance.
- Have a serious emotional disturbance.
  - Have a substance use disorder.
- Ages 18 years through 20 years, but otherwise meets the criteria for an emotional disturbance or a serious emotional.

Continued Eligibility for Services

Within six months of the original determination of eligibility for services and every six months thereafter, the members of the recipient's treatment team must document that the recipient continues to meet the eligibility criteria stated previously. The determination of eligibility must be maintained in the recipient's clinical record.

Services may be authorized for less than six months.

Additional Treatment Plan Documentation Requirements

If any component of the therapeutic behavioral on-site service is provided by a different provider, the provider's name must be indicated on the plan. The plan and progress notes must reflect ongoing coordination with the other provider for the provision of services to the same recipient.

The treatment plan must include a specific schedule for review of the plan with the recipient, the recipient's family, and others on the recipient's treatment team and other providers rendering a component of the service.

Therapeutic Behavioral On-Site Services for Recipients Under the Age of 21 Years, continued

Formal Aftercare Plan	The recipient and the recipient's family should collaborate with the treating staff to develop the recipient's individualized formal aftercare plan within 45 days of admission to therapeutic behavioral on-site services. 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. The formal aftercare plan must be placed in the recipient's clinical record.
Place of Service	Services must be provided in community settings, including where the recipient resides and is educated. When possible, services should be provided in settings where the recipient is experiencing emotional or behavioral difficulties. These services may not be provided in a psychiatric hospital, a psychiatric unit of a general hospital, a crisis stabilization unit, or any other setting where the same services are already being paid for by another source.
Therapy	Therapeutic behavioral on-site therapy services include the following: • Individual and family therapy • Collaborative development of the formal aftercare plan
Who Must Provide	Therapeutic behavioral on-site therapy services must be provided by one of the following qualified professionals: • Physician • Psychiatrist • LPHA • Master's level CAP • Master's level practitioner Practitioners must have training and experience in infant, toddler, and early childhood development and the observation and assessment of young children when treating recipients under the age of 6 years.

Therapeutic Behavioral On-Site Services for Recipients Under the Age of 21 Years, continued

Behavior Management

Therapeutic behavioral on-site behavior management services include the following:

- On-going monitoring and assessment of the relationship between interactions that motivate, maintain, or improve recipient behavior, and the skill deficits and assets of the recipient and recipient's family, caregivers, and other involved persons
- Development of an individual behavior plan, with measurable goals and objectives that must be integrated into the recipient's treatment plan
- Training the recipient's family, caregivers, and other involved persons in the implementation of the behavior plan
- Monitoring interactions between the recipient and the recipient's family, caregivers, and other involved persons to measure progress
- Coordinating treatment plan services

Who Must Provide

Therapeutic behavioral on-site behavior management services must be provided by a certified behavior analyst, 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

Practitioners must have training and experience in infant, toddler, and early childhood development and the observation and assessment of young children when treating recipients under the age of 6 years.

Therapeutic Support

Therapeutic behavioral on-site therapeutic support services include the following:

- One-to-one supervision and intervention with the recipient during therapeutic activities
- Providing skills training in accordance with the recipient's treatment plan to the recipient for restoration of basic living and social skills
- Assistance to the recipient and the recipient's family, caregivers, and other involved persons in implementing the recipient's behavior plan

Therapeutic Behavioral On-Site Services for Recipients Under the Age of 21 Years, continued

One-to-One vs. Group

Therapeutic behavioral on-site therapeutic support services are considered primarily one-to-one interactions. When provided in a group, it must be in response to a specific recommendation and must be justified by the treating physician or treating LPHA in the recipient's treatment plan.

Under no circumstances may the group-to-staff ratio exceed four group members to one staff person.

Who Must Provide

Therapeutic behavioral on-site 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

Services for recipients under the age of 6 years must be provided by bachelor's level infant mental health practitioners or higher. Practitioners must have training and experience in infant, toddler, and early childhood development and the observation and assessment of young children when treating recipients under the age of 6 years.

Nursing Facility Residents

Covered Services

Community behavioral health services for nursing facility residents, for whom the nursing facility is billing Medicaid on a per diem basis, are only reimbursable for recipients who have one of the following:

- Pre-Admission Screening and Resident Review-Level II (PASRR II) evaluation that recommends community behavioral health services for the recipient, completed by the Department of Children and Families or its designee.
- A physician recommendation for community behavioral health services.
- A written referral from the nursing facility to a community behavioral health services provider.

The referral from the nursing facility must be retained in the recipient's clinical record. In addition, the recipient's individualized treatment plan must be coordinated and integrated with the nursing facility's plan of care.

For nursing facilities billing Medicaid on a per diem basis, the following services are reimbursable for residents, regardless of where the services are rendered:

- Psychiatric evaluation by physician or psychiatrist
- Brief behavioral health status exam
- Psychiatric review of records
- In-depth assessment, new patient
- In-depth assessment, established patient
- Bio-psychosocial evaluation
- Psychological testing
- Limited functional assessment
- Treatment plan development
- Treatment plan review
- Medication management
- Brief individual medical psychotherapy
- Individual and family therapy

Excluded Services

Community Behavioral Health

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

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

- Services provided to a recipient on the day of admission into the Statewide Inpatient Psychiatric Program (SIPP); 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
- Basic childcare programs for developmental delays, preschool, or enrichment programs
- Travel time
- 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 persons that benefit the recipient, or services performed using telemedicine) that are not performed face-to-face with the recipient, except those defined as:
  - 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 community behavioral health services.

In This Chapter

This chapter contains the following section topics:

Reimbursement Information

Procedure Codes

The procedure codes 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.

Copayment

Providers are required to collect a copayment of $2.00, per service, per day from the recipient unless the recipient of the service is exempt.

Note: For information on copayments and the categories of recipients and services exempt from the copayment, see the Florida Medicaid Provider General Handbook.

In-Home Services for Recipients Under the Age of 6 Years

In-home services with the recipient's parent, guardian, or caregiver can be billed as part of the day services program. If provided on a day when no behavioral health day services are billed, an in-home service may be billed as individual or family therapy or therapeutic behavioral on-site therapy services.

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.

Combinations of Services that Cannot be Reimbursed in Conjunction with Behavioral Health Day Services for Recipients Ages 2 Years Through 5 Years

The following services may not be reimbursed in conjunction with behavioral health day services for the same recipient on the same day:

Service	Procedure Code	Modifier (if required)
Psychosocial Rehabilitative Services	H2017	
Therapeutic Behavioral On-Site Services—Therapy	H2019	HO
Therapeutic Behavioral On-Site Services—Behavior Management	H2019	HM
Therapeutic Behavioral On-Site Services—Therapeutic Support	H2019	HN
Specialized Therapeutic Foster Care—Level I	S5145	
Specialized Therapeutic Foster Care—Level II	S5145	HE
Specialized Therapeutic Foster Care—Crisis	S5145	HK
Therapeutic Behavioral On-Site—Juvenile Justice	H2020	HK
Therapeutic Behavioral On-Site—Child Welfare	H2020	HA

Service Limits

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.

How to Read the Fee Schedule

Introduction	Procedure codes allowed for community behavioral health 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.
Procedure Code	The code in the Procedure Codes and Fee Schedule, found in the appendices, that corresponds to community behavioral health 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.

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
Assessment Services					
Psychiatric evaluation by physician	H2000	HP		$210.00 per evaluation	Medicaid reimburses a maximum of two psychiatric evaluations per recipient, per state fiscal year.*
Psychiatric evaluation by physician—telemedicine	H2000	HP	GT	$210.00 per evaluation	
Psychiatric evaluation by nonphysician	H2000	HO		$150.00 per evaluation	
Brief behavioral health status exam	H2010	HO		$14.66 per quarter hour	There is a maximum daily limit of two quarter-hour units. Medicaid reimburses for brief behavioral health status examinations a maximum of 10 quarter-hour units annually (2.5 hours), per recipient, per state fiscal year.* A brief behavioral assessment is not reimbursable on the same day that a psychiatric evaluation, bio-psychosocial assessment, or in-depth assessment has been completed by a qualified treating practitioner.
Brief behavioral health status exam—telemedicine	H2010	HO	GT	$14.66 per quarter hour	
Psychiatric review of records	H2000			$26.00 per review	Medicaid reimburses a maximum of two psychiatric reviews of records, per recipient, per state fiscal year.* This service may not be billed for review of lab work (see medication management).

*July 1 through June 30.

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement and Service Limitations
Assessment Services, continued					
In-depth assessment, new patient, mental health	H0031	HO		$125.00 per assessment	Medicaid reimburses one in-depth assessment, per recipient, per state fiscal year.* An in-depth assessment is not reimbursable on the same day for the same recipient as a bio-psychosocial evaluation. A bio-psychosocial evaluation is not reimbursable for the same recipient after an in-depth assessment has been completed, unless there is a documented change in the recipient's status and additional information must be gathered to modify the recipient's treatment plan.
In-depth assessment, new patient, mental health—telemedicine	H0031	HO	GT	$125.00 per assessment	
In-depth assessment, established patient, mental health	H0031	TS		$100.00 per assessment	
In-depth assessment, established patient, mental health—telemedicine	H0031	TS	GT	$100.00 per assessment	
In-depth assessment, new patient, substance abuse	H0001	HO		$125.00 per assessment	
In-depth assessment, new patient, substance abuse—telemedicine	H0001	HO	GT	$125.00 per assessment	
In-depth assessment, established patient, substance abuse	H0001	TS		$100.00 per assessment	
In-depth assessment, established patient, substance abuse—telemedicine	H0001	TS	GT	$100.00 per assessment	
Bio-psychosocial Evaluation, mental health	H0031	HN		$48.00 per assessment	Medicaid reimburses one bio-psychosocial evaluation, per recipient, per state fiscal year.* A bio-psychosocial evaluation is not reimbursable on the same day for the same recipient as an in-depth assessment.
Bio-psychosocial evaluation, mental health—telemedicine	H0031	HN	GT	$48.00 per assessment	
Bio-psychosocial evaluation, substance abuse	H0001	HN		$48.00 per assessment	
Bio-psychosocial evaluation, substance abuse—telemedicine	H0001	HN	GT	$48.00 per assessment	
Psychological testing	H2019			$15.00 per quarter hour	Medicaid reimburses a maximum of 40 quarter-hour units (10 hours) of psychological testing, per recipient, per state fiscal year.*

*July 1 through June 30.

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement and Service Limitations
Assessment Services, continued					
Limited functional assessment, mental health	H0031			$15.00 per assessment	Medicaid reimburses a maximum of three limited functional assessments, per recipient, per state fiscal year.*
Limited functional assessment, mental health—telemedicine	H0031	GT		$15.00 per assessment	
Limited functional assessment, substance abuse	H0001			$15.00 per assessment	
Limited functional assessment, substance abuse—telemedicine	H0001	GT		$15.00 per assessment	
Treatment Plan Development and Modification					
Treatment plan development, new and established patient, mental health	H0032			$97.00 per event	Medicaid reimburses for the development of one treatment plan per provider, per state fiscal year.* Medicaid reimburses for a maximum total of two treatment plans per recipient per state fiscal year.* The reimbursement date for treatment plan development is the day it is authorized by the treating practitioner.
Treatment plan development, new and established patient, substance abuse	T1007			$97.00 per event	
Treatment plan review, mental health	H0032	TS		$48.50 per event	Medicaid reimburses a maximum of four treatment plan reviews, per recipient, per state fiscal year.* The reimbursement date for a treatment plan review is the day it is authorized by the treating practitioner.
Treatment plan review, substance abuse	T1007	TS		$48.50 per event	

*July 1 through June 30.

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement and Service Limitations
Medical and Psychiatric Services					
Medication management	T1015			$60.00 per event	Medicaid reimburses medication management as medically necessary. Medication management is not reimbursable on the same day, for the same recipient, as brief group medical therapy or brief individual medical psychotherapy.
Medication management—telemedicine	T1015	GT		$60.00 per event	
Brief individual medical psychotherapy, mental health	H2010	HE		$15.00 per quarter hour	There is a maximum daily limit of two quarter-hour units. Medicaid reimburses a maximum of 16 quarter-hour units (4 hours) of brief individual medical psychotherapy, per recipient, per state fiscal year.* Brief individual medical psychotherapy is not reimbursable on the same day, for the same recipient, as brief group medical therapy or medication management.
Brief individual medical psychotherapy, mental health—telemedicine	H2010	HE	GT	$15.00 per quarter hour	
Brief individual medical psychotherapy, substance abuse	H2010	HF		$15.00 per quarter hour	
Brief individual medical psychotherapy, substance abuse—telemedicine	H2010	HF	GT	$15.00 per quarter hour	

*July 1 through June 30.

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement and Service Limitations
Medical and Psychiatric Services, continued					
Brief group medical therapy	H2010	HQ		$8.65 per quarter hour	There is a maximum daily limit of two quarter-hour units. Medicaid reimburses a maximum of 18 quarter-hour units (4.5 hours) of group medical therapy, per recipient, per state fiscal year.* Brief group medical therapy is not reimbursable on the same day, for the same recipient as brief individual medical psychotherapy or behavioral health-related medical services: verbal interactions, medication management.
Behavioral health medical screening, mental health	T1023	HE		$43.62 per event	Medicaid reimburses two behavioral health medical screening services, per recipient, per state fiscal year.* Behavioral health-related medical screening services are not reimbursable on the same day, for the same recipient, as behavioral health-related medical services: verbal interactions, medication management.
Behavioral health medical screening, substance abuse	T1023	HF		$43.62 per event	

*July 1 through June 30.

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement and Service Limitations
Medical and Psychiatric Services, continued					
Behavioral health—related medical services: verbal interaction, mental health	H0046			$15.00 per event	Medicaid reimburses 52 behavioral health-related medical services: medical procedures, per recipient, per state fiscal year.* Behavioral health-related medical services: verbal interactions are not reimbursable on the same day as behavioral health screening services.
Behavioral health-related medical services: verbal interaction, mental health—telemedicine	H0046	GT		$15.00 per event	
Behavioral health-related medical services: verbal interaction, substance abuse	H0047			$15.00 per event	
Behavioral health-related medical services: verbal interaction, substance abuse—telemedicine	H0047	GT		$15.00 per event	
Behavioral health-related medical services: medical procedures, mental health	T1015	HE		$10.00 per event	Medicaid reimburses 52 behavioral health-related medical services: medical procedures, per recipient, per state fiscal year.*
Behavioral health-related medical services: medical procedures, substance abuse	T1015	HF		$10.00 per event	
Behavioral health-related medical services: alcohol and other drug screening specimen collection	H0048			$10.00 per event	Medicaid reimburses 52 behavioral health-related medical services: alcohol and other drug screening specimen collections, per recipient, per state fiscal year.*
Medication-assisted treatment services	H0020			$67.48, weekly rate	Medicaid reimburses medication-assisted treatment services 52 times, per recipient, per state fiscal year.* The service is billed one time per seven days. This service is not reimbursable using any other procedure code.

*July 1 through June 30.

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement and Service Limitations
Behavioral Health Therapy Services					
Individual and family therapy	H2019	HR		$18.33 per quarter hour	Medicaid reimburses a maximum of 104 quarter-hour units (26 hours) of individual and family therapy services, per recipient, per state fiscal year.* There is a maximum daily limit of four quarter-hour units (1 hour).
Individual and family therapy—telemedicine	H2019	HR	GT	$18.33 per quarter hour	
Group therapy	H2019	HQ		$6.67 per quarter hour	Medicaid reimburses a maximum of 156 quarter-hour units (39 hours) of group therapy services, per recipient, per state fiscal year.*
Behavioral health day services, mental health	H2012			$12.50 per hour	Medicaid reimburses a maximum of 190-hour units (47.5 hours; 11.9 half-days) per recipient, per state fiscal year.* Medicaid will not reimburse for behavioral health day services the same day as psychosocial rehabilitation services.
Behavioral health day services, substance abuse	H2012	HF		$12.50 per hour	

*July 1 through June 30.

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement/ Service Limitations
Community Support and Rehabilitative Services					
Psychosocial rehabilitation services	H2017			$9.00 per quarter hour	Medicaid reimburses a maximum of 1,920 units (480 hours; 20 days) of psychosocial rehabilitation services, per recipient, per state fiscal year.* These units count against clubhouse service units.
Clubhouse services	H2030			$5.00 per quarter hour	Medicaid reimburses clubhouse services for a maximum of 1920 quarter-hour units (480 hours; 20 days) annually, per recipient, per state fiscal year.* These units count against psychosocial rehabilitation units of service.
Therapeutic Behavioral On-Site Services for Recipients Under the Age of 21 Years					
Therapeutic behavioral on-site services, therapy	H2019	HO		$16.00 per quarter hour	Medicaid reimburses therapeutic behavioral on-site therapy services a maximum combined limit of a total of 36, 15-minute units per month(9 hours) by a master's level or certified behavioral analyst.

*July 1 through June 30.

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement/ Service Limitations
Therapeutic Behavioral On-Site Services for Recipients Under the Age of 21 Years, continued					
Therapeutic behavioral on-site services, behavior management	H2019	HN		$10.00 per quarter hour	Medicaid reimburses therapeutic behavioral on-site behavior management and therapeutic behavioral on-site therapy services for a maximum combined total of 36, 15-minute units per month by a master's level practitioner, certified behavioral analyst, or certified associate behavioral analyst.
Therapeutic behavioral on-site services, therapeutic support	H2019	HM		$4.00 per quarter hour	Medicaid reimburses therapeutic behavioral on-site therapeutic support services for a maximum of 128 quarter-hour units per month (32 hours), per recipient.

APPENDIX B
TEMPORARY SERVICE AUTHORIZATION

TEMPORARY SERVICE AUTHORIZATION

Recipient name: _____

Recipient Medicaid number: _____

Date of service(s): _____

Service(s) provided: _____

_____

_____

Medicaid procedure code(s): _____

_____

_____

I have reviewed the relevant clinical information and confirm that the service(s) provided was (were) medically necessary.

_____ _____

Treating Practitioner's Signature Date

_____

Treating Practitioner's Name

To be placed in the recipient's medical record.

AHCA Form 5000-3510, Revised December 2012 (incorporated by reference in Rule 59G-4.050, F.A.C.)