



Florida Medicaid

Behavior Analysis Services Coverage Policy

Agency for Health Care Administration
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Table of Contents

1.0	Introduction	2
1.1	Florida Medicaid Policies.....	2
1.2	Statewide Medicaid Managed Care Plans	2
1.3	Legal Authority.....	2
1.4	Definitions	2
2.0	Eligible Recipient	3
2.1	General Criteria	3
2.2	Who Can Receive.....	3
2.3	Coinsurance and Copayment.....	3
3.0	Eligible Provider	3
3.1	General Criteria	3
3.2	Who Can Provide	3
4.0	Coverage Information	4
4.1	General Criteria	4
4.2	Specific Criteria	4
4.3	Early and Periodic Screening, Diagnosis, and Treatment.....	6
5.0	Exclusion	6
5.1	General Non-Covered Criteria.....	6
5.2	Specific Non-Covered Criteria	6
6.0	Documentation	7
6.1	General Criteria	7
6.2	Specific Criteria	7
7.0	Authorization	8
7.1	General Criteria	8
7.2	Specific Criteria	8
8.0	Reimbursement	9
8.1	General Criteria	9
8.2	Claim Type.....	9
8.3	Billing Code, Modifier, and Billing Unit	9
8.4	Diagnosis Code	9
8.5	Rate	9

1.0 Introduction

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render BA services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

1.2 Statewide Medicaid Managed Care Plans

This is not a covered service in the Statewide Medicaid Managed Care program.

1.3 Legal Authority

Behavior analysis services are authorized by the following:

- Section 409.906, Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Policy.

1.4.1 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.4.2 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.4.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.4 Independent Physician

A physician with financial independence in accordance with Title 42, United States Code (U.S.C.), section 1395nn (42 U.S.C.1395nn).

1.4.5 Lead Analyst

Practitioner responsible for the implementation of BA services including: the completion and review of behavior assessments, reassessments, behavior plans, and behavior plan reviews.

1.4.6 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.4.7 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.8 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring BA services that are medically necessary to address behavior that impairs a recipient's ability to perform a major life activity. Such functional impairment is expressed through the following behaviors:

- Safety - aggression, self-injury, property destruction, elopement
- Communication - problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language
- Self-stimulating – abnormal, inflexible, or intense preoccupations
- Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting
- Other behaviors not identified above but not limited to complexity of treatment, programming, or environmental variables

The recipient must be referred by an independent physician or practitioner qualified to assess and diagnose disorders related to functional impairment, including:

- Primary care physician with family practice, internal medicine, or pediatrics specialty
- Board certified or board eligible physician with specialty in developmental behavioral pediatrics, neurodevelopmental pediatrics, pediatric neurology, adult or child psychiatry
- Child psychologist

The referral must include a comprehensive diagnostic evaluation (CDE) performed according to national evidence-based practice standards. CDEs may be performed by a multidisciplinary team or individual practitioner. In either case, the CDE must be led by a licensed practitioner working within their scope of practice. The CDE must include assessment findings and treatment recommendations appropriate to the recipient. For example, the CDE may include data from behavioral reports by parents, guardians, and/or teachers; diagnostic testing related to recipients' development, behavior, hearing, and/or vision; genetic testing; and/or other neurological and/or medical testing.

Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayment

There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria

Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid BA services.

3.2 Who Can Provide

Services must be rendered by one of the following:

- Lead Analysts who are one of the following:

- Board certified behavior analyst (BCBA) credentialed by the Behavior Analyst Certification Board®
- Florida certified behavior analyst (FL-CBA) credentialed by the Behavior Analyst Certification Board®
- Practitioner fully licensed in accordance with Chapters 490 or 491, F.S., performing within their scope of practice
- Board certified assistant behavior analysts (BCaBA) credentialed by the Behavior Analyst Certification Board® working under the supervision of a BCBA
- Registered behavior technicians (RBT) credentialed by the Behavior Analyst Certification Board® working under the supervision of a BCBA or BCaBA

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following BA services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Behavior Assessment and Behavior Plan

A behavior assessment must be conducted prior to the initiation of behavior analysis interventions. The assessment must identify behavioral deficits that interfere with a major life activity including the events and subsequent interactions that elicit and sustain targeted behavior.

The initial assessment must include the administration, scoring, and reporting of two core standardized behavior instruments, as follows:

- Vineland-3 Comprehensive Parent Interview Form Including Maladaptive Behavior Domain, for all recipients
- Behavior Assessment System for Children, Third Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), for all recipients 2 years old and less than 19 years old

The complete scoring report, including outcome measure scores, must be submitted with service prior authorization requests. Additional assessment tools may be used at the Lead Analyst's discretion.

The behavior plan identifies intervention strategies that are likely to eliminate, mitigate or replace the behavior to produce change sufficient to reengage the recipient in the major life activity. The plan must include specific behavior goal(s), intervention strategies for each goal, anticipated timeframes that are of sufficient duration to address the targeted behavior, and how the ongoing progress of intervention strategies will be reported.

The behavior plan must reflect the requested authorization period (up to six months).

A reassessment and updated behavior plan to renew prior authorization for continued services must be completed at least every six months. The core instruments must be included with reassessments every 12 months.

More frequent assessments must be conducted when:

- New behavior emerges that interferes with a recipient's participation in a major life activity

- Additional BA services are medically necessary and are likely to address the emergent behavior

A full assessment may be requested if there is a change in provider; however, a change of a practitioner status (e.g., an RBT becoming certified as a BCaBA) is not grounds for conducting a reassessment or updating a behavior plan.

4.2.2 Behavior Analysis Interventions

Florida Medicaid covers up to 40 hours per week of BA intervention services as indicated in the recipient's prior-authorized behavior plan. These services must be delivered to reduce maladaptive behaviors and assist the recipient reach the best possible functional level for that individual. The recipient's parent or guardian should participate in treatment when possible and clinically appropriate. The provider must make every effort to accommodate parental participation and must document those efforts in treatment plan updates. If parent or guardian participation is not possible, the treatment plan and session notes must document the reasons for non-participation. Documentation should also explain potential impacts of non-participation and how potential impacts are being mitigated.

Services include:

- Adaptive behavior treatment by protocol – behavior analysis services provided according to the authorized treatment protocol
 - Services may be provided by Lead Analyst, BCaBA, or RBT
- Adaptive behavior treatment with protocol modification – behavior analysis services provided with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
 - Services may be provided by Lead Analyst or BCaBA
- Group adaptive behavior treatment by protocol – behavior analysis services provided in a group setting according to the authorized treatment protocol
 - Maximum group size is six recipients
 - Services may be provided by Lead Analyst, BCaBA, or RBT
- Group adaptive behavior treatment with protocol modification – behavior analysis services provided in a group setting with modifications to the authorized treatment protocol to address behavior and/or response changes or progress
 - Maximum group size is six recipients
 - Services may be provided by Lead Analyst or BCaBA
- Family adaptive behavior treatment guidance – parent, guardian, and/or caregiver training on the implementation of the behavior plan and intervention strategies
 - The recipient may or may not be present depending upon clinical appropriateness
 - Services may be provided by Lead Analyst or BCaBA
 - The Lead Analyst may provide up to two hours per week of training to parents or guardians via telemedicine in accordance with Rule 59G-1.057, Florida Administrative Code (F.A.C.)

4.2.3 Supervision

Florida Medicaid requires supervision of BCaBAs and RBTs in accordance with certification board requirements and specified in the supervision plan of the approved behavior plan.

4.2.4 Discharge

Recipients receiving Florida Medicaid BA services who meet one or more of the following will be considered for discharge from services:

- The recipient is no longer eligible for BA services as outlined in the Florida Medicaid Behavior Analysis Services Coverage Policy, incorporated by reference in Rule 59G-4.125, F.A.C.
- The recipient no longer meets medical necessity criteria as defined in Rule 59G-1.010, F.A.C.
- The recipient no longer engages in maladaptive behaviors.
- Data indicates the frequency and severity of maladaptive behavior(s) or level of functional impairment no longer poses a barrier to the recipient's ability to function in his/her environment.
- The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
- Parent or guardian withdraws consent for treatment.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

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). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Any procedure or physical crisis management technique that involves the use of seclusion or manual, mechanical, or chemical restraint utilized to control behaviors
- Services for the delivery of recipient supervision, personal care assistance (e.g., acting as a 1:1 aid), companion, chaperone, or shadow regardless of activity or setting. This may include supports and services that are reimbursed through a different Florida Medicaid service benefit or are able to be provided by individuals without professional skills or training.
- Caregiver or childcare services
- Psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, or long-term counseling
- Services funded under section 110 of the Rehabilitation Act of 1973
- Services not listed on the fee schedule
- Services on the same day as behavioral health overlay services*
- Services on the same day as therapeutic behavioral on-site services*
- Services on the same day as therapeutic group care services*
- Services provided simultaneously by more than one BA provider, unless determined to be medically necessary, prior authorized, and indicated in the approved behavior plan
- Travel Time

*These services include behavior analysis treatment.

Florida Medicaid may cover some services listed in this section through a different service benefit.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Requirements Policy.

6.2 Specific Criteria

Providers must maintain the following documentation in the recipient's file:

6.2.1 Referral Information

Original referral documentation must be maintained in the recipient's medical record.

6.2.2 Behavior Assessment and Behavior Plan

The behavior assessment and behavior plan must be signed by the Lead Analyst and the recipient's parent or guardian. Each behavior assessment and behavior plan must include:

- Patient information
- Reason for referral
- Medical and developmental history, including medications prescribed to ameliorate behaviors
- Relevant family history
- Clinical interview
- Review of recent assessments/reports (file review)
- Assessment procedures and results
- Behavior plan
 - Treatment setting(s)
 - Proposed treatment targets, goals, and objectives related to medically necessary behavioral interventions
 - For each:
 - Definition in observable, measurable terms
 - Direct observation and measurement procedures
 - Current level (baseline)
 - Behavior reduction or acquisition procedures
 - Condition(s) under which behavior is to be demonstrated and mastery criteria
 - Date of introduction
 - Estimated date of mastery
 - Plan for generalization
 - Timely reporting of progress, including statements as to whether goal or objective is met; not met; or, modified (with explanation)
- Parent/guardian/caregiver training
 - Proposed targets, goals, and objectives (as above)
 - Training procedures
 - Date of introduction
 - Estimated date of mastery
- Number of units requested
 - Number of units for each billing code
 - Medical necessity for units requested
- Supervision plan, including name(s) of authorized supervisor(s)
- Care coordination with parents/caregivers, schools, state disability programs, and others as applicable
- Transition (fading) plan

- Crisis management plan
- Discharge plan

6.2.3 Assessment and Behavior Plan for Reauthorization and Continuation of Services

In addition to the documentation requirements indicated in 6.2.2, subsequent assessments and behavior plans for reauthorization and continuation of services must include:

- Data reflecting progress of all behaviors targeted for improvement. Each behavior under treatment must have its own data table and corresponding graph.
- A narrative discussion of progress and a statement of justification for continuation of care at the intensity level requested.

If significant clinical progress is not made over the course of an authorization period, the provider must explain why clinically significant progress was not made and treatment changes to promote progress.

6.2.4 Session Notes

Session notes must be signed and dated by the rendering practitioner. Session notes must include:

- Date, time, location, and duration of services
- Maladaptive behaviors observed during the session
- The replacement/compensatory skills targeted during the session
- Description of the recipient's response to the treatment interventions
- Protocol modification, changes to goals/objectives, and/or therapist directions provided during the session, if included
- Explanation if recipient's parent or guardian is not present during BA service delivery
- Participants, including observers, teachers, parents, caregivers, or other health care providers if present

Providers must maintain confidentiality of other recipients receiving services in a group setting.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization (QIO) prior to the initiation of BA services and at least every 180 days thereafter.

Providers must request a new authorization if clinical conditions require a new assessment as described in Section 4.2.1.

Authorization requests for services to be delivered in a school must include the recipient's Individualized Education Plan (IEP). In the absence of an IEP, or when an IEP does not include BA services, the provider must include documentation providing justification for the services requested and an estimated timeframe of when an IEP will be completed or updated. If a school does not conduct IEPs, a 504 plan may be submitted in its place. If a school does not provide either, the provider must include documentation that includes the name of the school and an explanation that neither plan is available.

Authorization requests must include assessment findings as required in Section 4.2.1.

Authorization requests for service continuation must include data about parental guardian participation in services.

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

Providers must only bill for services performed for 8 minutes or more when determining the number of billable 15-minute units. For services that exceed 15 minutes, providers must use the total minutes of service provided and divide by 15 to obtain the number of units.

Remaining minutes of service greater than or equal to 8 minutes count as one unit and may be billed as such. Remaining minutes less than 8 do not count as a unit and are not billable.

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.4.1 Co-occurring Disorders

Providers must report diagnoses of co-occurring disorders that may impact the medical necessity for BA services.

8.5 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

8.5.1 Supervision

The supervisor may be reimbursed for observing a supervisee implementing the behavior plan. The supervisee will not be reimbursed when the supervisor is reimbursed for the same time period.