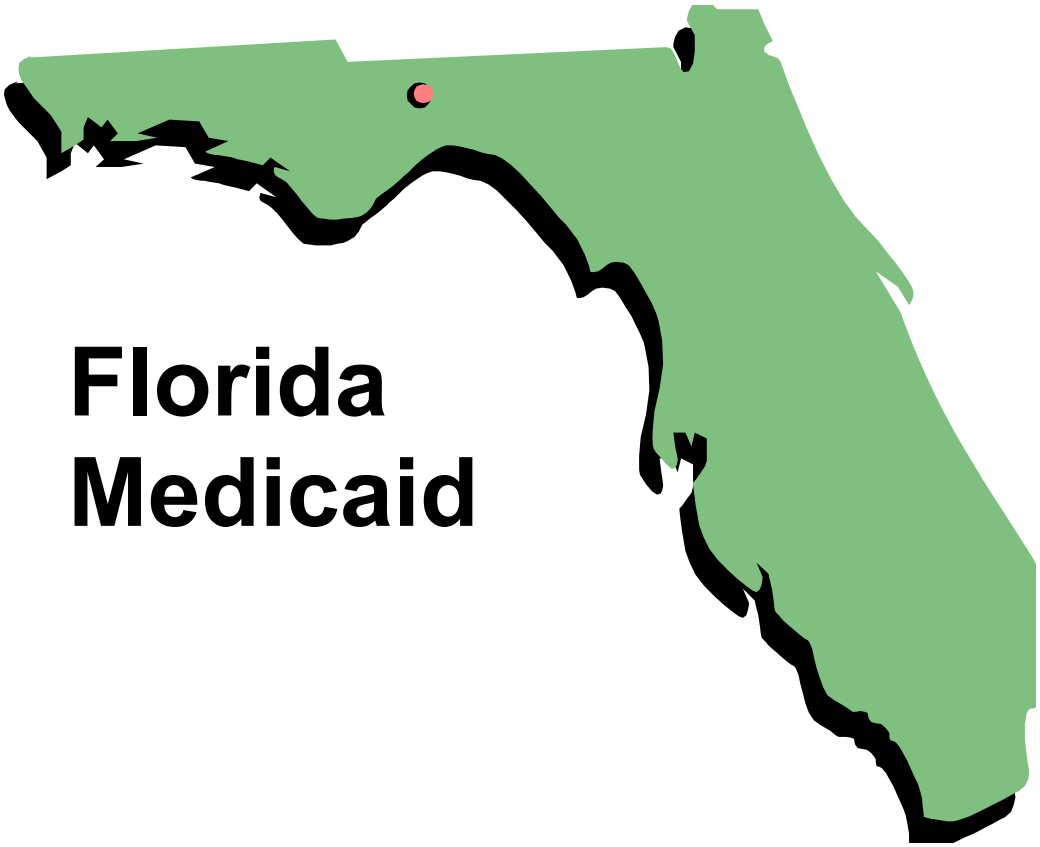

Florida Medicaid

Behavioral Health Assessment Services Coverage Policy

Agency for Health Care Administration

[Month YYYY]

Draft Rule

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1.0 Introduction

1.1 Description

Florida Medicaid behavioral health assessment services provide for the screening and identification of mental health and substance use disorders in order to develop, plan, and maintain a schedule of services to restore a recipient to the best possible functional level.

1.1.1 Florida Medicaid Policies

This policy is intended for use by providers that render behavioral health assessment 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 (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Behavioral health assessment services are authorized by the following:

- Title XIX of the Social Security Act, (SSA)
- Title 42, Code of Federal Regulations, (CFR), section 440.130(d)
- Section 409.906, Florida Statutes (F.S.)
- Rule 59G-4.028, F.A.C.

1.3 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.

1.3.1 Claim Reimbursement Policy

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

1.3.2 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.

1.3.3 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.

1.3.4 Medically Necessary/Medical Necessity

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

1.3.5 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.

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

1.3.7 Treating Practitioner
A fully licensed practitioner who directs the course of treatment for recipients.

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 requiring medically necessary behavioral health assessment services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance, Copayment, or Deductible
Recipients are responsible for a $2.00 copayment in accordance with the section 409.9081, F.S., unless the recipient is exempt from copayment requirements or the copayments is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For more information on copayment and coinsurance requirements and exemptions please refer to Florida Medicaid's General Policies on copayment and coinsurance.

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 behavioral health assessment services.

3.2 Who Can Provide
Services must be rendered by one of the following:

- Practitioners licensed in accordance with 464, 458, or 459, F.S.
- Practitioners fully licensed in accordance with 490 or 491, F.S.
- Community behavioral health agencies that employ or contract with practitioners who perform services under the supervision of a treating practitioner, including:
  - Certified addiction professionals
  - Certified behavioral health technicians
  - Certified mental health technicians
  - Certified psychiatric rehabilitation practitioners
  - Certified recovery peer specialists
  - Certified recovery support specialists
  - Practitioners with a bachelor's or master's degree from an accredited college in a human services related field

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 behavioral health assessment services in accordance with the applicable Florida Medicaid fee schedules:

4.2.1 Initial Assessment/Reassessment

One initial assessment and one reassessment per fiscal year, per recipient, provided by a medical practitioner.

4.2.2 Brief Behavioral Health Assessment

Up to ten units per fiscal year, per recipient (maximum of two units per day), provided by a medical practitioner.

4.2.3 Psychological Testing

Up to 40 units of testing per fiscal year, per recipient for the administration of standardized tests that assess a recipient's mental functioning provided by a medical practitioner or LPHA.

Florida Medicaid does not cover the treatment plan development and review, separately. The treatment plan development and review is a required component of the assessment or evaluation.

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 SSA, 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 General Policies on authorization requirements.

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:

- A brief behavioral assessment on the same day as an initial assessment.
- Obtaining a detailed personal history as part of psychological testing.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's General Policies on recordkeeping and documentation.

6.2 Specific Criteria

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

6.2.1 Assessments

Assessments and evaluations must be written by the individual rendering the service.

All assessments and testing are complete when reviewed, signed, and dated by a medical practitioner.

6.2.1.1 Initial and Reassessment

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

- Alcohol and other drug use history
- Biological factors
- Clinical interview with the primary caretaker
- Developmental history and history of the mother's pregnancy
- Educational history
- Family psychosocial history and medical history
- History of the presenting illness or problem
- Integrated summary
- Legal history or involvement
- Medication history
- Personal strengths
- Physical history
- Psychiatric history
- Psychiatric review of records
- Psychological factors
- Presenting Problems
- Relevant personal and family medical history
- Social factors
- Status examination
- Status examination
- Trauma history
- Treatment plan development

6.2.1.2 Brief Behavioral Health Assessment

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

- Chief complaint-recipient's perception of problems, needs, or prominent symptoms
- Purpose of the Examination
- Status of the examination
- Personal history, including:
  - Clinical interview with the primary caretaker
  - Current alcohol and other drug use
  - Current behavioral health status
  - Current educational analysis
  - Current legal involvement
  - Current medical information
  - Identifying information
  - Integrated summary
  - Psychiatric review of records
  - Resources and strengths
  - Status examination
  - Traumatic experiences
  - Treatment plan review

6.2.2 Treatment Plans
Treatment plans are complete when signed and dated by a treating practitioner.

6.2.2 Psychological Testing
Standardized tests are complete when administered by a medical practitioner.

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 General Policies on authorization requirements.

7.2 Specific Criteria
There are no specific authorization criteria for this service.

7.0 Reimbursement

8.1 General Criteria
The reimbursement information in this section is applicable to the fee-for-service delivery system.

8.2 Claim Type
Professional (837P/CMS-1500)

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.

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