



# Florida Medicaid

Behavioral Health Community Support and  
Rehabilitation Services Coverage Policy  
**Agency for Health Care Administration**  
[Month YYYY]



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## 1.0 Introduction

### 1.1 Description

Florida Medicaid behavioral health community support and rehabilitation services are provided to promote recovery from behavioral health disorders or cognitive symptoms by improving the ability of recipients to strengthen or regain skills necessary to function successfully in the community.

#### 1.1.1 Florida Medicaid Policies

This policy is intended for use by providers that render behavioral health community support and rehabilitation 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 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 community support and rehabilitation services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), part 440.130
- Section 409.906, Florida Statutes (F.S.)
- Rule 59G-4.031, 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 Behavioral Health Day Service

Intensive therapeutic treatment approaches utilized to stabilize the symptoms of a behavioral health disorder as a transition from an acute episode or to prevent the need for a more intensive level of care.

#### 1.3.2 Claim Reimbursement Policy

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

#### 1.3.3 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.

#### 1.3.4 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.

**1.3.5 Medically Necessary/Medical Necessity**

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

**1.3.6 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.

**1.3.7 Recipient**

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

**1.3.8 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 community support and rehabilitation services and who exhibit psychiatric, behavioral, or cognitive symptoms, including addictive behaviors impairments in day-to-day personal, social, prevocational, and educational functioning.

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

**2.3 Coinsurance and Copayments**

Recipients are responsible for a \$2.00 copayment in accordance with section 409.9081, F.S., unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For more 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 community support and rehabilitation services.

**3.2 Who Can Provide**

Services must be rendered by one of the following:

- Practitioners licensed in accordance with Chapters 464, 458, or 459, F.S.
- Practitioners fully licensed in accordance with Chapter 490 or 491, F.S.
- Practitioners with the appropriate education and training who perform services under a treating practitioner, including:
  - Master's level certified addiction professional
  - Certified Addiction Professional
  - Certified behavioral health technician
  - Certified recovery peer specialist
  - Certified recovery support specialist
  - Certified psychiatric rehabilitation practitioner

- Practitioners with a bachelors or master’s degree from an accredited college in a human services related field
- Substance abuse technician (Psychosocial Rehabilitation Services only)

## 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 community support and rehabilitation services in accordance with the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

#### 4.2.1 Behavioral Health Day Services

Up to 190 hours of behavioral health day services per state fiscal year, per recipient, provided to assist a recipient to develop the skills necessary for daily living and symptom management.

Florida Medicaid covers recipients ages two through five years who score in the moderate impairment (or higher) range on a behavioral and functional rating scale developed for use with this age group.

#### 4.2.2 Psychosocial Rehabilitation Services

Up to 3,840 units of psychosocial rehabilitation services provided in a group setting (up to 12 participants) per fiscal year, per recipient, consisting of independent living and social skills trainings that improve the recipient’s ability to achieve or maintain desired recovery goals, including:

- Development of appropriate social relationships
- Employment or occupational achievements
- Food planning and preparation
- Medication maintenance
- Money management
- Maintenance of the living environment
- Training in appropriate use of community services

### 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**

There are no specific non-covered exclusion criteria for this service.

**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 document daily progress for each service provided.

**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 General Policies on authorization requirements.

**7.2 Specific Criteria**

There are no service specific authorization criteria for this service.

**8.0 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>.