



Florida Medicaid

Behavioral Health Therapy Services Coverage Policy

Agency for Health Care Administration
[Month YYYY]



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1.0 Introduction

1.1 Description

Florida Medicaid behavioral health therapy services are provided to recipients, their families, or other responsible persons to improve the symptoms of mental health or substance use disorders through the use of evidence-based, insight-oriented, therapeutic interventions.

1.1.1 Florida Medicaid Policies

This policy is intended for use by providers that render behavioral health therapy 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 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 therapy 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-4.050, 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 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 therapy services. 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 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 therapy 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 licensed in accordance with 490 or 491, F.S. (This does not include interns or provisional licensees).
- 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 therapy services, including documentation, education, and referrals, in accordance with the applicable Florida Medicaid fee schedule, or as specified in this policy:

4.2.1 Individual and Family Therapy

Up to 104 units of individual and family therapy per state fiscal year, per recipient (maximum of four units per day)

4.2.2 Group Therapy

Up to 156 units of group therapy per state fiscal year, per recipient, for a group of two to fifteen participants (two to ten participants for recipients under the age of six years)

A recipient must be the primary focus of services if the recipient is not present during family or group therapy.

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:

- Individual, family, or group therapy services provided on the same day as behavior analysis services
- Services for a recipient receiving any 24 hour Florida Medicaid residential or institutional 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 the approved services on the treatment plan developed and maintained in accordance with Rule 59G-4.028, F.A.C.

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, 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, 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>.