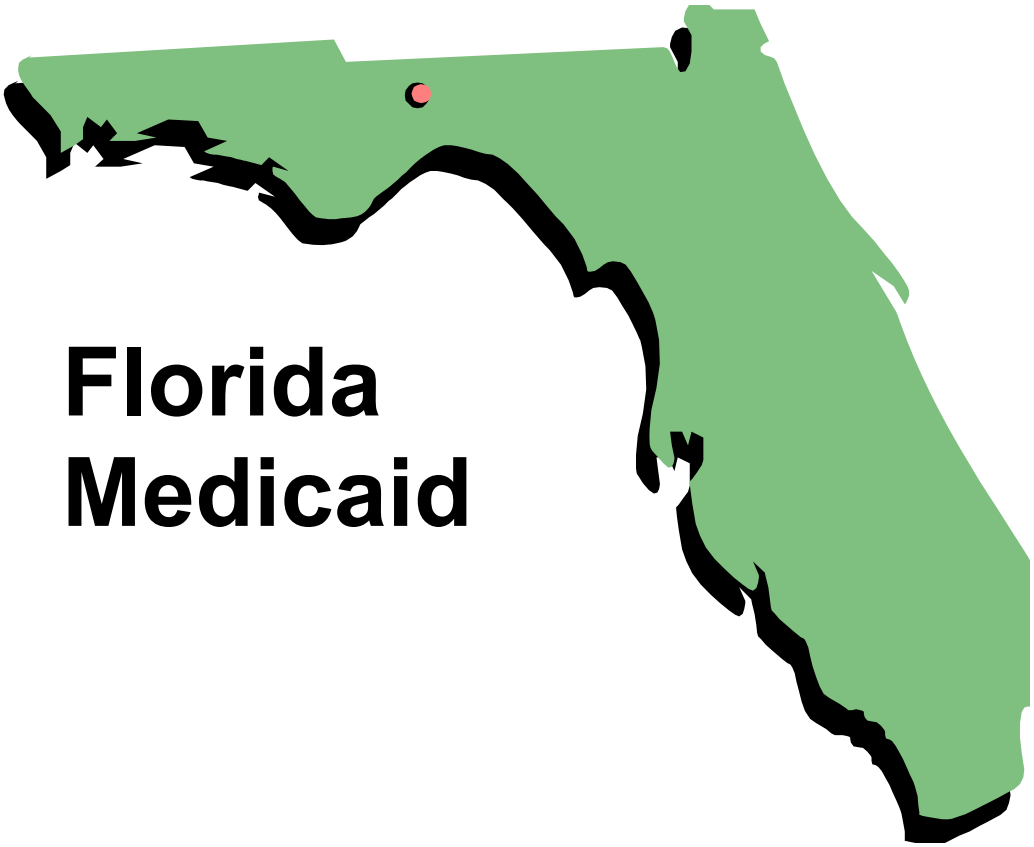

Florida Medicaid

Behavioral Health Assessment Services Coverage Policy

Agency for Health Care Administration

[Month YYYY]

Draft Rule

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1.0 Introduction

Florida Medicaid provides behavioral health assessment services to recipients for 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 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.

1.2 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 service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Florida Medicaid 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
- 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 Assessment

An intensive clinical and functional face-to-face evaluation of a recipient's presenting mental health or substance use disorder, which results in the issuance of a written report that provides the clinical basis for the development of the recipient's treatment or service plan.

1.4.2 Claim Reimbursement Policy

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

1.4.3 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.

1.4.4 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.

1.4.5 Medically Necessary/Medical Necessity

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

1.4.6 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.

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

1.4.8 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 assessment 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 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 behavioral health assessment services.

3.2 Who Can Provide
Services must be rendered by one of the following:
- Practitioners licensed in accordance with Chapters 397, 458, 459, 464, 490, and 491, F.S. and working within the scope of their practice
- Community behavioral health agencies that employ or contract with practitioners who perform services under the supervision of a treating practitioner

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 in accordance with the Healthcare Common Procedure Coding System and the applicable Florida Medicaid fee schedule, or as specified in this policy:

4.2.1 Bio-psychosocial Evaluation

One per recipient, per state fiscal year

4.2.2 Brief Behavioral Health Status Examination
Up to 10 quarter-hour units per recipient, per state fiscal year (maximum of two quarter-hour units per day)

4.2.3 Comprehensive Assessment
Up to 20 hours per recipient, per state fiscal year

4.2.4 In-depth Assessment
One per recipient, per state fiscal year

4.2.5 Limited Functional Assessment
Up to three per recipient, per state fiscal year

4.2.6 Psychiatric Evaluation
Up to two per recipient, per state fiscal year

4.2.7 Psychiatric Review of Records
Up to two per recipient, per fiscal year

4.2.8 Psychological Testing
Up to ten hours per recipient, per state fiscal year

4.2.9 Treatment Plan Development
Up to two per recipient, per state fiscal year (each treatment plan must be developed by a different provider)

4.2.10 Treatment Plan Review
Up to four per recipient, per state fiscal year

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 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:

- Behavior analysis assessments or reassessments on the same day as behavioral health assessments
- Bio-psychosocial evaluation 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
- Brief behavioral assessment on the same day that a psychiatric evaluation, bio-psychosocial assessment, or in-depth assessment has been completed
- Treatment plan development and record reviews, separately

6.0 Documentation

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

6.2 Specific Criteria
Providers must maintain a treatment plan in the recipient's file that includes the all of the following, at a minimum:

- Diagnosis code(s)
- Individualized, strength-based, appropriate goals
- Objectives with target completion dates that are identified for each goal
- A list of the services to be provided
- The specific amount, frequency, and duration of each service. Providers may not specify that services will be provided "as needed" or within a given range.

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
There are no specific authorization criteria for this service.

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)

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.