

Subject: Therapeutic Behavioral On-Site Services for Recipients Under the Age of 21 Years

Status: New

Current Effective Date: January 2018

Last Review Date: February 27, 2017

Description

Therapeutic behavioral on-site services are intended to prevent recipients who have complex needs from requiring placement in a more intensive, restrictive behavioral health setting. These services are coordinated through individualized treatment teams and are designed to assist recipients and their families. Therapeutic behavioral on-site services are intended to maintain the recipient in the home (permanent or foster). Services are limited to recipients under the age of 21 years meeting specific eligibility criteria.

The treatment team must include the recipient and recipient's family, guardian, caregivers, other persons who provide natural, informal support to the family system, and the professionals involved in providing services. The recipient-specific plan for therapeutic behavioral on-site services must be based on a thorough assessment, with input from the recipient and recipient's family, to identify needs, strengths, and desired service outcomes. When indicated by the assessment and agreed to by the family, the plan must reflect referral to, and coordination with, other agencies and resources.

It is recognized that involvement of the family in the treatment of the recipient is necessary and appropriate. Provision of therapeutic behavioral on-site services with the family must clearly be directed toward meeting the recipient's identified treatment needs. Services provided to the recipient's family, independent of meeting the recipient's identified needs, are not reimbursable by Medicaid.

If the assessment indicates a need for intensive, clinical therapeutic behavioral on-site services, and the family agrees to these services, the following services are reimbursable under Medicaid:

- Therapeutic behavioral on-site—therapy services
- Therapeutic behavioral on-site—behavior management services
- Therapeutic behavioral on-site—therapeutic support services

Clinical Indications

Medically Necessary:

In order to receive therapeutic behavioral on-site services, a recipient must meet **ONE** of the following eligibility criteria:

- 1) Under the age of 2 years and meets one of the following criteria:
 - a. Exhibiting symptoms of an emotional or behavioral nature that are atypical for the recipient's age and development that interferes with social interaction and relationship development;
 - b. Failure to thrive (due to emotional or psychosocial causes, not solely medical issues);
- 2) Ages 2 years through 5 years and meets **BOTH** of the following criteria:
 - a. Exhibiting symptoms of an emotional or behavioral nature that are atypical for the recipient's age and development;
 - b. Score in at least the moderate impairment range on a behavior and functional rating scale developed for the specific age group;
- 3) Ages 6 years through 17 years and meets **ONE** of the following criteria:
 - a. Have an emotional disturbance;
 - b. Have a serious emotional disturbance;

- i. Have a substance use disorder;
- 4) Ages 18 years through 20 years, but otherwise meets the criteria for an emotional disturbance or a serious emotional.

Assessment Requirement

Prior to the development of a treatment plan the provider must complete and provide to the recipient an assessment of:

- 1) Mental health status;
- 2) Substance use concerns;
- 3) Functional capacity;
- 4) Strengths; **AND**
- 5) Service needs; **OR**
- 6) Have an assessment on file that has been conducted in the last six months.

The purpose of the assessment is to gather information to be used in the formulation of a diagnosis and development of a plan of care that includes the discharge criteria.

For recipients under the age of 6 years, a comprehensive behavioral health assessment completed within the past year, in accordance with the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook, may satisfy the current assessment requirement for services.

Assessment

Assessment services include the following:

- Psychiatric evaluation
- Brief behavioral health status examination
- Psychiatric review of records
- In-depth assessment
- Bio-psychosocial evaluation
- Psychological testing
- Limited functional assessment

Each type of assessment components and requirements are listed below

Psychiatric evaluation

A psychiatric evaluation must provide information on the following components:

- 1) Presenting problems;
- 2) History of the presenting illness or problem;
- 3) Psychiatric history;
- 4) Physical history;
- 5) Trauma history;
- 6) Medication history;
- 7) Alcohol and other drug use history;
- 8) Relevant personal and family medical history;
- 9) Personal strengths;
- 10) Mental health status examination;
- 11) Summary of findings;
- 12) Diagnostic formulation;
- 13) Treatment recommendations or plan.

Who Must Provide

A psychiatric evaluation must be provided by one of the following qualified treating practitioners:

- 1) Treating physician;
- 2) Treating psychiatrist;
- 3) Psychiatric physician assistant (PPA);
- 4) Psychiatric ARNP.

Brief Behavioral Health Status Examination

A brief behavioral health status examination is:

- 1) A brief clinical;
- 2) Psychiatric;
- 3) Diagnostic; **OR**
- 4) Evaluative interview to assess behavioral stability or treatment status
- 5) A brief behavioral health status examination must be completed prior to the development of the recipient's individualized treatment plan.

A brief behavioral health status examination is not required when:

- 1) A psychiatric evaluation;
- 2) A Bio-psychosocial assessment; **OR**
- 3) A in-depth assessment has been completed by a physician, psychiatrist, LPHA, or a master's level CAP within six months prior to the development of recipient's treatment plan.

A brief behavioral health status examination must provide information on all of the following components:

- 1) Purpose of the exam;
- 2) Mental health status;
- 3) Summary of findings;
- 4) Diagnostic formulation;
- 5) Treatment recommendations or plan.

Who Must Provide

A brief behavioral health status examination must be provided by one of the following qualified practitioners:

- 1) Physician
- 2) Psychiatrist
- 3) LPHA
- 4) Master's level CAP on the behalf of recipients with a primary diagnosis of a substance use disorder and no co-occurring mental health concerns

Psychiatric review of records

A psychiatric review of records includes a review of:

- 1) Recipient records;
- 2) Psychiatric reports;
- 3) Psychometric or projective tests; **AND**
- 4) Clinical and psychological evaluation data for diagnostic use in evaluating and planning for recipient care.

A written report must be done by the individual rendering the service and must be included in the recipient's clinical record.

A psychiatric review of records does not include a review of:

- 1) The provider agency's own records except for psychological testing; **AND**
- 2) Other evaluations or evaluative data used explicitly to address documented diagnostic questions.

Who Must Provide

A psychiatric review of records must be provided by one of the following qualified practitioners:

- 1) Physician;
- 2) Psychiatrist;
- 3) PPA;
- 4) Psychiatric ARNP.

Specific Documentation Requirements

A psychiatric review of records may be documented in:

- 1) A report format; **OR**
- 2) A progress note in the recipient's clinical record.

The sole use of checklists or fill in the blank forms is not allowed.

In-depth assessment

An in-depth assessment is a diagnostic tool for gathering information to:

- 1) Establish or support a diagnosis;
- 2) Provide the basis for the development of or modification to the treatment plan;
- 3) Develop the discharge criteria;
- 4) Integrated summary.

Written documentation must be included in the recipient's clinical record to support the recipient's eligibility for this service.

The in-depth assessment must provide detailed information on all the following components:

- 1) Chief complaint—recipient's perception of problems, needs, or prominent symptoms.
- 2) Personal history, including:
 - a. Identifying information
 - b. Medical
 - c. Alcohol and other drug use
 - d. Traumatic experiences
 - e. Legal involvement
 - f. Educational analysis
 - g. Resources and strengths.
- 3) History of treatment (as applicable), including:
 - a. Psychiatric treatment to include previous and current psychotropic medications
 - b. Inpatient behavioral health treatment
 - c. Acute care treatment
 - d. Therapy and counseling
 - e. Mental health status examination
 - f. Desired services and goals from the recipient's viewpoint
 - g. Treatment recommendations or plan

For recipients under the age of 6 years, the in-depth assessment must include the following additional components:

- 1) Presenting symptoms and behaviors;
- 2) Developmental and medical history:
 - a. History of the mother's pregnancy and the recipient's delivery;
 - b. Past and current medical conditions; **AND**
 - c. Developmental milestones;

- 3) Family psychosocial and medical history (can be as reported or based upon collateral information);
- 4) Family functioning, cultural and communication patterns, and current environmental conditions and stressors;
- 5) Clinical interview with the primary caretaker and observation of the caregiver–infant or –child relationship and interactive patterns;
- 6) Provider’s observation and assessment of the recipient, including affective, language, cognitive, motor, sensory, self-care, and social functioning.

A new in-depth assessment can be provided to recipients who meet one of the following criteria:

- 1) Recipients who are being admitted to treatment when it is documented that a psychosocial evaluation or bio-psychosocial evaluation was insufficient in providing a comprehensive basis for treatment planning;
- 2) Recipients who have been identified as high-risk;
- 3) Recipients, under the age of 6 years, who are exhibiting symptoms of an emotional or behavior nature that are atypical for the child’s age and development.

An established patient in-depth assessment may be provided to recipients who meet one of the following criteria:

- 1) Recipients for whom outpatient services, as initially prescribed, have been unsuccessful and whose clinical record documents a need for a more intensive level of treatment;
- 2) Recipients who have been identified through the utilization management process as being high risk or high utilizers of behavioral health services.

Who Must Provide

The in-depth assessment and integrated summary must be provided by one of the following qualified practitioners:

- 1) Physician
- 2) Psychiatrist
- 3) LPHA
- 4) Master’s level CAP
- 5) Master’s level practitioner

For recipients, under the age of 6 years, the in-depth assessment must be provided by one of the above professionals who has training and experience in infant, toddler, and early childhood development and the observation and assessment of young children.

The integrated summary is developed after the in-depth assessment has been completed. The integrated summary is written to evaluate, integrate, and interpret from a broad perspective, the history and assessment information collected. The summary identifies and prioritizes the recipient’s service needs, establishes a diagnosis, provides an evaluation of the efficacy of past interventions, and helps to establish discharge criteria.

Bio-psychosocial evaluation

- 1) A bio-psychosocial evaluation describes:
 - 2) Biological;
 - 3) Psychological; **AND**
 - 4) Social factors that may have contributed to the recipient’s need for services;
 - 5) A brief mental status exam and preliminary service recommendations.

When it is consistent with the recipient’s treatment needs, bio-psychosocial evaluations can be completed using telemedicine.

A bio-psychosocial evaluation must provide information on all the following components:

- 1) Presenting problems;

- 2) Biological factors;
- 3) Psychological factors;
- 4) Social factors;
- 5) Mental health status examination;
- 6) Summary of findings;
- 7) Diagnostic impression;
- 8) Treatment recommendations or plan.

Who Must Provide

A bio-psychosocial evaluation must be provided by one of the following qualified practitioners:

- 1) Physician;
- 2) Psychiatrist;
- 3) LPHA;
- 4) Master's level CAP;
- 5) Master's level practitioner;
- 6) CAP;
- 7) Bachelor's level practitioner.

Who Must Review

A bio-psychosocial evaluation completed by a bachelor's level practitioner must be:

- 1) Reviewed, signed, and dated by:
 - a. A master's level practitioner; **OR**
 - b. Bachelor's level CAP; **OR**
 - c. A treating practitioner prior to completion of the treatment planning process.
- 2) The review must include:
 - a. Clinical impressions;
 - b. A provisional diagnosis; **AND**
 - c. A statement by the reviewer that indicates concurrence or alternative recommendations regarding treatment.

Psychological Testing

Psychological testing is the assessment, evaluation, and diagnosis of the recipient's mental status or psychological condition through the use of standardized testing methodologies.

Who Can Receive

Recipients are eligible to receive psychological testing only under one or more of the following circumstances:

- 1) At the onset of illness or suspected illness or when the recipient first presents for treatment;
- 2) If an extended hiatus in treatment or a marked change in status occurs, or if the recipient is being considered for admission or readmission to a psychiatric inpatient setting;
- 3) When there is difficulty determining a diagnosis or where there are differential diagnostic impressions;
- 4) When additional information is needed to evaluate or redirect treatment efforts.

Who Must Provide

Psychological testing must be provided by an individual practitioner within the scope of professional licensure, training, protocols, and competence.

Limited functional assessment

A limited functional assessment is restricted to administration of:

- 1) The Functional Assessment Rating Scale (FARS); **AND**
- 2) The Children's Functional Assessment Rating Scale (C-FARS);

- 3) The American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R); **OR**
- 4) Any other functional assessment required by the Department of Children and Families (DCF).

When it is consistent with the recipient's treatment needs, limited functional assessments can be completed using telemedicine.

Who Must Provide

The FARS and the C-FARS must be provided by an individual who is certified by DCF to administer the assessment.

As of July 1, 2014, the American Society of Addiction Medicine Patient Placement Criteria must be provided by an individual who has completed provider agency training on how to use the instrument to make accurate level of care determinations.

In addition to meeting the general documentation requirements, a written report of evaluation and testing results for services listed in this section must be completed by the individual rendering the service.

Treatment Plan Development and Modification:

Treatment Plan Development:

- 1) The treatment plan must be:
 - a. Jointly developed by the recipient; **AND**
 - b. The treatment team.
 - c. The treatment plan must be recipient-centered; **AND**
 - d. Consistent with the recipient's identified strengths, abilities, needs, and preferences.
- 2) The recipient's parent, guardian, or legal custodian should be included in the development of the recipient's individualized treatment plan, if the recipient is under the age of 18 years.
- 3) Treatment planning for a recipient under the age of 18 years that does not include the recipient's parent, guardian, or legal custodian in a situation of exception requires a documented explanation.

Required Components of the Treatment Plan:

The treatment plan must contain all of the following components:

- 1) The recipient's diagnosis code(s) consistent with assessment(s);
- 2) Goals that are individualized, strength-based, and appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the recipient;
- 3) Measurable objectives with target completion dates that are identified for each goal;
- 4) A list of the services to be provided (treatment plan development, treatment plan review, and evaluation or assessment services provided to establish a diagnosis and to gather information for the development of the treatment plan need not be listed);
- 5) The amount, frequency, and duration of each service for the six month duration of the treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the recipient will receive a service "x to y times per week";
- 6) Dated signature of the recipient;
- 7) Dated signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18 years);
- 8) Signatures of the treatment team members who participated in development of the plan
- 9) A signed and dated statement by the treating practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs;
- 10) Discharge criteria.

If the recipient's age or clinical condition precludes participation in the development and signing of the treatment plan, an explanation must be provided on the treatment plan.

There are exceptions to the requirement for a signature by the recipient's parent, guardian, or legal custodian. Documentation and justification of the exception must be provided in the recipient's clinical record. The following exceptions are:

- 1) As allowed by Chapter 397, F.S., recipients under the age of 18 years seeking substance use services from a licensed service provider;
- 2) Recipients ages 13 years and older, experiencing an emotional crisis in accordance with section 394.4784 (1), (2), F.S.;
- 3) Recipients in the custody of the Department of Juvenile Justice who have been court ordered into treatment or require emergency treatment such that delay in providing treatment would endanger the mental or physical well-being of the recipient. The signature of the parent, guardian, or legal custodian must be obtained as soon as possible after emergency treatment is administered;
- 4) For recipients in the care and custody of the DCF (foster care or shelter status), the child's DCF or Community Based Care (CBC) caseworker must sign the treatment plan if it is not possible to obtain the parent's signature. The caseworker and foster parent should be encouraged to participate in the treatment planning. In cases where DCF is working toward reunification, the parent should be involved and must sign the treatment plan.

The treatment plan becomes effective on:

- 1) The date it is signed and dated by the treating practitioner; AND
- 2) Medicaid will reimburse for services provided within 45 days prior to the signature of the treating practitioner.

Use of Addendum

An addendum may be used:

- 1) To make changes to the treatment plan;
- 2) When significant changes have not occurred; **AND**
- 3) In lieu of rewriting the entire plan;
- 4) To add additional services; **OR**
- 5) To modify services prescribed on the treatment plan; **AND**
- 6) To become part of the recipient's treatment plan;
 - a. The addendum must be signed and dated by the treating practitioner and the recipient.
- 7) Development of an addendum is not a reimbursable service.

The treatment plan review requires the participation of the recipient and the treatment team identified in the recipient's individualized treatment plan as responsible for addressing the treatment needs of the recipient.

Frequency of the Treatment Plan Review

A formal review of the treatment plan must be conducted at least;

- 1) Every six months;
- 2) Reviewed more often than once every six months when significant changes occur.

Specific Documentation Requirements for Treatment Plan Reviews

Activities, notations of discussions, findings, conclusions, and recommendations must be documented during the treatment plan review. Any modifications or additions to the treatment plan must be documented based on the results of the review.

The treatment plan review must contain **ALL** of the following components:

- 1) Current diagnosis code(s) and justification for any changes in diagnosis;
- 2) Recipient's progress toward meeting individualized goals and objectives;
- 3) Recipient's progress toward meeting individualized discharge criteria;
- 4) Updates to aftercare plan;
- 5) Findings;
- 6) Recommendations;
- 7) Dated signature of the recipient;
- 8) Dated signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18 years);
- 9) Signatures of the treatment team members who participated in review of the plan;
- 10) A signed and dated statement by the treating practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs.

If the treatment plan review process indicates that the goals and objectives have not been met, documentation must reflect the treatment team's re-assessment of services and justification if no changes are made.

The written documentation must be included in the recipient's clinical record upon completion of the treatment plan review activities.

Aftercare Plan

The recipient and the recipient's family should collaborate with the treating staff to develop the recipient's individualized formal aftercare plan within 45 days of admission to therapeutic behavioral on-site services.

A formal aftercare plan should include:

- 1) Community resources;
- 2) Activities;
- 3) Services; **AND**
- 4) Supports that will be utilized to help the recipient sustain gains achieved during treatment; **AND**
- 5) Placement in the recipient's clinical record.

Services

Therapy

Therapeutic behavioral on-site therapy services include the following:

- 1) Individual and family therapy;
- 2) Collaborative development of the formal aftercare plan.

Who Must Provide

Therapeutic behavioral on-site therapy services must be provided by one of the following qualified professionals:

- 1) Physician;
- 2) Psychiatrist;
- 3) LPHA;
- 4) Master's level CAP;
- 5) Master's level practitioner;

Practitioners must have training and experience in:

- 1) Infant;
- 2) Toddler; **AND**

- 3) Early childhood development and the observation and assessment of young children when treating recipients under the age of 6 years.

Behavior Management

Therapeutic behavioral on-site behavior management services include the following:

- 1) On-going monitoring and assessment of the relationship between interactions that motivate, maintain, or improve recipient behavior, and the skill deficits and assets of the recipient and recipient's family, caregivers, and other involved persons;
- 2) Development of an individual behavior plan, with measurable goals and objectives that must be integrated into the recipient's treatment plan;
- 3) Training the recipient's family, caregivers, and other involved persons in the implementation of the behavior plan;
- 4) Monitoring interactions between the recipient and the recipient's family, caregivers, and other involved persons to measure progress;
- 5) Coordinating treatment plan services.

Who Must Provide

Therapeutic behavioral on-site behavior management services must be provided by a certified behavior analyst, certified assistant behavior analyst, or by one of the following licensed practitioners who has three years of behavior analysis experience and a minimum of 10 hours of documented training every year, dedicated to behavior analysis:

- 1) Clinical social worker;
- 2) Mental health counselor;
- 3) Marriage and family therapist;
- 4) Psychologist.

Practitioners must have training and experience in:

- 1) Infant;
- 2) Toddler; **AND**
- 3) Early childhood development and the observation and assessment of young children when treating recipients under the age of 6 years.

Therapeutic Support

Therapeutic behavioral on-site therapeutic support services include the following:

- 1) One-to-one supervision and intervention with the recipient during therapeutic activities;
- 2) Providing skills training in accordance with the recipient's treatment plan to the recipient for restoration of basic living and social skills;
- 3) Assistance to the recipient and the recipient's family, caregivers, and other involved persons in implementing the recipient's behavior plan;
- 4) When provided in a group, it must be in;
 - a. Response to a specific recommendation; **AND**
 - b. Must be justified by the treating physician or treating LPHA in the recipient's treatment plan; **AND**
 - c. Under no circumstances may the group-to-staff ratio exceed four group members to one staff person.

Who Must Provide

Therapeutic behavioral on-site therapeutic support services must be provided by one of the following qualified professionals:

- 1) Physician
- 2) Psychiatrist

- 3) PPA
- 4) Psychiatric ARNP
- 5) LPHA
- 6) Master’s level CAP
- 7) Master’s level practitioner
- 8) Bachelor’s level practitioner
- 9) Certified behavior analyst
- 10) Certified assistant behavior analyst
- 11) Certified recovery peer specialist
- 12) Certified psychiatric rehabilitation practitioner
- 13) Certified recovery support specialist
- 14) Certified behavioral health technician

Services for recipients under the age of 6 years must be provided by bachelor’s level infant mental health practitioners or higher.

Practitioners must have training and experience in:

- 1) Infant;
- 2) Toddler; **AND**
- 3) Early childhood development and the observation and assessment of young children when treating recipients under the age of 6 years.

Continued Stay Criteria

Within six months of the original determination of eligibility for services and every six months thereafter, the members of the recipient’s treatment team must document that the recipient continues to meet the eligibility criteria stated previously. The determination of eligibility must be maintained in the recipient’s clinical record.

Services may be authorized for less than six months.

Not Medically Necessary:

If at any time during the course of treatment the member does not meet eligibility criteria, TBOS services will no longer be reimbursed.

Coding

All assessment services must be billed with the correct procedure code and modifier found in the appendices.

PROCEDURE CODES AND FEE SCHEDULE				
These procedure codes are to be used for dates of service April 1, 2014 and after.				
Description of Service	Procedure Code	Modifier 1	Modifier 2	Reimbursement and Service Limitations
Assessment Services				
Psychiatric evaluation by physician	H2000	HP		Medicaid reimburses a maximum of two psychiatric evaluations per recipient, per state fiscal year.*
Psychiatric evaluation by physician—telemedicine	H2000	HP	GT	
Psychiatric evaluation by nonphysician	H2000	HO		

Brief behavioral health status exam	H2010	HO		There is a maximum daily limit of two quarter-hour units.
Brief behavioral health status exam—telemedicine	H2010	HO	GT	Medicaid reimburses for brief behavioral health status examinations a maximum of 10 quarter-hour units
				annually (2.5 hours), per recipient, per state fiscal year.* A brief behavioral assessment is not reimbursable on the same day that a psychiatric evaluation, bio-psychosocial assessment, or in-depth assessment has been completed by a qualified treating practitioner.
Psychiatric review of records	H2000			Medicaid reimburses a maximum of two psychiatric reviews of records, per recipient, per state fiscal year.* This service may not be billed for review of lab work (see medication
In-depth assessment, new patient, mental health	H0031	HO		Medicaid reimburses one in-depth assessment, per recipient, per state fiscal year.*
In-depth assessment, new patient, mental health—telemedicine	H0031	HO	GT	An in-depth assessment is not reimbursable on the same day for the same recipient as a bio-psychosocial evaluation.
In-depth assessment, established patient, mental health	H0031	TS		A bio-psychosocial evaluation is not reimbursable 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.
In-depth assessment, established patient, mental health—telemedicine	H0031	TS	GT	
In-depth assessment, new patient, substance abuse	H0001	HO		
In-depth assessment, new patient, substance abuse—telemedicine	H0001	HO	GT	
In-depth assessment, established patient, substance abuse	H0001	TS		

In-depth assessment, established patient, substance abuse—telemedicine	H0001	TS	GT	
Bio-psychosocial Evaluation, mental health	H0031	HN		<p>Medicaid reimburses one bio-psychosocial evaluation, per recipient, per state fiscal year.*</p> <p>A bio-psychosocial evaluation is not reimbursable on the same day for the same recipient as an in- depth assessment.</p>
Bio-psychosocial evaluation, mental health—telemedicine	H0031	HN	GT	
Bio-psychosocial evaluation, substance abuse	H0001	HN		
Bio-psychosocial evaluation, substance abuse—telemedicine	H0001	HN	GT	
Psychological testing	H2019			Medicaid reimburses a maximum of 40 quarter-hour units (10 hours) of psychological testing, per recipient, per state fiscal year.*
Limited functional assessment, mental health	H0031			<p>Medicaid reimburses a maximum of three limited functional assessments, per recipient, per state fiscal year.*</p>
Limited functional assessment, mental health—telemedicine	H0031	GT		
Limited functional assessment, substance abuse	H0001			
Limited functional assessment, substance abuse—telemedicine	H0001	GT		
Treatment Plan Development and Modification				
Treatment plan development, new and established patient, mental health	H0032			<p>Medicaid reimburses for the development of one treatment plan per provider, per state fiscal year.*</p> <p>Medicaid reimburses for a maximum total of two treatment plans per recipient per state fiscal year.*</p> <p>The reimbursement date for treatment plan development is the day it is authorized by the treating</p>
Treatment plan development, new and established patient, substance abuse	T1007			

Treatment plan review, mental health	H0032	TS		Medicaid reimburses a maximum of four treatment plan reviews, per recipient, per state fiscal year.* The reimbursement date for a treatment plan review is the day it is authorized by the treating practitioner.
Treatment plan review, substance abuse	T1007	TS		
Therapeutic Behavioral On-Site Services for Recipients Under the Age of 21 Years				
Therapeutic behavioral on-site services, therapy	H2019	HO		Medicaid reimburses therapeutic behavioral on-site therapy services a maximum combined limit of a total of 36, 15-minute units per month(9 hours) by a master's level or certified behavioral analyst.
Therapeutic behavioral on-site services, behavior management	H2019	HN		Medicaid reimburses therapeutic behavioral on-site behavior management and therapeutic behavioral on-site therapy services for a maximum combined total of 36, 15-minute units per month by a master's level practitioner, certified behavioral analyst, or certified associate behavioral analyst.
Therapeutic behavioral on-site services, therapeutic support	H2019	HM		Medicaid reimburses therapeutic behavioral on-site therapeutic support services for a maximum of 128 quarter-hour units per month (32 hours), per recipient.

* Source: Florida Medicaid, Community Behavioral Health Services Coverage and Limitations Handbook. Agency for HealthCare Administration, March 2014.

Discussion/General Information

Information contained in this document is from the Florida Community Behavioral Health Services Coverage and Limitations Handbook in conjunction with Florida Medicaid Provider Reimbursement Handbook, Centers for Medicare and Medicaid 1500, Florida Medicaid Provider General Handbook.

Services must be provided in community settings, including where the recipient resides and is educated. When possible, services should be provided in settings where the recipient is experiencing emotional or behavioral difficulties.

These services may not be provided in a psychiatric hospital, a psychiatric unit of a general hospital, a crisis stabilization unit, or any other setting where the same services are already being paid for by another source.

Assessment Requirements

A psychiatric evaluation is a comprehensive evaluation that investigates the recipient's clinical status.

The purpose of a psychiatric evaluation is to establish a therapeutic doctor–patient relationship, gather accurate data in order to formulate a diagnosis, and initiate an effective treatment plan.

A psychiatric evaluation must be conducted at the onset of illness. It can be utilized again if an extended hiatus occurs, a marked change in mental status occurs, or admission or readmission to an inpatient setting for a psychiatric illness is being considered or occurs.

Provision of a psychiatric evaluation is not considered necessary when the recipient has a previously established diagnosis of organic brain disorder (dementia), unless there has been a change in mental status requiring an evaluation to rule-out additional psychiatric or neurological processes that may be treatable.

Treatment Planning

A treatment plan is an individualized, structured, and goal-oriented schedule of services with measurable objectives that promotes the maximum reduction of the recipient's disability and restoration to the best possible functional level. Treatment plan development and modification include:

- Treatment plan development
- Treatment plan review

Individualized recipient treatment plans must directly address the primary diagnosis(es) that is(are) consistent with the assessment.

A treatment plan should directly address additional diagnoses that are consistent with assessment and that are in the range of the provider's expertise. The provider must document efforts to coordinate services for diagnoses outside their expertise that, if treated, would assist meeting the recipient's goals.

Community behavioral health services must be prescribed on a treatment plan authorized by one of the group provider's treating practitioners.

Treatment Plan Reimbursement Limitations

Medicaid reimburses for one treatment plan development per provider, per state fiscal year (July 1 through June 30). Medicaid reimburses for a maximum total of two treatment plans per recipient, per state fiscal year (July 1 through June 30).

Treatment Plan Review

The treatment plan review is a process conducted by the treatment team to ensure that treatment goals, objectives, and services continue to be appropriate to the recipient's needs and to assess the recipient's progress and continued need for services.

Definitions

All definitions from *Community Behavioral Health Services Coverage and Limitations Handbook*¹

Bachelor's Level Practitioner: A bachelor's level practitioner must meet all of the following criteria:

- A bachelor's degree from an accredited university or college with a major in counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field.
- Training in the treatment of behavioral health disorders, human growth and development, evaluations, assessments, treatment planning, basic counseling and behavior management interventions, case management, clinical record documentation, psychopharmacology, abuse regulations, and recipient rights.
- Work under the supervision of a master's level practitioner.

Certified Addictions Professional (CAP):

- A CAP must be certified by the FCB in accordance with Chapter 397, F.S.
- A bachelor's level CAP must have a bachelor's degree and be certified in accordance with Chapter 397, F.S. by the FCB.
- A master's level CAP must have a master's degree and be certified in accordance with Chapter 397, F.S. by the FCB.

Emotional Disturbance: A person under the age of 21 years who is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community. The emotional disturbance must not be considered to be a temporary response to a stressful situation.

Licensed Practitioner of the Healing Arts (LPHA):

- Clinical social workers licensed in accordance with Chapter 491, F.S.
- Mental health counselors, licensed in accordance with Chapter 491, F.S.
- Marriage and family therapists licensed in accordance with Chapter 491, F.S.
- Psychologists licensed in accordance with Chapter 490, F.S.
- Clinical nurse specialists (CNS) with a subspecialty in child/adolescent psychiatric and mental health or psychiatric and mental health licensed in accordance with Chapter 496, F.S.
- Psychiatric advanced registered nurse practitioners licensed in accordance with Chapter 464, F.S.
- Psychiatric physician assistants licensed in accordance with Chapters 458 and 459, F.S.

Master's Level Practitioner: A master's level practitioner must have a master's degree from an accredited university or college with a major in the field of counseling, social work, psychology, nursing, rehabilitation, special education, health education, or a related human services field with one of the following:

- Two years of professional experience in providing services to persons with behavioral health disorders.
- Current supervision under an LPHA as described in this section.

Master's level practitioners hired after July 1, 2014 with degrees other than social work, psychology, marriage and family therapy, or mental health counseling must have completed graduate level coursework in at least four of the following thirteen content areas: human growth and development; diagnosis and treatment of psychopathology; human sexuality; counseling theories and techniques; group theories and practice; dynamics of marriage and family systems; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; personality theories; social and cultural foundations; counseling in community settings; and substance use disorders.

Medical Necessity: Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.

Rule 59G-1.010 (166), Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:

"The medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more

conservative or less costly treatment is available statewide; and

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

"(b) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

Psychiatric Advanced Registered Nurse Practitioner (ARNP): A psychiatric ARNP must have education or training in psychiatry and be authorized to provide these services in accordance with Chapter 464, F.S., and protocols filed with the Florida Board of Nursing.

Psychiatric Physician Assistant (PPA): A PPA must be a licensed prescribing physician assistant as defined in Chapter 458 or 459, F.S., with a Psychiatric Certificate of Added Qualification. The PPA's supervising physician must be a provider type 25 or 26 that is linked to the community behavioral health group provider type 05.

Serious Emotional Disturbance: A person under the age of 21 years who is all of the following:

- Diagnosed as having a mental, emotional, or behavioral disorder that meets one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- Exhibits behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community, which behaviors are not considered to be a temporary response to a stressful situation.

References

Government Agency, Medical Society, and Other Authoritative Publications:

1. Florida Medicaid: Community Behavioral Health Services Coverage and Limitations Handbook. Agency for HealthCare Administration, March 2014.

Websites for Additional Information

1. [Agency for HealthCare Administration, Medicaid Policy and Quality](#), Accessed April 24, 2017
2. [Agency for HealthCare Administration, Behavioral Health and Health Facilities](#), Accessed April 24, 2017

History

Status	Date	Action
New	February 27, 2017	Creation of document.