Handbook UPDATE LOG
Community Behavioral Health Services
Coverage and Limitations Handbook

How to Use the Update Log

Introduction
The current Medicaid provider handbooks are posted on the Medicaid fiscal agent’s Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material and if he maintains a paper copy, file it in the handbook. It is the provider’s responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log
Providers can use the update log to determine if they have received all the updates to the handbook.

Update is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions
When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent’s Web site at mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent’s Provider Support Contact Center at 800-289-7799.

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

Provider General Handbook describes the Florida Medicaid Program. Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules. Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the Coverage and Limitations Handbooks and the Reimbursement Handbooks are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

Title XIX of the Social Security Act.
Title 42 of the Code of Federal Regulations.
Chapter 409, Florida Statutes.
Chapter 59G, Florida Administrative Code.

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# Handbook Use and Format

## Purpose
The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.

The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.

## Provider
The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.

## Recipient
The term “recipient” is used to describe an individual who is eligible for Medicaid.

## General Handbook
General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.

## Coverage and Limitations Handbook
Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.

## Reimbursement Handbook
Each reimbursement handbook is named for the claim form that it describes.

## Chapter Numbers
The chapter number appears as the first digit before the page number at the bottom of each page.

## Page Numbers
Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.

## White Space
The "white space" found throughout a handbook enhances readability and allows space for writing notes.
## Characteristics of the Handbook

### Format
The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.

### Information Block
Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

### Label
Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.

### Note
Note is used most frequently to refer the user to important material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

### Topic Roster
Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

## Handbook Updates

### Update Log
The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an “Update” and the “Effective Date.”

### How Changes Are Updated
The Medicaid handbooks will be updated as needed. Changes may be:

1. Replacement handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy.
2. Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.
**Handbook Updates, continued**

<table>
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<th><strong>Effective Date of New Material</strong></th>
<th>The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.</th>
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<tr>
<td><strong>Identifying New Information</strong></td>
<td>New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.</td>
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<tr>
<td><strong>New Label and New Information Block</strong></td>
<td>A new label and a new information block will be identified with yellow highlight to the entire section.</td>
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<tr>
<td><strong>New Material in an Existing Information Block or Paragraph</strong></td>
<td>New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence and/or paragraph affected by the change.</td>
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CHAPTER 1
COMMUNITY BEHAVIORAL HEALTH SERVICES PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction
This chapter describes the community behavioral health services program, legal authority for the program, its purpose and characteristics, provider enrollment standards, prior authorization, targeted utilization management, and staff qualifications.

Background
Community behavioral health services are governed by Title 42, Code of Federal Regulations (CFR), Part 440.130 and through the authority of Chapter 409.906, Florida Statutes (F.S.). The Florida Administrative Code, Chapter 59G, authorizes implementation of Medicaid policy for community behavioral health services.

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Program Purpose and Definitions

Purpose
This handbook is intended for use by community behavioral health services providers who are enrolled in the Medicaid program. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which contains general information about the Florida Medicaid program.

**Program Purpose and Definitions, continued**

**Community Behavioral Health Services**

Community behavioral health services include mental health and substance abuse services provided to individuals with mental health, substance abuse and mental health and substance abuse co-occurring disorders for the maximum reduction of the recipient's disability and restoration to the best possible functional level. Services are limited to those which are medically necessary, are recommended by a treating practitioner, and included in an individualized treatment plan.

*Services can be delivered once or repeated over a course of time as determined by the recipient and service provider. Unless otherwise specified in this policy manual, the date(s) of service on each claim must correspond to the date(s) the service was rendered.*

*Note*: See Staff Qualifications in this chapter for a definition of treating practitioner.

**Medically Necessary**

Medicaid reimburses for medically necessary services that do not duplicate another provider’s service, are determined medically necessary. Per 59G-1.010, F.A.C., in addition, the services must meet the following criteria to be medically necessary:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient’s needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflective of the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

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 covered service.

*Note*: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically necessary.

**Circuit or Regional District Substance Abuse and Mental Health Program Office**

In the Medicaid community mental health services program, the Circuit or Regional district Substance Abuse and Mental Health office is the local mental health and substance abuse authority within the Substance Abuse and Mental Health office, as designated by the Department of Children and Families Circuit or Regional District Administrator.
**Program Purpose and Definitions, continued**

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<th>Term</th>
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<td><strong>Aftercare Planning</strong></td>
<td>Services that will provide the recipient with the appropriate follow-up treatment and care that is needed after the recipient is discharged from a behavioral health program.</td>
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<td><strong>Discharge Planning</strong></td>
<td>Services that involve the formal termination of the recipient from a behavioral health program, generally when treatment goals have been completed or through administrative authority. Discharge planning must begin at the onset of treatment.</td>
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<td><strong>Human Services Field</strong></td>
<td>A human services field is one in which major course work includes the study of human behavior and development. The primary purpose of the human services field should be to prepare the individual for a career in behavioral health care.</td>
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<tr>
<td><strong>Institutions for Mental Diseases</strong></td>
<td>An institution for mental diseases is a hospital or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care to persons with behavioral diseases (Title 42 CFR Part 441.13 and 435.1008). Note: The CFR is available on the Internet at: <a href="http://www.gpoaccess.gov/cfr/index.html">http://www.gpoaccess.gov/cfr/index.html</a>.</td>
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<td><strong>Interventions</strong></td>
<td>Strategies or approaches intended by the provider to prevent undesirable outcomes, promote desirable outcomes, or alter the course of existing conditions for a recipient. Documentation will include a brief description of the strategy or approach and the recipient’s response to the intervention.</td>
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<td><strong>Other Responsible Persons</strong></td>
<td>Other responsible persons are defined as a relative, legal guardian or caretaker. For services provided in the school, this may also include a child’s classroom teacher or guidance counselor. Provision of services where the family or other responsible persons are involved must clearly be directed to meeting the identified treatment needs of the recipient. Services provided to family members or other responsible persons independent of meeting the identified needs of the recipient are not reimbursable by Medicaid. For services provided in the school, this may also include a child’s classroom teacher or guidance counselor.</td>
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<td><strong>Recovery</strong></td>
<td>A process of healing and transformation that enables a person to achieve his or her full potential in leading a meaningful life in communities of his or her choice.</td>
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<td><strong>Resilience</strong></td>
<td>A capacity that empowers a person to prevent, minimize, or overcome the effects of adversity.</td>
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**Program Purpose and Definitions, continued**

| **Shelter Status** | "Shelter Status" means the legal status that begins when the child is taken into protective custody of the Department of Children and Families (DCF) and ceases when the court grants custody to a parent, or, after disposition of the petition for dependency, the court orders the child released to a parent or placed in the temporary custody of DCF, a relative, or a non-relative. |
| **Treating Practitioner** | A treating practitioner is a licensed practitioner of the healing arts, psychiatrist or other physician, who is enrolled in Florida Medicaid and who authorizes services on behalf of the Medicaid group provider. **For recipients with a primary diagnosis of a substance abuse disorder, treating practitioners include certified addictions professionals with a master’s degree.** |
| **Treatment Team** | The treatment team includes all staff involved in planning and providing behavioral health services to the recipient. |
Provider Enrollment Standards

Introduction

The qualifications listed in this section apply to the following providers:

- Community Behavioral Health Services (Provider Type 05)
- Behavioral Health Overlay Services (Provider Type 05)
- Comprehensive Behavioral Health Assessments (Provider Type 07, Specialty Code 66)
- Specialized Therapeutic Foster Care Services (Provider Type 07, Specialty Code 67)
- Therapeutic Group Care Services (Provider Type 05)

Provider Qualifications

To be eligible to enroll in Medicaid’s Community Behavioral Health Services program, providers must:

Meet standards outlined in Ch. 394, F.S.
Have a current contract for the provision of community behavioral health services with the Department of Children and Families district or regional Substance Abuse and Mental Health program office;

1. Employ or have under contract a Medicaid-enrolled psychiatrist or other physician who is enrolled with the Medicaid group provider; and

2. Achieve compliance on the Community Behavioral Health Services Provider Pre-Enrollment Certification Review (Provider Type 05, only).

In addition to the above:

- Alcohol prevention, treatment, or drug abuse treatment and prevention programs must hold a regular (i.e., not probationary or interim) license as defined in Chapter 397, F.S.

- Agencies seeking enrollment as providers of comprehensive behavioral health assessments, therapeutic group care services, behavioral health overlay services (for youth in juvenile justice or child welfare settings), or specialized therapeutic foster care services (Level I, Level II, and Crisis Intervention) must be reviewed and certified by Medicaid as meeting specific provider qualifications.

- Individuals seeking enrollment as providers of comprehensive behavioral health assessments must be reviewed and certified by Medicaid as meeting specific provider qualifications.

Note: See Chapter 2, Section 1 for more information on the specific provider certification review requirements.
Provider Enrollment Standards, continued

**Note:** For additional information on provider enrollment and qualifications for comprehensive behavioral health assessment and specialized therapeutic foster care services, see Chapter 2, Section 3.

**Note:** For information on the Behavioral Health Overlay Services Child Welfare and Department of Juvenile Justice Certification Process, which must occur in addition to the provider certification review and prior to seeking reimbursement for behavioral health overlay services, see Chapter 2, Sections 4 and 7.

**Note:** For information on the certification process for Specialized Therapeutic Group Care services, see Chapter 2, Section 6.

### Enrollment of the Treating Practitioner

A treating practitioner must be independently enrolled in the Florida Medicaid program:

- Treating physicians must enroll as a provider type 25.

- Treating licensed practitioners of the healing arts (LPHA) and certified addictions professionals with a master’s degree (master’s level C.A.P.) must enroll as provider type 07. LPHAs and master’s level C.A.P.s must also be affiliated with a group provider (provider type 05) in order to be enrolled and reimbursed as an individual provider type 07.

### Subcontracting

Federal regulations allow a provider to contract with an individual practitioner, but not with another agency for service delivery. All subcontracted individuals must be provided with the same orientation, training, screening, and credentialing as a permanent employee. Providers must document the above in the individual’s employee file.

### Pre-Enrollment Provider Certification Review

Agencies or organizations seeking enrollment as community behavioral health providers are subject to a pre-enrollment certification review to assure compliance with state and federal guidelines and standards of care as defined by Medicaid. The review includes:

- Standards for facility and environment, leadership, management of human resources, staff credentials, records management, scope of and need for services provided, and service area; and

- Standards for access to care, quality improvement assurance, provision of services to be provided, and records documentation of services.
Provider Enrollment Standards, continued

Additional Service Sites

Providers who wish to expand into another Department of Children and Families district or region Medicaid Area must obtain a contract from the district or regional Substance Abuse and Mental Health Program Office, complete and submit a Medicaid Provider Enrollment Application, and undergo a pre-enrollment certification review of the new facility.

Providers who have offices at more than one site (e.g., satellite offices) within the same Medicaid Area, the Department of Children and Families region or district must have a separate location code for each site. Providers must use the code assigned to the location when billing for services provided at that location.

Additional service sites are subject to an on-site review by the local Medicaid area field office.
### Staff Qualifications

**Qualifications**

Staff must provide services within the scope of their professional licensure, education, training, protocols, and competence, and within the purview of statutes applicable to their respective profession.

Specific staffing requirements are identified for each service.

**Minimum Qualifications**

Staff qualifications represent minimum qualifications.

**Advanced Registered Nurse Practitioner (ARNP)**

An ARNP is a licensed advanced registered nurse practitioner who works in collaboration with a physician according to protocol to provide diagnostic and interventional patient care. An ARNP must be authorized to provide these services by Chapter 464, F.S., and protocols filed with the Board of Medicine.

**Bachelor’s Level Practitioner**

A bachelor’s level practitioner is an individual who meets all the following criteria:

- Has 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. In addition, the practitioner must have training in the treatment of behavioral health disorders, human growth and development, evaluations, assessments, treatment planning, basic counseling and behavioral management interventions, case management, documentation, psychopharmacology, abuse regulations, patient rights and special clinical circumstances such as emergencies, suicide, and out-of-control behavior, and
- Is working under the supervision of a master’s level practitioner.
A behavioral health technician is an individual who:

- Has a high school diploma or equivalent and in-service training in: the treatment of mental health disorders, abuse regulations, recipients' rights, crisis management interventions, and confidentiality; or
- Has five years experience working directly with seriously emotionally disturbed children or seriously mentally ill adults and in-service training in: the treatment of mental health disorders, abuse regulations, recipients' rights, crisis management interventions, and confidentiality; and
- Is working under the supervision of a bachelor/master's degree level practitioner.

For the provision of psychosocial rehabilitation services, a behavioral health technician must be certified as a Behavioral Health Technician by the Florida Certification Board.

Effective July 1, 2006, for the provision of psychosocial rehabilitation services, a behavioral health technician must be a Certified Behavioral Health Technician.

Information on initial and renewal certification requirements can be found on the Florida Certification Board website at www.flcertificationboard.org.

A bachelor's level practitioner is an individual who meets all the following criteria:

- Has 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. In addition, the practitioner must have training in the treatment of behavioral health disorders, human growth and development, evaluations, assessments, treatment planning, basic counseling and behavioral management interventions, case management, documentation, psychopharmacology, abuse regulations, patient rights and special clinical circumstances such as emergencies, suicide, and out-of-control behavior; and
- Is under the supervision of a master's level practitioner.
### Staff Qualifications, continued

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<tr>
<th>Certified Addictions Professional</th>
<th>A certified addictions' professional (C.A.P.) is an individual who is certified in accordance with Chapter 397, F.S. by the Florida Certification Board (FCB). A Bachelor's level C.A.P. is an individual with a bachelor's degree who is certified in accordance with Chapter 397, F.S. by the FCB. A Master's level C.A.P. is an individual with a master’s degree who is certified in accordance with Chapter 397, F.S. by the FCB.</th>
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<tr>
<td>Certified Behavior Analyst</td>
<td>A Certified Behavior Analyst is a National Board Certified or Florida Certified Behavior Analyst or Associate Behavior Analyst, who maintains active certification as required for a Florida Board Certified Behavior Analyst or Florida Board Certified Associate Behavior Analyst. Current criteria, as of January 31, 2005, for certification as a Board Certified Behavior Analyst require at least a Master's Degree, 180 classroom hours of specific graduate level course work, experience requirements and a passing score on the Behavior Analyst Certification Examination. Current criteria, as of January 31, 2005, for certification as a Board Certified Associate Behavior Analyst require at least a Bachelors Degree, 90 classroom hours on specific course work, certain experience requirements and a passing score on the Associate Behavior Certification Examination. Additional Note: Information on certification requirements can be found at the official website of the Behavioral Analyst Certification Board, Inc. at <a href="http://www.bacb.com">http://www.bacb.com</a>.</td>
</tr>
<tr>
<td>Certified Psychiatric Rehabilitation Practitioner</td>
<td>A certified psychiatric rehabilitation practitioner is an individual who is certified by the Psychiatric Rehabilitation Certification Program; and is working under the supervision of a master's level practitioner or higher. Note: Eligibility requirements can be found online at: <a href="http://www.uspra.org">http://www.uspra.org</a></td>
</tr>
<tr>
<td>Certified Recovery Peer Specialist - Adult</td>
<td>A certified adult peer specialist is an individual who is certified by the Florida Certification Board; and is working under the supervision of a master’s level practitioner, master’s level C.A.P., or higher. Note: Eligibility requirements can be found online at: <a href="http://www.flcertificationboard.org">http://www.flcertificationboard.org</a></td>
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</table>
Staff Qualifications, continued

Certified Recovery Peer Specialist - Family

A certified family peer specialist is an individual who is certified by the Florida Certification Board; and

Is working under the supervision of a master’s level practitioner, master’s level C.A.P., or higher.

Note: Eligibility requirements can be found online at: http://www.flcertificationboard.org

Certified Recovery Support Specialist

A certified recovery support specialist is an individual who is certified by the Florida Certification Board; and

Is working under the supervision of a master’s level practitioner, master’s level C.A.P., or higher.

Note: Eligibility requirements can be found online at: http://www.flcertificationboard.org

Licensed Practical Nurse

A licensed practical nurse is an individual who is licensed to practice practical nursing in accordance with Chapter 464, F.S.

Licensed Practitioner of the Healing Arts

A licensed practitioner of the healing arts is a Florida licensed psychiatric nurse, registered nurse, advanced registered nurse practitioner, physician assistant, clinical social worker, mental health counselor, marriage and family therapist, or psychologist who is licensed in accordance with Chapter 394, 458, 464, 490, or 491, F.S., and

Master’s Level Practitioner

A master’s level practitioner is an individual with:

- 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; and
- Two years of professional experience in providing services to persons with behavioral illness; or
- 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; and who is working under the supervision of a licensed practitioner of the healing arts (as described above).

Effective October 1, 2014, graduate level coursework must include 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.
Staff Qualifications, continued

Physician Assistant
A physician assistant is a person who is a graduate of an approved program or its equivalent or meets standards approved by the Board of Medicine and is certified to perform medical services delegated by the supervising physician in accordance with Chapter 458, F.S.

Psychiatric ARNP
A psychiatric ARNP is a licensed advanced registered nurse practitioner who works in collaboration with a physician according to protocol to provide diagnostic and interventional patient care. The psychiatric ARNP must also have education or training in psychiatry and be authorized to provide these services by Chapter 464, F.S. and protocols filed with the Board of Medicine.

Psychiatric Nurse
A psychiatric nurse is a registered nurse with a master’s degree or a doctor’s degree in psychiatric nursing and two years of post-master’s clinical experience working under the supervision of a physician in accordance with Chapter 394, F.S.

Registered Nurse (RN)
A registered nurse is an individual who is licensed to practice professional nursing in accordance with Chapter 464, F.S.

Substance Abuse Counselor
A substance abuse counselor is an individual who has 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. In addition, the counselor must have training in the treatment of substance abuse disorders, including signs and symptoms associated with abuse and dependence, human growth and development, evaluations and assessments, treatment planning, addictions counseling and behavioral management interventions, twelve-step recovery, case management, documentation, pharmacology, abuse regulations, patient rights and special circumstances such as emergencies, suicide, and out-of-control behavior.

Substance Abuse Technician
A substance abuse technician is an individual with:

- A high school degree or equivalent and in-service training in the treatment of substance abuse disorders; or
- Five years experience working directly with recipients experiencing substance abuse disorders.

The substance abuse technician must be able to function as a member of a multidisciplinary team, provide basic addictions counseling and support and recognize the signs and symptoms associated with abuse and dependence. The substance abuse technician must be familiar with substance abuse rules and regulations, confidentiality, twelve-step recovery concepts, documentation...
requirements and patient rights and be able to respond appropriately to special circumstances such as emergencies, suicide, and out-of-control behavior.

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**Provider Requirements**

**General Requirements**

In addition to the provider requirements and responsibilities that are contained in this handbook, providers are also responsible for complying with the provisions contained in Chapter 2 of the Florida Medicaid Provider General Handbook.

**HIPAA Responsibility**

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003, and HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes information necessary to comply with HIPAA.

**Note:** For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook.

**Note:** For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

**Note:** For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

**Provider Reimbursement for Medicare Crossover and Third Party Resource Claims**

For dually-eligible Medicare and third party liability (TPL) recipients, Medicaid is the payer of last resort for covered Medicare and TPL behavioral health care services.

In order to bill and be reimbursed for Medicare crossover and TPL claims, a community mental behavioral health (CMH) provider is required to have two different “types” of Medicaid provider group numbers:

- One community behavioral health (provider type 05) group provider number in order to be reimbursed by Medicaid for the community behavioral health program procedure codes found in Appendix P of this handbook; and

- One physician (provider type 25) group provider number in order to bill crossover and third party resource claims and be reimbursed for Medicare and TPL behavioral health care Current Procedure Terminology (CPT) procedure codes.

Since there is not a CBH—community behavioral health program under Medicare
or under most third party resources, the provider has to bill Medicaid under the type of practitioner’s (i.e., physician type 25) group provider number, and then the claim will crossover to the applicable Medicaid CPT program code accordingly.

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<th>Prior Authorization and Targeted Utilization Management Process</th>
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<td><strong>Managed Care Plan Coverage</strong></td>
<td>When verifying a recipient’s eligibility for Medicaid, the provider must also verify whether the recipient is enrolled in a Medicaid mental health managed care plan. If a recipient is a Medicaid managed care plan member, the provider must seek authorization from the plan in which the recipient is currently enrolled prior to providing services, unless it is an emergency.</td>
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<tr>
<td></td>
<td>If the recipient is in a Medicaid managed care plan, Medicaid will not pay a provider for any plan covered services. Providers must seek authorization and reimbursement from the plan for services the plan covers for its members.</td>
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<td></td>
<td><strong>Note</strong>: See the Provider General Handbook for information on verifying recipient eligibility and Medicaid Managed Care enrollment.</td>
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| **HMO Description**                                           | Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients. |
|                                                               | Medicaid pays each HMO a fixed monthly fee for managing and providing care to each enrolled recipient. In accordance with contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical and mental health services for this monthly Medicaid fee. |
|                                                               | Medicaid HMOs may provide quality and benefit enhancements and they may also provide other expanded benefits as described in the Florida Medicaid Provider General Handbook. |

| **Introduction**                                              | Proviso language adopted by the Florida State Legislature in May 2002 required the Agency for Health Care Administration (AHCA) to adopt a prior authorization process using a targeted utilization management approach focusing on providers which have been determined to exceed specified parameters with regard to service and claims patterns, audit findings or other indicators of potential fraud, abuse or over-billing. |

| **Prior Authorization**                                       | Providers are subject to prior authorization of certain services unless they meet exemption criteria. The prior authorization criteria can be obtained from the First Health Services, Inc. website at http://Florida.fhsc.com. |

| **Utilization Management Plan**                               | Effective July 1, 2003, all providers are required, on an annual basis, to comply with utilization management criteria in order to be exempt from the prior authorization process. Utilization management criteria can be obtained from the First Health Services, Inc. website at http://Florida.fhsc.com. |

| **HMO Covered Services**                                      | The services provided under contract with each HMO are negotiated with each HMO contractor. However, every HMO plan must include basic services, up to the limits required by Medicaid fee-for-service, including coverage of community mental health services. To see a list of other covered services that an HMO must provide, see the Florida Medicaid Provider General Handbook. |
Mental Health Services in Medicaid Managed Care Plans, continued

**HMO Limitations**
An HMO’s services cannot be more restrictive than those provided under Medicaid fee-for-service.

**Prepaid Mental Health Plan (PMHP) Description**
Medicaid contracts with prepaid mental health plan contractors for mental health services provided to recipients who enroll in MediPass. These recipients receive physical health care services from MediPass primary care providers and mental health care services from the prepaid mental health plan contractors. MediPass primary care providers and the prepaid mental health plan contractors coordinate the recipient’s health care needs to ensure that medical and behavioral health services are provided collaboratively for continuity of care.

Mental health services are managed and reimbursed by the prepaid mental health plan contractors.

Providers should contact the appropriate managed care contractors prior to rendering mental health services.

**HMO and PMHP Covered Services**
The following services are mandatory and must be covered by the HMO and PMHP plans:

- Mental health related inpatient and outpatient hospital services;
- Crisis Stabilization Unit (CSU) services;
- Psychiatric services;
- Community mental health services (excluding substance abuse);
- Mental health targeted case management;
- Psychiatric evaluations for enrollees applying for nursing home admission;
- Assessment and treatment at assisted living facilities with a limited mental health license; and
- Monitoring of and discharge coordination for individuals in children’s residential or state mental health facilities and oversight and coordination for enrollees who are medically complex, have co-occurring substance abuse diagnoses or are in the criminal justice system.

**HMO and PMHP Exempt Services**
The following services are not included in HMO and PMHP plans. They are billable on a fee-for-service or per diem basis:

- Behavioral Health Overlay Services-Juvenile Justice
- Behavioral Health Overlay Services-Child Welfare
- Substance Abuse Services
- Comprehensive Behavioral Health Assessments (CBHA)
- Specialized Therapeutic Foster Care (STFC)
- Therapeutic Group Care (TGC)
- Statewide Inpatient Psychiatric Program Services (SIPP)
- Mental Health Services provided by Federally Qualified Health Clinics
- Mental Health Services provided through Certified School Match
Problems
• Physician services provided by a physician without a psychiatric specialty code, even if the treatment is for a covered mental health diagnosis.

Mental Health Services in Medicaid Managed Care Plans, continued

Child Welfare Pre-paid Mental Health Plan (CW-PMHP)
Description
The Child Welfare Prepaid Mental Health Plan (CW-PMHP) is a statewide plan that serves children who receive foster care or protective services from the DCF contracted Community-Based Care agencies. This plan covers most counties in Florida. Contact your local Medicaid Area office to determine if your county is covered by this plan.

Unless an individual resides in an exempt county, any recipient eligible for Medicaid in the Florida Safe Families Network (FSFN), formerly Home Safe Net, should be enrolled in this PMHP, regardless of their other Medicaid and managed care status. If the child in care is not yet identified in FSFN, and is in another mental health care capitated plan (Area Medicaid PMHP or an HMO), then authorization for behavioral health services will need to be obtained from that plan until the system is updated to add the recipient to the CW-PMHP. Medical care coverage will continue to be covered by the individual’s managed care plan or fee-for-service Medicaid, as applicable.

Child Welfare Pre-paid Mental Health Plan (CW-PMHP)
Covered Services
The following services are mandatory and must be covered by the CW-PMHP:

• Mental health related inpatient and outpatient hospital;
• Crisis Stabilization Unit (CSU) services;
• Psychiatric services;
• Community Mental Health services (excluding substance abuse);
• Comprehensive Behavioral Health Assessments (CBHA);
• Specialized Therapeutic Foster Care (STFC);
• Therapeutic Group Care (TGC);
• Mental Health Targeted Case Management;
• Monitoring of, and discharge coordination for, individuals in children’s residential treatment programs; and
• Coordination of enrollees who are medically complex or in the criminal justice system.

Child Welfare Pre-paid Mental Health Plan (CW-PMHP)
Exempt Services
The following services are not included in the CW-PMHP. They are billable on a fee-for-service or per diem basis:

• Behavioral Health Overlay Services-Juvenile Justice
• Behavioral Health Overlay Services- Child Welfare
• Substance abuse services
• Statewide Inpatient Psychiatric Program services
• Mental Health services provided by Federally Qualified Health Clinics
• Mental Health services provided through Certified School Match Programs
• Physician services provided by a physician without a psychiatry specialty code, even if treatment is for a covered mental health diagnosis.
CHAPTER 2
COMMUNITY BEHAVIORAL HEALTH
COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction
This chapter describes the covered services, limitations and exclusions under the Florida Medicaid Community Behavioral Health Services Program.

This chapter is divided into seven sections:

- Section 1 describes community behavioral health covered services, limitations and exclusions;
- Section 2 describes comprehensive behavioral health assessments;
- Section 3 describes specialized therapeutic foster care services;
- Section 4 describes behavioral health overlay services for youth in juvenile justice settings;
- Section 5 describes services for children ages 0 through 5 years;
- Section 6 describes behavioral health overlay services for youth in juvenile justice settings;
- Section 7 describes behavioral health overlay services for youth in child welfare settings.

Page Numbers in This Chapter
Beginning with Section 1, the page numbers in Chapter 2 of the Community Behavioral Health Services Coverage and Limitations Handbook are arranged in the following order:

- Chapter number;
- Section number; and
- Page number within the section.

For example, page one of section one is numbered 2-1-1.
This section contains information on community behavioral health covered services, limitations, and exclusions.

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This section contains information on comprehensive behavioral health assessment.

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This section contains information on behavioral health overlay services for youth in juvenile justice settings.

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**Topic Roster for Section 7**

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</tr>
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</tr>
<tr>
<td><strong>Appendix O</strong> – Provider Agency Certification Form for Behavioral Health Overlay Services – in Child Welfare Settings</td>
</tr>
</tbody>
</table>
SECTION 1

COMMUNITY BEHAVIORAL HEALTH SERVICES
COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Service Requirements

Introduction
The following requirements apply to all Medicaid reimbursable community behavioral health services.

General Requirement
Providers must request reimbursement only for services:

- Rendered in the Department of Children and Families district or region in which they have a current Substance Abuse and Mental Health contract.
- Provided by individuals employed by, under contract with, or compensated monetarily by the provider.

Authorization of the Group’s Treating Practitioner
Community behavioral health services are provided under the authorization of the group’s treating practitioner who has authorized services on the recipient’s treatment plan. Provider claims for community behavioral health services must include the provider’s group Medicaid number, where the services were rendered, and the treating practitioner’s individual Medicaid number regardless of who actually renders the service. Billing must reflect the date that the service was actually rendered.

Assessment Requirement
Prior to the authorization of services, the recipient must receive an assessment of mental status, functional capacity, strengths and service needs. 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 including criteria for discharge.

Service Authorization
Services must be rendered as prescribed on the treatment plan and authorized in writing by the treating practitioner.

Covered Diagnosis Codes
Claims for services rendered by community behavioral health services providers will be paid only for the following diagnosis codes: 290 through 298.9, 300 through 301.9, 302.7, 303 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9. Diagnosis codes are found in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

Claims must contain only the mental health or substance abuse diagnosis from the list above for which the community behavioral health services are being provided.
Service Requirements, continued

Recipient Clinical Record

The clinical record must contain:

- A signed consent for treatment that is signed by the recipient or the recipient’s legal guardian;
- An evaluation or assessment conducted by a licensed practitioner of the healing arts for diagnostic and treatment planning purposes. For new admissions, the evaluation or assessment by a licensed practitioner of the healing arts for treatment planning purposes must have been completed within the past six months;
- Copies of relevant assessments, reports and tests;
- Service notes (progress toward treatment plans and goals);
- Documentation of service eligibility, if applicable;
- Current (within last 6 months) treatment plans, reviews and addenda;
- A written description, including clinical findings of the face-to-face interview evaluation or assessment with the recipient that is signed and dated by a psychiatrist, physician, treating practitioner, master’s level certified addictions professional (only for recipients with a substance abuse diagnosis), or licensed practitioner of the healing arts who conducted the interview;
- Copies of all certification forms (e.g., comprehensive behavioral health assessment); and
- The physician’s orders and results of diagnostic and laboratory tests, medication assessment, prescription and management.

Service documentation must be original and not photocopied.
Documentation Requirements

A provider must maintain a medical clinical record for each recipient treated. Written, legible documentation must be maintained to support each service for which Medicaid reimbursement is requested. Documentation must clearly distinguish and reference each separate service billed.

Service documentation must contain all of the following:

- Recipient’s name;
- Date the service was rendered;
- Start and end times for procedures with specified minimum time frames and procedures billed on a per unit basis;
- Identification of the setting in which the service was rendered;
- Identification of the specific problem, behavior, or skill deficit for which the service is being provided;
- Identification of the service rendered, including the specific intervention;
- Updates regarding the recipient’s progress toward meeting goals and objectives identified in the treatment plan; and
- For original documentation written or printed on paper, the original, legible signature and credential (e.g., licensed clinical social worker) or functional title (e.g., treating practitioner) of the person rendering the service, or
- For original documentation typed and stored electronically, the permissible electronic signature and credential, or functional title, of the person rendering the service.
Service Requirements, continued

Electronic Records
Electronic records are permissible. Medicaid providers’ electronic records policies should address the technical safeguards required by the Code of Federal Regulations (CFR) Title 45, Part 164.312 where applicable.

Electronic signatures are permissible as defined by Chapter 668, Part 1, F.S. and CFR Title 45, Part 164.312.

See Florida Medicaid Provider General Handbook for requirements.

Note: The Medicaid Provider General Handbook is available at: http://mymedicaid-florida.com Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

The CFR is available on the Internet at www.gpoaccess.gov/cfr/index.html.

Compliance and Quality of Care Reviews
A provider’s compliance with service eligibility determination procedures, service authorization policy, staffing requirements, and service documentation requirements may be reviewed periodically by staff designated by the Agency for Health Care Administration. Services provided to recipients in violation of these items requirements listed above may be terminated and funds that were paid for such services are subject to recoupment or fines in accordance with 409.913, F.S.

Quality of care reviews are done periodically in conjunction with the compliance review. If significant quality deficiencies are identified, a corrective action plan may be required.

Service Limits and Restrictions on Provider Reimbursement

Service Limits
Service limits are per recipient, per state fiscal year (July 1 through June 30).

An exception to service limits is treatment plan development, which is reimbursed once per provider, per state fiscal year (July 1 through June 30). Medicaid reimburses a maximum total of two treatment plans per recipient per state fiscal year.

Medicaid will not reimburse for the same procedure code twice in one day.
**Service Exclusions**

Medicaid does not pay for community behavioral health services for treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation. Medicaid may reimburse for community behavioral health services provided to recipients who have one or more of the preceding conditions, and who also have behavioral health needs. The presence of one of these conditions does not prohibit the recipient from receiving services for behavioral health needs.

Services are not considered to be medically reasonable when the recipient has an organic brain disorder (dementia or delirium) or other psychiatric or neurological conditions that have produced a cognitive deficit severe enough to prohibit benefit to the recipient.

**Requesting Exceptions to Service Limits**

Requests for exceptions to service limits may be made for recipients under age 21 through Medicaid’s prior authorization process. The criteria for exceptions to service limits can be obtained from the Magellan Medicaid Administration, Inc. of Florida Web site First Health Services, Inc. website at [https://florida.fhsc.com/](https://florida.fhsc.com/)

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on requesting prior authorizations.

**Service Restrictions for Nursing Facility Residents**

Community behavioral health services for nursing facility residents, for whom the nursing facility is billing Medicaid on a per diem basis, are only reimbursable if:

- An evaluator under contract with the Department of Children and Families has completed a Pre-Admission Screening and Resident Review (PASRR) evaluation and determination that recommends the community behavioral health services for the recipient; and

- The recipient’s physician recommends the community behavioral health services; and

- The nursing facility makes a written referral to the community behavioral health services provider.
Service Exclusions, continued
The referral from the nursing facility must be retained in the recipient’s clinical record. In addition, the recipient’s individualized treatment plan must be coordinated and integrated with the nursing facility’s plan of care.

The following services are reimbursable for residents for whom the nursing facility is billing Medicaid on a per diem basis, regardless of where the services are rendered:

<table>
<thead>
<tr>
<th>Services</th>
<th>Procedure Code</th>
<th>Modifier (if Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Evaluation by physician</td>
<td>H2000</td>
<td>HP, HQ</td>
</tr>
<tr>
<td>Brief Behavioral Health Status Exam</td>
<td>H2010</td>
<td>HO</td>
</tr>
<tr>
<td>Psychiatric Review of Records</td>
<td>H2000</td>
<td></td>
</tr>
<tr>
<td>In-depth Assessment</td>
<td>H0031, H0001</td>
<td>HO, TS</td>
</tr>
<tr>
<td>Bio-psychosocial Evaluation</td>
<td>H0031, H0001</td>
<td>HN</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>H2019</td>
<td></td>
</tr>
<tr>
<td>Limited Functional Assessment</td>
<td>H0031, H0001</td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Development and Modification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment plan development, new and established patient, mental health</td>
<td>H0032, T1007</td>
<td></td>
</tr>
<tr>
<td>Treatment plan review</td>
<td>H0032, T1007</td>
<td>TS</td>
</tr>
<tr>
<td>Medical and Psychiatric Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td>T1015</td>
<td></td>
</tr>
<tr>
<td>Brief Individual Medical Psychotherapy</td>
<td>H2010</td>
<td>HE, HF</td>
</tr>
<tr>
<td>Behavioral Health therapy services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual and Family therapy</td>
<td>H2019</td>
<td>HR</td>
</tr>
</tbody>
</table>

Community behavioral health services for nursing facility residents, for whom the nursing facility is billing Medicaid on a per diem basis, are only reimbursable if:

An evaluator under contract with the Department of Children and Families has completed a Pre-Admission Screening and Resident Review (PASRR) evaluation and determination that recommends the community behavioral health services for the recipient; and

The recipient’s physician recommends the community behavioral health services; and

The nursing facility makes a written referral to the community behavioral health services provider.

No community behavioral health services are reimbursable for a recipient in a nursing facility unless the recipient has first been assessed by the nursing facility and subsequently referred, in writing, to a community behavioral health services provider. The referral from the nursing facility must be retained in the recipient’s clinical record. In addition, the recipient’s individualized treatment plan must be coordinated and integrated with the nursing facility’s plan of care.

The following services are not reimbursable for residents for whom the nursing facility is billing Medicaid on a per diem basis, regardless of where the services are rendered.

<table>
<thead>
<tr>
<th>Services</th>
<th>Procedure Code</th>
<th>Modifier (if Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Service Restrictions for Nursing Facility Residents

The following services are not reimbursable for residents for whom the nursing facility is billing Medicaid on a per diem basis, regardless of where the services are rendered:

<table>
<thead>
<tr>
<th>Services</th>
<th>Procedure Code</th>
<th>Modifiers (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Screening</td>
<td>T1023</td>
<td>HE, HF</td>
</tr>
<tr>
<td>Behavioral Health Services, specimen collection, taking of vital signs, administering injections.</td>
<td>T1015</td>
<td>HE, HF</td>
</tr>
<tr>
<td>Methadone or Buprenorphine</td>
<td>H0020</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Day Services</td>
<td>H2012</td>
<td>(none), HF</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation Services</td>
<td>H2017</td>
<td></td>
</tr>
<tr>
<td>Clubhouse Services</td>
<td>H2030</td>
<td></td>
</tr>
</tbody>
</table>

Community Behavioral Health Services Program Exclusions

The following are not covered under the community behavioral health services program:

- Procedure codes not found on the Procedure Code Table in Chapter 3.4 of this handbook;
- Services delivered to a recipient on the day of admission into a statewide inpatient psychiatric program (SIPP). However, community behavioral health services are reimbursable on the day of discharge;
- Case management;
- Partial hospitalization;
- Services rendered to residents of institutions for mental diseases*;
- Services rendered to residents of nursing facilities except in circumstances described in the previous section on the prior page;
- Services rendered to institutionalized individuals, as defined in Code of Federal Regulations, Chapter IV 435.1009;
- Travel time;
- Activities performed to maintain and review records for facility utilization, continuous quality improvement, recipient eligibility status processing and staff training purposes;
- Activities not performed face-to-face with the recipient except those defined below;
- Services rendered by unpaid interns or volunteers;
- Services paid for by another funding source; and
- Escorting a recipient to and from a service site.

*Note: See Chapter 1 of this handbook for the definition of institutions for mental diseases.
Service Exclusions, continued

Face-to-Face Interactions and Exceptions to the Requirements

Interactions must be face-to-face with the recipient in order to be eligible to receive reimbursement under Medicaid’s community behavioral health services program with the following exceptions:

- Comprehensive medication services when providing review of records.
- Therapeutic behavioral on-site services when providing family counseling or developing the behavioral health management plan.
- Individual and Family Therapy services when assisting recipients’ families and other responsible persons, significant others, in achieving treatment objectives.
- Telepsychiatry and telebehavioral health individual therapy services.

Note: See Chapter 1 of this handbook for the definition of other responsible persons.

Assessment Services

Introduction

The following services must be billed with the correct procedure code and modifier (see Appendix P for specific procedure codes):

- Psychiatric Evaluation
- Brief Behavioral Health Status Examination
- Psychiatric Review of Records
- In-Depth Assessment
- Bio-psychosocial Evaluation
- Psychological Testing
- Limited Functional Assessment

Note: See Appendix P for a description of each procedure code.

Note: See Chapter 3-4 in this handbook for information on procedure code modifiers. See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for information on entering modifiers on the claim.

General Documentation Requirements for Assessments

The individual rendering the service must sign and date a report or progress note of the assessment.

Documentation is considered part of all assessment services. The recipient need not be present during documentation.

A written, legible report of evaluation and testing results must be done by the individual rendering service and must be included in the recipient’s medical/c clinical record for all evaluation and testing services listed in the evaluation and testing section.
Assessment Services, continued

**Psychiatric Evaluation**

A psychiatric evaluation is a comprehensive evaluation that investigates the recipient’s clinical status including the presenting problem; the history of the present illness; previous psychiatric history, physical history, and medication history; relevant personal, and family medical history; personal strengths; and a brief mental status examination. This examination concludes with a summary of findings, diagnostic formulation, and treatment recommendations.

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 should be conducted at the onset of illness or suspected illness or when the recipient first presents for treatment. It may 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.

**Who Must Provide**

Psychiatric evaluations must be provided by a psychiatrist, other physician, or psychiatric ARNP who is enrolled in Florida Medicaid.

**Reimbursement Limitations**

Medicaid reimburses a maximum of two psychiatric evaluations per recipient, per state fiscal year (July 1 through June 30).

The procedure codes are paid at two different rates depending on the service provided. See Appendix P of this handbook for the procedure codes and maximum reimbursement rate.

**Brief Behavioral Health Status Examination**

A brief behavioral health status examination is a brief clinical, psychiatric, diagnostic, or evaluative interview to assess behavioral stability or treatment status.

**Who Must Provide**

The brief behavioral health status examination must be provided, at a minimum, by a licensed practitioner of the healing arts or master’s level certified addictions professional.
### Assessment Services, continued

<table>
<thead>
<tr>
<th>Reimbursement Limitations</th>
<th>Medicaid reimburses for brief behavioral health status examinations a maximum of 10 quarter-hour units annually, per recipient, per state fiscal year (July 1 through June 30).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Documentation Requirements</td>
<td>Brief Behavioral Health Status Examination documentation must include the purpose of the exam, setting, mental status of the recipient, findings, and plan.</td>
</tr>
<tr>
<td><strong>Psychiatric Review of Records</strong></td>
<td>Psychiatric review of records includes the review of recipient records, psychiatric reports, psychometric or projective tests, 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 service and must be included in the recipient’s medical clinical record. Psychiatric review of records does not include a review of the provider agency’s own records except for psychological testing and other evaluations or evaluative data used explicitly to address documented diagnostic questions. This service may not be billed for review of lab work (see medication management).</td>
</tr>
<tr>
<td>Who Must Provide</td>
<td>Psychiatric review of records must be provided, at a minimum, by a psychiatrist or other physician, or psychiatric ARNP; at a minimum, must render psychiatric review of records.</td>
</tr>
<tr>
<td>Reimbursement Limitations</td>
<td>Medicaid reimburses a maximum of two psychiatric reviews of records, per recipient, per state fiscal year (July 1 through June 30).</td>
</tr>
<tr>
<td>Specific Documentation Requirements</td>
<td>A psychiatric review of records may be documented in report format or by a progress note in the recipient’s clinical record. The sole use of checklists or fill in the blank forms is not allowed.</td>
</tr>
</tbody>
</table>
Assessment Services, continued

In-Depth Assessment
An in-depth assessment is a diagnostic tool for gathering information to establish or support a diagnosis, to provide the basis for the development of or modification to the treatment plan and development of discharge criteria. The in-depth assessment must include an integrated summary as described below. Written documentation must be included in the recipient's clinical record to support the recipient's eligibility for this service.

Assessment Components
The in-depth assessment must provide detailed information on the components below.

- Chief complaint – recipient’s perception of problem or prominent symptoms;
- Personal history – identifying information, legal involvement, educational analysis, and resources and strengths;
- History of treatment (as applicable):
  - Psychiatric treatment to include previous and current psychotropic medications;
  - Inpatient behavioral health treatment;
  - Acute care treatment; Medical;
  - Alcohol and other drug use;
  - Therapy and counseling;
- Current behavioral and mental status; and
- Desired services and goals from the recipient’s viewpoint.

Integrated Summary Component
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, 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.

**Assessment Services, continued**

<table>
<thead>
<tr>
<th>Who May Receive Services</th>
<th>Recipients who meet one of the following criteria are eligible to receive an in-depth assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Recipients with a documented need for a level of inpatient treatment beyond outpatient individual or group therapy or medication management (i.e., (outpatient services have been tried and failed);</td>
</tr>
<tr>
<td></td>
<td>• Recipients who have been identified as high risk (i.e., stepped down from or denied admission to an inpatient setting);</td>
</tr>
<tr>
<td></td>
<td>• Recipients who have received behavioral health therapy services, community support and rehabilitative services, or therapeutic behavioral on-site services, for 6 months or longer and for whom the documentation supports lack of significant progress; or</td>
</tr>
<tr>
<td></td>
<td>• Recipients who have been receiving intensive services for 6 months or longer and for whom the documentation supports lack of significant progress; or</td>
</tr>
<tr>
<td></td>
<td>• Recipients who have been identified through the utilization management process as being high risk or high utilizers; or</td>
</tr>
<tr>
<td></td>
<td>• Infants and toddlers ages 0—5 who are exhibiting symptoms of an emotional or behavioral nature that are atypical for the child’s age and development.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who Must Provide</th>
<th>The in-depth assessment and integrated summary must be provided by a master’s level practitioner.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement Limitations</td>
<td>Medicaid reimburses one in-depth assessment, per recipient, per state fiscal year (July 1 through June 30). An in-depth assessment is not reimbursable on the same day for the same recipient as a bio-psychosocial evaluation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bio-psychosocial Evaluation</th>
<th>A bio-psychosocial evaluation describes the biological, psychological and social factors that may have contributed to the recipient’s need for services. The evaluation includes a brief mental status exam and preliminary service recommendations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who Must Provide</td>
<td>A bio-psychosocial evaluation must be provided, at a minimum, by a bachelor’s level practitioner or certified addictions professional.</td>
</tr>
<tr>
<td>Who Must Review</td>
<td>The evaluation must be reviewed, signed and dated by a master’s level practitioner or bachelor’s level certified addictions professional prior to completion of the treatment planning process. The review must include clinical impressions, a provisional diagnosis and a statement by the reviewer that indicates concurrence or alternative recommendations regarding treatment.</td>
</tr>
</tbody>
</table>
Assessment Services, continued

Reimbursement Limitations
Medicaid reimburses one bio-psychosocial evaluation, per recipient, per state fiscal year (July 1 through June 30). A bio-psychosocial evaluation is not reimbursable on the same day for the same recipient as an in-depth assessment.

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

Who May Receive
Recipients are eligible to receive psychological testing only under the following circumstances:

- At the onset of illness or suspected illness or when the recipient first presents for treatment;
- Testing may be repeated 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;
- When there is difficulty determining a diagnosis or where there are differential diagnostic impressions; or
- To gather additional information 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 and in accordance with applicable statutes.

Reimbursement Limitations
Medicaid reimburses a maximum of 40 quarter-hour units of psychological testing, per recipient, per state fiscal year (July 1 through June 30).

Specific Documentation Requirements
A written report of evaluation and testing results must be done by the individual rendering service and must be included in the recipient’s medical/clinical record for all evaluation and testing services listed in the evaluation and testing section.
### Assessment Services, continued

#### Limited Functional Assessment

This assessment is restricted to administration of the Multnomah Community Ability Scale (MCAS), the Functional Assessment Rating Scale (FARS), and the Children’s Functional Assessment Rating Scale (C-FARS), the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC–2R) or any other functional assessment required by the Department of Children and Families (DCF).

#### Who Must Provide

The assessment must be provided by an individual who has been authorized by DCF to administer the assessment.

Note: See https://samh-fars.dcf.state.fl.us/fars/fars_home.aspx, or https://samh-fars.dcf.state.fl.us/cfars/cfars_home.aspx for approved DCF training.

#### Reimbursement Limitations

For the MCAS, FARS, and C-FARS, Medicaid reimburses a maximum of three limited functional assessments, per recipient, per state fiscal year (July 1 through June 30).

For the ASAM PPC–2R, Medicaid reimburses a maximum of 3 limited functional assessments, per recipient, per state fiscal year (July 1 through June 30).

#### Specific Documentation Requirements

A copy of the assessment must be placed in the recipient’s clinical record. This service does not require authorization in the treatment plan.
Treatment Plan Development and Modification

Introduction

Treatment plan development and modification includes:

- Treatment Plan Development
- Treatment Plan Review

The provider should use the primary diagnosis as the basis for the treatment plan if an individual is dually diagnosed.

Treatment Plan Development

The individualized treatment plan is an individualized course of care that promotes resiliency and recovery. The treatment plan must be self-directed by the recipient. The recipient plans his or her personal goals, and chooses the course to reach those goals with the assistance of the treatment team. The treatment team facilitates recovery by documenting these goals in objectively measureable statements. The treatment plan should focus on identifying current strengths and developing new coping skills to increase important factors in recovery such as empowerment, hope, support, and a mindset of personal responsibility towards wellness. The structured, goal-oriented schedule of services developed jointly by the recipient and the treatment team. The plan must contain written treatment-related goals and measurable objectives. The treatment plan must be developed with the recipient’s active participation. The recipient’s parent or guardian should also be included, if applicable the recipient is under the age of 18.

A Brief Behavioral Health Status Examination, Psychiatric Evaluation or other assessment conducted by a licensed practitioner of the healing arts must be completed prior to the development of the treatment plan. An assessment by a licensed practitioner of the healing arts completed with the past six months may be used to satisfy this requirement.
The treatment plan must contain all of the following components:

- The recipient’s ICD-9-CM diagnosis code(s), consistent with assessment(s);
- Goals that are individualized, strengths-based, and appropriate to the recipient’s diagnosis, age, culture, strengths, abilities, preferences and needs expressed by recipient(s);
- Measurable objectives and target dates;
- A list of the services to be provided (Treatment Plan Development, Treatment Plan Review, and Comprehensive Behavioral Health Assessment need not be listed);
- Identification of staff who will render the prescribed clinical interventions;
- The amount, frequency and duration of each service for the 6 month duration of the treatment plan (e.g., 4 units of therapeutic behavioral on-site services 2 days per week for 6 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.”
- Signature of the recipient (must include documentation of attempts made to obtain required signatures) or;
- Signature of the recipient’s parent, guardian, or legal custodian (if the recipient is under the age of 18);
- Signatures of the treatment team members who participated in development of the plan;
- A signed statement by the treating practitioner that services are medically necessary and appropriate to the recipient’s diagnosis and needs;
- Discharge Criteria, and
- Aftercare Planning.

Note: See the following pages for exceptions to the requirement for signature of parent, guardian, or legal custodian.
Exceptions to the Requirement for the Recipient’s Signature

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

Exceptions to the Requirement for Signature of Parent, Guardian, or Legal Custodian

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 medical record. The following are exceptions:

- As allowed by Chapter 397, F.S., recipients less than 18 years of age seeking substance abuse services from a licensed service provider.

- As stated in Chapter 394.4784 (1 & 2), F.S., recipients age 13 years or older, experiencing an emotional crisis to such a degree that he or she perceives the need for professional assistance. The recipient has the right to request, consent to, and receive mental health diagnostic and evaluation services, outpatient crisis intervention services, including individual psychotherapy, group therapy, counseling, or other forms of verbal therapy provided by a licensed mental health professional, or in a mental health facility licensed by the state. The purpose of such services is to determine the severity of the problem and the potential for harm to the person or others if further professional services are not provided. Outpatient diagnostic and evaluative services will not include medication and other somatic methods, aversive stimuli, or substantial deprivation. Such services will not exceed two visits during any 1-week period in response to a crisis situation before parental consent is required for further services, and may include parental participation when determined to be appropriate by the mental health professional or facility.

- Recipients in the custody of the Department of Juvenile Justice that 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.

- For recipients in the care and custody of the Department of Children and Families (foster care or shelter status), the child’s DCF or 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 in which the Department of Children and Families is working toward reunification, the parent should be involved and should sign the treatment plan.
**Treatment Plan Development and Modification**, continued

<table>
<thead>
<tr>
<th><strong>Authorization and Effective Date of Treatment Plan</strong></th>
<th>Medicaid will reimburse for services 45 days prior to the authorization date. The treatment plan becomes effective on the date it is authorized (i.e., signed and dated) by the treating practitioner.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reimbursement Limitations</strong></td>
<td>Medicaid reimburses <strong>for the development of</strong> one treatment plan per provider, per state fiscal year (July 1 through June 30). Medicaid reimburses <strong>for a maximum total of two treatment plans per recipient per state fiscal year.</strong></td>
</tr>
<tr>
<td><strong>Use of Addenda</strong></td>
<td>An addendum may be used to make changes to the treatment plan in lieu of rewriting the entire plan. The addendum becomes part of the recipient’s treatment plan. The addendum must be signed and dated by the treating practitioner and the recipient. Development of an addendum is not a reimbursable service.</td>
</tr>
</tbody>
</table>
| **Temporary Limited Service Authorization**           | Any time there is a temporary increase in deviation from the prescribed services, the provider or frequency of services must be reported the increase using the Temporary Limited Service Authorization form. When used for this purpose, the form must be completed within 14 calendar days from the date the service was temporarily increased. This form is not required for any decreases in services. This form may also be used for documenting the need for services already provided when a recipient leaves treatment prior to completion of the treatment plan. When used for this purpose, the form must be completed within 45 days of intake. A Temporary Limited Service Authorization form must be completed and placed in the recipient’s clinical record.  
  
  **Note:** See Appendix A in this chapter for a copy of the Temporary Limited Service Authorization form. |
## Treatment Plan Development and Modification, continued

### Treatment Plan Review

The treatment plan review is a process conducted 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. 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 every six months. The treatment plan may be reviewed more often than once every six months when significant changes occur.

### Specific Documentation Requirements

During the treatment plan review, activities, notations of discussions, findings, conclusions, and recommendations must be documented. Any modifications or additions to the treatment plan must be documented based on the results of the review. The written documentation must be included in the recipient’s medical clinical record upon completion of the treatment plan review activities.

If the assessment 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.

### Required Signatures

The reviewed plan must be signed, certified, and dated by the treating physician or treating licensed practitioner of the healing arts and the recipient. These signatures indicate concurrence with and provide authorization for all components of the recipient’s treatment plan.

If the recipient’s age or clinical condition precludes participation in the plan review and signing, a written explanation and justification of why the recipient is unable to participate must be provided in the medical clinical record.

If the recipient is under the age of 18, a signature is required by the recipient’s parent or legal guardian.

### Reimbursement Limitations

Medicaid reimburses a maximum of four treatment plan reviews, per recipient, per state fiscal year (July 1 through June 30).
**Medical and Psychiatric Services**

**Introduction**

These services include: evaluation of the need for medication; evaluation of clinical effectiveness and side effects of medication; prescribing, dispensing, and administering of psychiatric medications; medication education and facilitating informed consent (including discussing side effects, risks, benefits and alternatives with the individual or other responsible persons); planning related to service delivery; and evaluating the status of the individual's community functioning.

The following services are included under medical and psychiatric services: (see Appendix P for specific procedure codes):
- Medication management
- Telepsychiatry
- Brief individual medical psychotherapy
- Group medical therapy
- Behavioral health screening services
- Behavioral health services: specimen collection, taking of vital signs, administering injections, or verbal interactions
- Methadone or Buprenorphine administration

**Medication Management**

Medication management is the review of relevant laboratory test results, prior pharmacy interventions (e.g., medication dosages, blood levels if available, and treatment duration), and current medication usage. Medication management includes the discussion of indications and contraindications for treatment, risks, and management strategies with the recipient or other responsible persons. These services should be provided in a manner consistent with applicable best practice standards.

**Who Must Provide**

Medication management must be provided, at a minimum, by a Medicaid enrolled psychiatrist, other physician, physician assistant, or psychiatric ARNP.

**Reimbursement Limitations**

Medicaid reimburses medication management as medically necessary.

**Specific Documentation Requirements**

Results of the assessment, findings, and plan must be included in the recipient's clinical record.

**Telepsychiatry**

The use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between the recipient, and the treating practitioner to provide psychiatric care when distance separates participants who are in different geographical locations.
Medical and Psychiatric Services, continued

Who Must Provide

Telepsychiatry must be provided, at a minimum, by a psychiatrist who is enrolled in Medicaid and employed by or under contract with a community behavioral health services provider (provider type 05).

Reimbursement Limitations

- Telepsychiatry may not be utilized for an initial psychiatric evaluation, assessment, or examination.
- A current psychiatric evaluation must be present in the recipient’s clinical record before the telepsychiatry service may be provided.
- A psychiatrist can only deliver telepsychiatry from a service location that is enrolled in Medicaid as a community behavioral health services provider.
- Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide this service.
- Telepsychiatry providers must implement technical written policies and procedures for telemedicine systems that comply with the HIPAA privacy regulations as well as applicable state and federal laws that pertain to patient privacy. Policies and procedures must also address the technical safeguards required by the Code of Federal Regulations (CFR) Title 45, Part 164.312 where applicable.
  
  Note: For the complete text of the HIPAA privacy rule, see the HHS Office of Civil Rights Website at www.hhs.gov/ocr/hipaa.
  
  Note: For information on AHCA’s implementation of HIPAA privacy regulations, see AHCA’s Website at http://ahca.myflorida.com.
  
  Note: The CFR is available on the Internet at www.gpoaccess.gov/cfr/index.html.
- The following interactions do not constitute reimbursable telepsychiatry:
  
  - Telephone conversations;
  - Video cell phone interactions;
  - E-mail messages;
  - Facsimile transmission;
  - “Store and forward” visits and consultations, which are transmitted after the recipient or psychiatrist is no longer available.

Specific Documentation Requirements

When telepsychiatry services are provided, the clinical record must include a brief explanation of why the services could not be provided face to face. Results of the assessment, findings, and plan must be included in the recipient’s clinical record.
**Medical and Psychiatric Services, continued**

| **Brief Individual Medical Psychotherapy** | Brief individual medical psychotherapy is treatment activity designed to reduce maladaptive behaviors related to the recipient’s behavioral health disorder, to maximize behavioral self-control, or to restore normalized functioning and more appropriate interpersonal and social relationships. Brief medical psychotherapy includes insight oriented, cognitive behavioral, or supportive therapy. |
| **Who Must Provide** | Brief individual medical psychotherapy must be provided, at a minimum, by a psychiatrist or other physician, physician assistant, or psychiatric ARNP. |
| **Reimbursement Limitations** | Medicaid reimburses a maximum of 16 quarter-hour units of brief individual medical psychotherapy, per recipient, per state fiscal year (July 1 through June 30). |
| **Specific Documentation Requirements** | Results of the assessment, findings, and plan must be included in the recipient’s clinical record. |

| **Group Medical Therapy** | Group medical therapy is a treatment activity designed to reduce maladaptive behaviors; maximize behavioral self-control; or to restore normalized functioning, reality orientation and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. This service includes continuing medical diagnostic evaluation and drug management, when indicated, and may include insight oriented, cognitive behavioral, or supportive therapy. |
| **Who Must Provide** | Group medical therapy must be personally rendered provided by a psychiatrist or psychiatric ARNP. |
| **Group Size Restrictions** | Medicaid will not reimburse for group medical therapy where total group size exceeds 10 participants. |
| **Reimbursement Limitations** | Medicaid reimburses a maximum of 18 quarter-hour units of group medical therapy, per recipient, per state fiscal year (July 1 through June 30). Group medical therapy is not reimbursable on the same day for the same recipient as medical and psychiatric services, behavioral health day services or therapeutic behavioral on-site services. |
| **Specific Documentation Requirements** | Group medical therapy documentation must include the group topic, assessment of the group, level of participation, findings, and plan. |
**Medical and Psychiatric Services**, continued

### Behavioral Health Screening Service
A behavioral health screening service must include a face-to-face assessment of physical status, a brief history, and decision-making of low complexity. Results of the examination must be included in the recipient’s medical record.

The assessment must include, at a minimum:

- Vital signs;
- Medication concerns to include side effects;
- Compliance with medication regimen;
- Brief mental status assessment; and
- Plan for follow-up, if indicated.

### Who Must Provide
Behavioral health screening services must be provided, at a minimum, by a psychiatrist, other physician, physician assistant, ARNP or registered nurse.

### Reimbursement Limitations
Medicaid reimburses two behavioral health screening services, per recipient, per state fiscal year (July 1 through June 30).

### Specific Documentation Requirements
Results of the screening must be included in the recipient’s clinical record.

### Behavioral Health Services
Behavioral health services are outpatient services provided to persons with a behavioral health disorder.

This procedure code covers the following services:

- Specimen collection, taking of vital signs, administering injections; or
- A face-to-face verbal interaction (15-minute minimum) between the practitioner and recipient.

This service must be directly related to the recipient’s behavioral health disorder or to monitoring side effects associated with medication.

### Who Must Provide
Specimen collection, taking vital signs, administering injections must be provided by an individual qualified by his professional licensure, training, protocols and competence and within the purview of statutes applicable to his profession.

Verbal interaction must be provided, at a minimum, by a physician’s assistant, ARNP, or R.N.
**Medical and Psychiatric Services**, continued

<table>
<thead>
<tr>
<th>Specific Documentation Requirements</th>
<th>Documentation for each service must describe the need and the recipient's interaction.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement Limitations</td>
<td>A behavioral health service is not reimbursable if it was provided on the same day for the same recipient as behavioral health screening services. Behavioral Health Services is not reimbursable for Methadone or Buprenorphine administration.</td>
</tr>
<tr>
<td><strong>Methadone or Buprenorphine Administration</strong></td>
<td>This service reimburses the administration of methadone or buprenorphine for opioid addiction treatment by a program licensed by the state and certified by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) in accordance with state and federal regulations.</td>
</tr>
<tr>
<td>Who Must Provide</td>
<td>Methadone or buprenorphine administration must be provided by an individual who is qualified by his professional licensure, training, protocols and competence and within the purview of statutes applicable to his profession.</td>
</tr>
<tr>
<td>Specific Documentation Requirements</td>
<td>Methadone or buprenorphine administration must be documented according to meet state and federal regulations, and placed in the clinical record.</td>
</tr>
<tr>
<td>Reimbursement Limitations</td>
<td>Medicaid reimburses methadone or buprenorphine administration fifty-two times, per recipient, per state fiscal year (July 1 through June 30). The service is billed one time per seven days. This service is not reimbursable using any other procedure code.</td>
</tr>
</tbody>
</table>

**Behavioral Health Therapy Services**

| Introduction | Behavioral health therapy services include (see Appendix P for specific procedure codes):  
|--------------|---------------------------------------------------------------------------------|
|              | • Individual and family therapy  
|              | • Telebehavioral health individual therapy  
|              | • Group therapy  
|              | • Behavioral health day services |
**Behavioral Health Therapy Services**, continued

| **Individual and Family Therapy** | Individual and family therapy services include the provision of insight oriented, cognitive behavioral, or supportive therapy to an individual or family. Individual and family therapy may involve the recipient, the recipient’s family (without the recipient present), or a combination of therapy with the recipient and the recipient’s family. The focus or primary beneficiary of individual and family therapy services must always be the recipient. |
| **Who Must Provide** | Individual and family therapy services must be provided, at a minimum, by a master’s level practitioner. |
| **Reimbursement Limitations** | Medicaid reimburses a maximum of 104 quarter-hour units of individual and family therapy services, per recipient, per state fiscal year (July 1 through June 30). There is a maximum daily limit of 4 quarter-hour units. |
| **Specific Documentation Requirements** | Individual and family therapy documentation must include the topic, assessment of the recipient(s), level of participation, findings, and plan. |

**Group Therapy**

Group therapy services include the provision of cognitive behavioral, supportive therapy or counseling to individuals or families and consultation with family or other responsible persons for sharing of clinical information. Also included is education, counseling or advising family or other responsible persons on how to assist the client. The group size limit is up to 10 recipients with a mental health diagnosis and up to 15 for participants with a substance abuse diagnosis. Co-occurring diagnosis groups (mental health and substance abuse) are limited to 10 recipients.

| **Who Must Provide** | Group therapy services must be provided, at a minimum, by a bachelor’s level practitioner or certified addictions professional. |
| **Reimbursement Limitations** | Medicaid reimburses a maximum of 156 quarter-hour units of group therapy services, per recipient, per state fiscal year (July 1 through June 30). Services are to be documented and billed for group therapy for a group of recipients or for family members who convene on behalf of the recipient families whom the family has convened. For example, a parent and a sibling may attend group on behalf of a child recipient. Group therapy is billed under the recipient’s identification and is documented in the recipient’s medical/clinical record. Billing is under the child recipient’s identification and is documented in the child recipient’s medical record. |
Behavioral Health Therapy Services, continued

**Specific Documentation Requirements**

| Group therapy documentation must include the topic, assessment of each recipient, level of participation, findings, and plan. This documentation must be placed in each individual recipient's medical/clinical record. |

**Telebehavioral Health Individual Therapy**

| The use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between the recipient, and the practitioner to provide individual therapy when distance separates participants who are in different geographical locations. |

**Who Must Provide**

| Telebehavioral health individual therapy must be provided, at a minimum, by a licensed practitioner of the healing arts (LPHA) or master's level C.A.P who is enrolled in Medicaid and employed by or under contract with a community behavioral health services provider (provider type 05). |
Behavioral Health Therapy Services, continued

**Reimbursement Limitations**

- Telebehavioral health individual therapy must not be utilized for any Medicaid behavioral health service other than individual therapy, including initial evaluations or assessments.

- An LPHA or master's level C.A.P. can only deliver telebehavioral health individual therapy from a service location that is enrolled in Medicaid as a community behavioral health services provider.

- Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide this service.

- Telebehavioral health individual therapy providers must implement written technical policies and procedures for telemedicine systems that comply with the HIPAA privacy regulations as well as applicable state and federal laws that pertain to patient privacy. Policies and procedures must also address the technical safeguards required by the Code of Federal Regulations (CFR) Title 45, Part 164.312 where applicable.

  Note: For the complete text of the HIPAA privacy rule, see the HHS Office of Civil Rights Website at www.hhs.gov/ocr/hipaa.

  Note: For information on AHCA’s implementation of HIPAA privacy regulations, see AHCA’s Website at http://ahca.myflorida.com.

  Note: The CFR is available on the Internet at www.gpoaccess.gov/cfr/index.html.

- The following interactions do not constitute reimbursable telebehavioral health therapy:
  - Telephone conversations;
  - Video cell phone interactions;
  - E-mail messages;
  - Facsimile transmission;
  - “Store and forward” visits and consultations, which are transmitted after the recipient or practitioner is no longer available.

**Specific Documentation Requirements**

When telebehavioral health individual therapy services are provided, the clinical record must include a brief explanation of why the services could not be provided face to face.

Documentation must include the topic, assessment of the recipient, level of participation, findings, and plan.
Behavioral Health Therapy Services, continued

Behavioral Health Day Services

These services are designed to enable individuals to function successfully in the community in the least restrictive environment and to restore or enhance ability for personal, social and pre-vocational life management services. This context is larger than that for group counseling, serving more recipients all at one time with greater variety and clinical objectives.

The primary functions of behavioral health day services are stabilization of the symptoms related to a behavioral health disorder in order to reduce or eliminate the need for more intensive levels of care; to provide transitional treatment after an acute episode; or, to provide a level of therapeutic intensity not possible in a traditional outpatient setting.

Components of Behavioral Health Day Services

Behavioral Health Day Services are comprised of individual, group or family therapy services and therapeutic care services.

Individual and family therapy services include the provision of insight oriented, cognitive behavioral, or supportive therapy to an individual or family.

Individual and family therapy may involve the recipient, the recipient’s family (without the recipient present), or a combination of therapy with the recipient and the recipient’s family.

Group therapy services include the provision of cognitive behavioral, or supportive therapy or counseling to individuals or families; and, consultation with family or other responsible persons for sharing of clinical information. Also included is education, counseling, or advising family or other responsible persons on how to assist the recipient.

Therapeutic care services are interventions and direct care service contacts that assist the recipient in the areas of personal care, meals, medical care and supervised observation related to assessing the recipient’s progress toward identified treatment goals.

Who Must Provide

Individual and family therapy services must be provided by a master’s level practitioner.

Therapeutic care services must be provided, at a minimum, by a certified peer specialist, certified psychiatric rehabilitation practitioner, or bachelor’s level practitioner working under the supervision of a master’s level practitioner.

Individual or group counseling services delivered as part of a substance abuse day treatment program must, at a minimum, be personally rendered by a substance abuse counselor or a certified addictions professional.

A licensed practitioner of the healing arts or master’s prepared substance abuse professional must be available to provide clinical consultation for both mental health and substance abuse day treatment services during all hours of operation.
Behavioral Health Therapy Services, continued

Reimbursement Limitations

Medicaid reimburses a maximum of 1920 one hour units, per recipient, per state fiscal year (July 1 through June 30).

Medicaid will not reimburse for behavioral health day services where total group size for group therapy exceeds 10 participants who are receiving treatment for a mental health disorder. For group therapy where recipients are receiving treatment for a substance abuse disorder, the total group membership may not exceed 15 participants.

Medicaid will not reimburse for behavioral health day services provided on the same day as psychosocial rehabilitation services.

For reimbursement, the service must be provided for a minimum of two hours per day, per recipient. The therapy services listed above (may be a combination of these services) must be provided face-to-face to the recipient for at least one hour per day, but do not have to be delivered concurrently. At least one hour per day must consist of individual, group therapy, or family services (may be a combination of these services).

Specific Documentation Requirements

Documentation must include at least a weekly summary, daily progress note with exact dates and times of attendance; and a description of the clinical services and the recipient’s response, with a focus on measurable outcomes and overall progress toward treatment goals. The description of the clinical services must include the length of time each service was provided and the name and credentials of the rendering practitioner.

Community Support and Rehabilitative Services

Introduction

Community support and rehabilitative services include [see Appendix P for specific procedure codes]:

- Psychosocial rehabilitation services
- Clubhouse

Psychosocial rehabilitation services may be provided in a facility, home, or community setting.

Clubhouse services are structured community-based group services that are provided in a group rehabilitation service setting.

These services encompass community-based services designed to assist the recipient in strengthening or regaining interpersonal skills; psycho-social therapy targeted toward rehabilitation; and development of environmental supports necessary to thrive in the community.
### Community Support and Rehabilitative Services, continued

#### Who May Receive
Community support and rehabilitative services are appropriate for recipients exhibiting psychiatric, behavioral or cognitive symptoms, addictive behavior, or clinical conditions of sufficient severity to bring about significant impairment in day-to-day personal, social, pre-vocational and educational functioning.

#### Psychosocial Rehabilitation Services
Psychosocial rehabilitation services combine daily medication use, independent living and social skills training, support to clients and their families, housing, pre-vocational and transitional employment rehabilitation training, social support and network enhancement, structured activities to diminish tendencies towards isolation and withdrawal and teaching of the recipient and family about symptom management, medication and treatment options.

This service describes activities that are intended to restore a recipient’s skills and abilities essential for independent living. Activities include development and maintenance of necessary daily living skills; food planning and preparation; money management; maintenance of the living environment; and training in appropriate use of community services.

These services are designed to assist the recipient to compensate for or eliminate functional deficits and interpersonal and environmental barriers created by their disabilities, and to restore social skills for independent living and effective life management. This activity differs from counseling and therapy in that it concentrates less upon the amelioration of symptoms and more upon restoring functional capabilities. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment focusing on maximum recovery and independence. It includes work readiness assessment, job development on behalf of the recipient, job matching, on the job training, and job support.

**Psychosocial rehabilitation services may be provided in a facility, home, or community setting.**
**Community Support and Rehabilitative Services**, continued

### Who Must Provide
Psychosocial rehabilitation services must be provided, at a minimum, by:

- Certified behavioral health technician;
- Under the supervision of a bachelor’s level practitioner;
- Bachelor’s level practitioner;
- Under the supervision of a master’s level practitioner;
- Substance abuse technician; or
- Certified addictions professional;
- Certified peer specialist - adult or family;
- Certified recovery support specialist; or
- Certified psychiatric rehabilitation practitioner

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**Effective October 1, 2006, behavioral health technicians must be certified by the Florida Certification Board in order to provide services.**

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### Reimbursement Limitations
Medicaid reimburses a maximum of 1920 units of psychosocial rehabilitation services, per recipient, per state fiscal year (July 1 through June 30). These units count against clubhouse service units. The total of psychosocial rehabilitation services plus clubhouse services is limited to 1920 units per recipient per state fiscal year.

Medicaid will not reimburse for psychosocial rehabilitation on the same day as behavioral health day services.

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### Specific Documentation Requirements
Psychosocial rehabilitation services require the following documentation:

- A daily service note that describes what activities the rehabilitation counselor did to enhance/support the recipient’s skills of daily medication use, independent living and social skills, housing, pre-vocational and transitional employment training, social support and networking, food planning, money and life management; and
- A monthly progress note that reflects how the services are linked to the goals and objectives of the recipient’s treatment plan; and describes the recipient’s progress relative to the treatment plan.

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### Group Size Restrictions
Medicaid will reimburse for provision of psychosocial rehabilitation services up to a total group size of 12 participants for recipients with a mental health diagnosis and 15 for recipients with a substance abuse diagnosis.
Clubhouse Services

A clubhouse is a place where people who have a mental illness come to rebuild their lives. Clubhouse services are structured, community-based group services provided in a group rehabilitation service setting. These services include a range of social, educational, pre-vocational and transitional employment rehabilitation training in a group rehabilitation service setting utilizing behavioral, cognitive or supportive interventions to improve a recipient’s potential for establishing and maintaining social relationships and obtaining occupational or educational achievements. Every opportunity provided is the result of the efforts of the members and staff, who work side by side, in a unique partnership.

In order to bill for this service, the Clubhouse program must be based upon the International Center for Clubhouse Development (ICCD) International Standards for Clubhouse Programs and must be working toward ICCD Certification, which must be obtained within three years of the first billing date. Providers will be required to become certified as meeting the standards for this procedure code. ICCD standards can be found at http://www.iccd.org

A clubhouse group service is designed to strengthen and improve the recipient’s interpersonal skills, provide psychosocial therapy toward rehabilitation that emphasizes a holistic approach focusing on the recipient’s strengths and abilities to promote recovery from mental illness. This service is primarily rehabilitative in nature, using a wellness model that offers a setting to restore independent living skills. These services are designed to assist the recipient to eliminate the functional, interpersonal and environmental barriers created by their disabilities and to restore social skills for independent living and effective life management. The service may also be used to facilitate cognitive and socialization skills necessary for functioning in a work environment focusing on maximum recovery and independence.

Who May Receive Services

To be eligible for clubhouse services, recipients must:

- Have a mental health diagnosis, and
- Be at least 16 years of age.

Who Must Provide

Clubhouse services must be provided, at a minimum, by a certified peer specialist, a certified psychiatric rehabilitation practitioner, or a bachelor’s level practitioner, all under the supervision of a master’s level practitioner.
### Reimbursement Limitations

Medicaid reimburses clubhouse services for a maximum of 1920 quarter-hour units annually, per recipient, per state fiscal year (July 1 through June 30). **The total of clubhouse services plus psychosocial rehabilitation services is limited to 1920 units per recipient per state fiscal year.** These units count against Psychosocial Rehabilitation units of service.

Clubhouse services may be reimbursed for the same recipient on the same day as behavioral health day services. Medicaid will reimburse for up to ten recipients per staff member.

*The provider must have a contract with the Department of Children and Families to specifically provide mental health clubhouse services and be an enrolled Medicaid provider.*

*Clubhouse services must be billed under a unique Medicaid provider number. If a provider has an existing Medicaid provider number then the provider must get a unique/new “location code” where the last two digits of the provider number indicate the Clubhouse service location.*

### Specific Documentation Requirements

In addition to a treatment plan, the following documents must be included in the recipient’s file:

1. A current psychiatric evaluation; and
2. A referral from a psychiatrist, psychiatric ARNP, certified addictions professional, or licensed practitioner of the healing arts;
3. **A weekly daily** progress note that describes what activities were performed to enhance/support the recipient’s rehabilitation in social, educational, pre-vocational and transitional employment, and what supportive interventions were used to improve a recipient’s potential for establishing and maintaining social relationships and obtaining occupational or educational achievements; and
4. A monthly progress note at the end of each month that:
   * Reflects how the services are linked to the goals and objectives of the recipient’s treatment plan; and
   * Describes the recipient’s progress relative to the treatment plan.
Therapeutic Behavioral On-Site Services for Children and Adolescents

Introduction

Therapeutic behavioral on-site services are designed to assist children who have complex needs and their families in an effort to prevent the need for a more intensive, restrictive behavioral health placement. The process must be driven by assessment of the individual needs and strengths of each child and family, and be developed and directed by a treatment team.

The treatment team must include the child and family, other persons who provide natural, informal support to the family system and the professionals involved in providing services. The child-specific plan for therapeutic behavioral on-site services must be based on a thorough assessment, with input from the child and family, regarding needs, strengths and desired outcomes of services. 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 child or adolescent is necessary and appropriate. Provision of therapeutic behavioral on-site services with the family must clearly be directed toward meeting the identified treatment needs of the child or adolescent. Services provided to family members independent of meeting the identified needs of the child or adolescent 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

The services are intended to maintain the child or adolescent in the home (biological or foster). Services are limited to recipients under age 21 meeting the specific eligibility criteria described on the following pages.
Therapeutic Behavioral On-Site Services for Children and Adolescents, continued

Additional Documentation Requirements for Therapeutic Behavioral On-Site Services

The assessments and treatment plan for therapeutic behavioral on-site services, in addition to meeting the requirements in Chapter 2, Section 1 of this handbook, must address the need for individual and family therapy, behavior management and therapeutic support services. For any services authorized, the plan must include the frequency and duration of these services as well as the person or agency responsible for delivering these services.

If any component of therapeutic behavioral on-site service is provided by a different agency, the agency’s name must be indicated on the plan. The plan and progress notes must reflect ongoing coordination with the other agency for the provision of services to the same child.

The treatment plan must include a specific schedule for review of the plan with the child and the family, others on the child’s treatment team and other agencies that are providing a component of the service.

Place of Service

Services must be provided in community settings where the child is experiencing emotional or behavioral difficulties, including where the child resides and gets educated, is living, working, or participating in educational activities.

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.
Eligibility Criteria

In order to receive therapeutic behavioral on-site services, a recipient must be 0 – 18 years of age and documentation must be provided in the child's clinical record, indicating that the child meets all of the following criteria:

1. Has an ICD-9-CM diagnosis in the following range: 294.8, 294.9, 300 through 305.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; and
   • Is enrolled in a special education program for the seriously emotionally disturbed (SED) or the emotionally handicapped; or
   • Has scored a 60 or below on the Axis V Children's Global Assessment of Functioning Scale within the last 6 months;

OR

2. Has an ICD-9-CM diagnosis of 295 through 298.9 (schizophrenia or other psychotic disorders, major depression or bipolar disorder) or 303.0 through 305.9 (substance abuse); and, prior to receipt of services, a licensed practitioner of the healing arts experienced in the diagnosis of behavioral health disorders must document that:
   • The child or adolescent meets the criteria defined above;
   • There is adequate evidence to indicate that the child or adolescent is at risk for a more intensive, restrictive and costly behavioral health placement; and
   • There is adequate evidence to indicate that the child's or adolescent's condition and functional level cannot be improved with a less intensive service such as individual or family therapy or group therapy.

Continued Eligibility for Services

Within six months of the original determination of eligibility for services and every six months thereafter, the members of the child's treatment team must document that the child continues to meet the eligibility criteria stated above.

Services may be authorized for less than six months.

Discharge Criteria

Within 45 days of admission to therapeutic behavioral on-site services, a plan must be developed with each child or adolescent and family, which contains specific discharge criteria. The discharge plan must be placed in the child's clinical record.

If at any time during the course of treatment the recipient is found to no longer meet eligibility criteria, Medicaid will no longer reimburse for these services.
**Therapeutic Behavioral On-Site Services for Children and Adolescents**, continued

<table>
<thead>
<tr>
<th>Therapeutic Behavioral On-Site Services – Therapy</th>
<th>Therapeutic behavioral on-site therapy services include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Strength-based, clinical assessment of the mental health, substance abuse, or behavioral disorders in order to evaluate, define, and delineate treatment needs;</td>
<td></td>
</tr>
<tr>
<td>• Individual and family therapy as agreed to by the child and family;</td>
<td></td>
</tr>
<tr>
<td>• Assessment and engagement of the child or adolescent and family’s natural support system to assist in implementation of the treatment plan; and</td>
<td></td>
</tr>
<tr>
<td>• Development, implementation, and monitoring of behavior programming for the child or adolescent.</td>
<td></td>
</tr>
</tbody>
</table>

| Who Must Provide | Therapeutic behavioral on-site therapy services must be provided by a master’s level practitioner supervised by a licensed practitioner of the healing arts. |

| Reimbursement Limitations | Medicaid reimburses therapeutic behavioral on-site therapy services a maximum combined limit of a total of 36, 15-minute units per month by a master's level or certified behavioral analyst—A minimum of 8 units per month must be provided by a master's level practitioner. Additional, medically necessary, therapeutic behavioral on-site services may be provided beyond the maximum limit after obtaining prior authorization. |

| Services Provided to a Group | Therapeutic behavioral on-site therapy services may not be billed when for services are provided to a group of recipients. |
Therapeutic Behavioral On-Site Services for Children and Adolescents, continued

Combinations of Services that Cannot be Reimbursed

The following services may not be reimbursed for the same recipient on the same day in conjunction with therapeutic behavioral on-site therapy services:

- Therapy services
- Group medical therapy
- Behavioral health day services
- Psychosocial rehabilitation
- Therapeutic foster care unless therapeutic behavioral on-site services are provided as part of a public school program or summer activities program (i.e., outside the home)
- Therapeutic group care
- Behavioral health overlay – Child Welfare and Department of Juvenile Justice

Therapeutic Behavioral On-Site Services – Behavior Management Services

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

- Assessment of behavior problems, and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the client’s behaviors and the interactions that motivate, maintain or improve behavior;
- Development of an individual behavior plan with measurable goals and objectives;
- Training caregivers and other involved persons in the implementation of the behavior plan;
- Monitoring the child and caregiver progress and revise as needed; and
- Coordinating services on the treatment plan with the treatment team.

Who Must Provide

Therapeutic behavioral on-site behavior management services must be provided by a certified behavior analyst or certified associate behavioral analyst, as defined in Chapter 1 of this handbook, working as a member of the child’s treatment team.

Bachelor’s level practitioners providing this service as of January 31, 2005 may continue to provide services for up to 18 months while completing requirements to become certified behavior analysts. These practitioners must earn certification by April 2006 in order to continue to be reimbursed for this service.

Non-certified associate behavioral analysts hired after January 1, 2005 must have completed course work required for certification and be supervised in order to be reimbursed for these services.
**Reimbursement Limitations**

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. A minimum of 8 units per month must be provided by a master's level practitioner. **Additional therapeutic behavioral on-site services may be provided beyond the maximum limit after obtaining prior authorization.**

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**Therapeutic Behavioral On-Site Services for Children and Adolescents, continued**

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**Services Provided to a Group**

Therapeutic behavioral on-site behavior management services may not be billed for services provided to a group of recipients.

---

**Combinations of Services that Cannot be Reimbursed**

The following services may not be reimbursed for the same recipient on the same day as in conjunction with therapeutic behavioral on-site behavior management services:

- Therapy services
- Group medical therapy
- Behavioral health day services
- Psychosocial rehabilitation
- Therapeutic foster care unless therapeutic behavioral on-site services are provided as part of a public school program or summer activities program (i.e., outside the home)
- Therapeutic group care
- Behavioral health overlay services – Child Welfare and Department of Juvenile Justice
Therapeutic Behavioral On-Site Services for Children and Adolescents, continued

**Therapeutic Behavioral On-Site – Therapeutic Support Services**

Therapeutic behavioral on-site therapeutic support services must be related to the child’s or adolescent’s treatment plan goals and objectives and must include one or more of the following services:

- One-to-one supervision and intervention with the child or adolescent during therapeutic activities in accordance with the child’s treatment plan;
- Skill training of the child or adolescent for restoration of those basic living and social skills necessary to function in the child or adolescent’s own environment; or
- Assistance to the child or adolescent and family in implementing the behavioral goals identified through family counseling and development of the treatment plan.

**Agency Requirements**

The provider responsible for delivering the services must be able to recruit qualified practitioners, have adequate administrative ability to assure availability of services, and must assure adequate staff pre-service and in-service training and appropriate supervision.

The provider employing or contracting with the person rendering service must maintain documentation that the practitioner:

- Has appropriate clinical supervision;
- Is experienced in treating children or adolescents with serious emotional disturbances or substance abuse disorders;
- Is capable of implementing services which address the needs identified in the child or adolescent’s treatment plan; and
- Demonstrates skills and abilities to deliver rehabilitative services to children or adolescents with serious emotional disturbances and their families.

Service practitioners/providers may not be relatives of the recipient.

**Who Must Provide**

Therapeutic behavioral on-site therapeutic support services must be provided, at a minimum, by a behavioral health technician supervised by a master’s level practitioner.
<table>
<thead>
<tr>
<th><strong>Reimbursement Limitations</strong></th>
<th>Medicaid reimburses therapeutic behavioral on-site therapeutic support services a maximum of 128 quarter-hour units per month, per recipient. Additional, medically necessary, therapeutic behavioral on-site support services may be provided beyond the maximum limit after obtaining prior authorization.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Special Documentation Requirements</strong></td>
<td>Documentation of therapeutic behavioral on-site therapeutic support services must provide a description of the intervention(s), how it addressed the progress in achieving treatment plan goals and objectives, and how the child or adolescent responded to the intervention.</td>
</tr>
<tr>
<td><strong>One-to-One Versus Group</strong></td>
<td>Therapeutic behavioral on-site therapeutic support services are considered primarily one-to-one interactions. When provided in a group it must be in response to a specific recommendation and justification by the treating physician or treating licensed practitioner of the healing arts in the child's treatment plan. Under no circumstances may the staff to group ratio exceed 4 group members to one staff person.</td>
</tr>
</tbody>
</table>
### SECTION 2

**COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT**

#### Description, Purpose and Recipient Eligibility

**Comprehensive Behavioral Health Assessment**

The comprehensive behavioral health assessment is an in-depth and detailed assessment of the child’s emotional, social, behavioral and developmental functioning within the family home, school, and community. A comprehensive behavioral health assessment must include direct observation of the child in the home, school and community, as well as in the clinical setting.

**Who May Receive Services**

In order to receive a comprehensive behavioral health assessment, a recipient must be 0-20 years of age and meet the following criteria:

- Be experiencing serious emotional disturbance;
- Be a victim of abuse or neglect; and
- Have been determined by the Department of Children and Families district or regional Child Welfare or Community Based Care Department of Children and Families CR or Community-Based Care lead agency or designee provider to require out-of-home care.

Or the child must:

- Have committed acts of juvenile delinquency;
- Be suffering from serious emotional disturbance; and
- Have been adjudicated delinquent and committed to the Department of Juvenile Justice; and the court must have ordered a low-risk residential community commitment setting for the child.

Or the child must:

- Be a victim of abuse or neglect; and
- Have been determined by the Department of Children and Families district or regional Child Welfare or Community Based Care Department of Children and Families CR or Community-Based Care lead agency or designee provider, to require out-of-home care and be placed in shelter status.
### Authorization for Services

**Before a provider renders service,** the district Substance Abuse and Mental Health office and district or regional Child Welfare or Community Based Care program office, or Juvenile Justice office must authorize the service on the Authorization for Comprehensive Behavioral Health Assessment Form. Substance Abuse and Mental Health will mail the completed form to the provider, who must keep it on file in the child's medical record.

For children who are located/reside in Areas covered by the Child Welfare Plan and, who are not enrolled in the plan, the Circuit Substance Abuse and Mental Health office or the Community-Based Care lead agency or designee must authorize the comprehensive behavioral health assessment services utilizing the authorization for Comprehensive Behavioral Health Assessment form.

For children in the Child Welfare Prepaid Mental Health Plan, the Child Welfare Plan vendor or designee must authorize the comprehensive behavioral health assessment services.

For children who are located/reside in areas not covered by the Child Welfare Plan, the Circuit Substance Abuse and Mental Health office or the Community-Based Care lead agency or the Department of Juvenile Justice office or the designee of one of these entities must authorize the services. After the Authorization for Comprehensive Behavioral Health Assessment form has been completed, the Circuit Substance Abuse and Mental Health office or Community-Based Care lead agency will mail the completed form to the provider. The provider must keep the form on file in the child’s clinical records.

Comprehensive behavioral health assessments cannot be authorized via the recipient’s treatment plan.

For a child placed in shelter status, only the district Child Welfare or Community Based Care representative must sign authorization. A completed Authorization for Comprehensive Behavioral Health Assessment Form serves in lieu of a recommendation in the individualized treatment plan.

Note: See Appendix B in this handbook for a copy of the Authorization for Comprehensive Behavioral Health Assessment Form.
**Provider Enrollment Requirements**

<table>
<thead>
<tr>
<th>Provider Enrollment for Comprehensive Behavioral Health Assessments</th>
</tr>
</thead>
</table>
| In addition to the community behavioral health provider enrollment requirements, in Chapter 1 of this handbook, providers of comprehensive behavioral health assessment services must meet the following requirements:

- Be certified by the Substance Abuse and Mental Health office, Area Medicaid staff, and the district or regional Child Welfare and Community Based Care program office or Juvenile Justice, prior to rendering services; and
- Enroll each individual treating practitioner who is certified to provide comprehensive behavioral health assessments;
- To bill Medicaid fee-for-service, the individual practitioner and the provider agency must be certified by the Medicaid Area office.
- To bill the Child Welfare Prepaid Mental Health Plan, the individual practitioner and the provider agency must be certified by the Child Welfare Prepaid Mental Health Plan vendor or designee.
- To bill the Child Welfare Prepaid Mental Health Plan and Medicaid fee-for-service, the individual practitioner and the provider agency must be certified by the Medicaid Area office and the Child Welfare Prepaid Mental Health Plan vendor or designee.
- Individual practitioners who meet eligibility criteria to provide comprehensive behavioral health assessments must be linked to a certified comprehensive behavioral health assessment provider agency, before rendering this service.

<table>
<thead>
<tr>
<th>Provider Certification</th>
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</thead>
</table>
| The designated Area Medicaid, Medicaid Area Substance Abuse and Mental Health office or Child Welfare and Community Based Care program office or Department of Juvenile Justice, and Area Medicaid staff must certify individual practitioners and provider agencies who are billing Medicaid fee-for-service providers annually if they continue to meet the specific qualifications to provide these services.

The Child Welfare Prepaid Mental Health Plan (CWPMHP) vendor must certify individual practitioners and providers agencies who are under contract with the CW-PMHP annually if they continue to meet the specific qualifications to provide these services.

Certification will be withdrawn if the provider fails to continue to meet the specific qualifications to provide these services. Any comprehensive behavioral health assessment individual practitioner or provider agency who fails to meet certification requirements will be terminated, not be reimbursed by Medicaid or the Medicaid managed care CWPMHP vendor for services.
Provider Enrollment Requirements, continued

Process for Provider Enrollment

The provider must submit a Comprehensive Behavioral Health Assessment Provider Certification Form with a Florida Medicaid Provider Enrollment Application to the Medicaid fiscal agent.

To enroll as a Florida Medicaid provider who can be reimbursed through Medicaid fee-for-service, a Comprehensive Behavioral Health Assessment Agency and Practitioner Certification form, along with a Florida Medicaid Provider Enrollment Application, must be submitted to the Medicaid fiscal agent.

The Comprehensive Behavioral Health Assessment Provider Agency and Practitioner Certification Form must be completed and signed by the Medicaid Area. Medicaid-designated district or regional Substance Abuse and Mental Health office, and district Child Welfare and Community-Based Care program office or Department of Juvenile Justice, and area Medicaid staff submitted in the enrollment package.

A provider may contract with the Child Welfare Prepaid Mental Health Plan (CW-PMHP) to provide Comprehensive Behavioral Health Assessments. To enroll under the CW-PMHP, the provider must contact the vendor for enrollment information. Having a contractual relationship with the CW-PMHP vendor does not enroll a provider in Florida Medicaid.

Note: See Appendix C for a copy of the Comprehensive Behavioral Health Assessment Provider Agency and Practitioner Certification Form.

Goals and Components

Goals of the Comprehensive Behavioral Health Assessment

The goals of a comprehensive behavioral health assessment are to:

- Provide assessment of areas where no other information exists;
- Update pertinent information not considered to be current;
- Integrate and interpret all existing and new assessment information;
- Provide functional information, including strengths and needs, to the referral source, child and family that will aid in the development of long and short-term, culturally sensitive intervention strategies to enable the child to live and receive his or her education in the most inclusive environment;
- Provide specific information and recommendations to accomplish family preservation, re-unification, or re-entry and permanency planning;
- Provide data to promote the most appropriate out-of-home placement, when necessary; and
- Provide information for development of an effective, individualized, strength based, culturally sensitive, comprehensive services plan and an Medicaid community mental behavioral health services individualized treatment plan, when indicated.
Goals and Components, continued

Components of a Comprehensive Behavioral Health Assessment
For Recipients Ages 6-20 Years

A comprehensive behavioral health assessment must be written in narrative form and provide detailed information on the following components. The use of a checklist or fill in the blank format in lieu of a narrative is prohibited.

The assessment must include, at a minimum, the following information related to the child and the child’s family:

- General identifying information (name, birth date, Medicaid identification number, social security number (if available), sex, address, siblings, school, referral source and diagnosis);
- Reason for referral;
- Personal and family history;
- Placement history, including adjustment and level of understanding about out-of-home placement;
- Sources of information (i.e., counselor, hospital, law enforcement);
- Interviews and interventions;
- Cognitive functioning (attention, memory, information, attitudes), perceptual disturbances, thought content, speech and affect; and an estimation of the ability and willingness to participate in treatment;
- Previous and current medications including psychotropics;
- Last physical examination, and any known medical problems including any early medical information which may affect the child’s mental health status, such as prenatal exposure, accidents, injuries, hospitalizations, etc.;
- History of mental health treatment of family and child;
- History of current or past alcohol or chemical dependency of parents and child;
- Legal involvement and status of child and family;
- Resources including income, entitlements, health care benefits, subsidized housing, social services, etc.;
- Emotional status – psychiatric or psychological condition;
- Educational analysis – school-based adjustment and performance history and current status;
- Functional analysis – presenting strengths and problems of both child and family;
- Cultural analysis – discovery of the family’s unique values, ideas, customs and skills that have been passed on to family members and that require consideration in working and planning with the family. This component includes assessment of the family’s own operational style, including habits, characteristics, preferences, roles and methods of communicating with each other;
  - **Situational analysis – direct observation of child in home, school, and other community settings;**
- Present level of functioning including social adjustment and daily living skills;
Components of a Comprehensive Behavioral Health Assessment For Recipients Ages 6-20 Years, continued

- Reaction, or pattern of reaction, to any previous out-of-home placements;
- Activities catalog – assessment of activities in which the child has interest or enjoys;
- Ecological analysis – relationship of parents (guardians), parent-child relationship, sibling relationships, relationships with friends and family;
- Vocational aptitude and interest evaluation, previous employment and the acquired vocational skills, activities, and interests, if age 14 and above;
- Assessment of the desired services and goals from the child and child’s family viewpoint;
- An ICD-9-CM diagnosis. If the child does not meet criteria for a covered ICD-9-CM diagnosis, the provider must use diagnosis code V71.09, observation and evaluation for other suspected mental condition, not found;

- The completion of a Medicaid and a Department of Children and Families approved standardized assessment tool to help determine the appropriate level of mental health treatment services. This tool may include, but is not limited to, the Child and Adolescent Needs and Strengths – Mental Health (CANS-MH), or the Child and Adolescent Needs and Strengths – Comprehensive Multisystem Assessment (CANS-Comprehensive).

The CANS can be downloaded from the following web-site: http://www.dcf.state.fl.us/programs/samh/links.shtml.

- The assessment includes the following:
  1. Problem presentation and symptoms
  2. Risk behaviors
  3. Functioning
  4. Family and caregiver needs and strengths; and,
  5. Child’s strengths

- Summary of findings and recommendations.
Goals and Components, continued

Components of a Comprehensive Behavioral Health Assessment For Recipients Ages 0 – 5 Years

A comprehensive behavioral health assessment for the birth – 5 years of age population must be written in narrative form and provide detailed information on the following components. The use of a checklist or fill in the blank format in lieu of a narrative is prohibited.

The assessment must include, at a minimum, the following information related to the child and the child’s family:

- General identifying information (name, birth date, Medicaid identification number, social security number (if available), sex, address, siblings, school, referral source and diagnosis);
- Reason for referral;
- Personal and family history;
- Placement history, including adjustment to a new care giver and home;
- Sources of information (i.e., counselor, hospital, law enforcement);
- Results of interviews and interventions conducted by the assessor;
- Cognitive functioning. Screening for emotional-social development, problem solving, communication, response of the child and family to the assessment and ability to collaborate with the assessor;
- Previous and current medications including psychotropics;
- Last physical examination, and any known medical problems including pre-natal, pregnancy and delivery history which may affect the child’s mental health status, such as prenatal exposure, accidents, injuries, hospitalizations, etc.;
- History of mental health treatment of parents and child’s siblings. The mother’s history, including a depression screen, is important in developing this section;
- History of current or past alcohol or chemical dependency of parents and child;
- Legal involvement and status of child and family;
- Resources including income, entitlements, health care benefits, subsidized housing, social services, etc.;
- Emotional status – hands on interactive assessment of the infant regarding sensory and regulatory functioning, attention, engagement, constitutional characteristics, and organization and integration of behavior;
- Educational analysis – daycare issues concerning behavioral and developmental concerns;
- Functional analysis – presenting strengths and problems of both child and family;
- Cultural analysis – discovery of the family’s unique values, ideas, customs and skills that have been passed on to family members and that require consideration in working and planning with the family. This component includes assessment of the family’s own operational style, including habits, characteristics, preferences, roles and family’s own operational style, including habits, characteristics, preferences, roles and methods of communicating with each other;
Goals and Components, continued

Components of a Comprehensive Behavioral Health Assessment, For Recipients Ages 0 – 5 Years, continued

- Situational analysis – direct observation of the parent/caregiver interaction with the child in home- and community settings;
- Present level of functioning including social adjustment and daily living skills;
- Activities catalog – assessment of activities in which the child has interest or enjoys;
- Ecological analysis – relationship of parents (guardians), parent-child relationship, sibling relationships, relationships with friends and family. A relational assessment should be provided to assess any attachment issues that the child exhibits;
- Assessment of the desired services and goals from the child and child’s family/ parent or guardian’s viewpoint;
- An ICD-9-CM diagnosis. If the child does not meet criteria for a covered ICD-9-CM diagnosis, the provider must use diagnosis code V71.09, observation and evaluation for other suspected mental condition, not found;
- For children 0 through 3 years of age, Medicaid recommends use of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0–3) for assistance in determining the infant or child’s ICD-9-CM diagnosis.
- The completion of a Medicaid and a Department of Children and Families approved standardized assessment tool to help determine the appropriate level of mental health treatment services. For children ages 0 – 5 years of age, the Child and Adolescent Needs and Strengths (CANS-0-3) must be used. The CANS can be downloaded from the following web-site: http://www.dcf.state.fl.us/programs/samh/links.shtml.
- The assessment includes the following:
  1. Problem presentation and symptoms
  2. Risk behaviors
  3. Functioning
  4. Family and caregiver needs and strengths; and
  5. Child’s strengths

Summary of findings and recommendations

Use of Evaluations and Tests

A review of evaluations and tests previously completed by the provider or others that are deemed to be appropriate and current, may be used in development of the comprehensive behavioral health assessment.
Documentation Requirements and Reimbursement Limitations

Documentation

Each activity related to development of the comprehensive behavioral health assessment must be thoroughly documented to reflect time spent on information collection, interpretation, assessment, report writing, and other related activities.

Time Frame for Completion of a Comprehensive Behavioral Health Assessment for Child in Shelter

In order to be reimbursed for a comprehensive behavioral health assessment for a child in shelter status, the assessment must be completed and received by the Department of Children and Families or the community based care organization that signed the authorization no later than 24 calendar days after the date of referral for the service. For example, if the referral is dated August 1, 2004, the assessment must be completed and received by DCF no later than August 25, 2004. The date of the referral is included on the Authorization for Comprehensive Behavioral Health Assessment form (Appendix B of this handbook).

Reimbursement Limitations

A comprehensive behavioral health assessment may not be billed until all components are completed. The date that the report is completed is the date of service for billing purposes, unless an exception applies. However, if the child has entered a statewide inpatient psychiatric program (SIPP) or if the child loses Medicaid eligibility prior to completion of the assessment, the date of referral must be used as the date of service.

The comprehensive behavioral health assessment may be reimbursed only once per state fiscal year (July 1 through June 30) per recipient. Reimbursement is limited to a total of 20 hours per recipient per fiscal year.

Claims for Comprehensive Behavioral Health Assessment services must be submitted under the Comprehensive Behavioral Health Assessment provider agency's Medicaid number, and the Medicaid number of the individual practitioner who completed the assessment.

Reimbursement for report writing shall not exceed one hour for every three hours of other assessment activities. Reimbursement for the report writing portion of a comprehensive behavioral health assessment must not exceed five hours total.

The comprehensive biopsychosocial evaluation is considered part of the reimbursement for the comprehensive behavioral health assessment and may not be billed separately.

A comprehensive behavioral health assessment is not reimbursable for the same recipient in the same fiscal year (July 1 through June 30) as an in-depth assessment unless the child qualifies for the comprehensive behavioral health assessment by entering into shelter status and the child has already received an in-depth assessment.
## Staff Qualifications

### Who Must Provide
Comprehensive behavioral health assessments must be personally rendered by one of the following individuals who have been certified by Substance Abuse and Mental Health district staff, Medicaid Area office, or designee as meeting the specific education and training requirements as listed below:

- Psychiatric Nurse
- Clinical Social Worker
- Mental Health Counselor
- Marriage and Family Therapist
- Mental Health Professional
- Psychologist
- Psychiatrist

### Psychiatric Nurse Qualifications
A psychiatric nurse must:

- Be licensed pursuant to the provisions of Chapter 464, Florida Statutes;
  
  (Effective October 1, 2014, a psychiatric nurse must be a registered nurse with a master's degree or a doctorate degree in psychiatric nursing and two years of post-master's clinical experience working under the supervision of a physician, in accordance with Chapter 394, F.S.);
- Have a minimum of two years of direct experience working with children and families who are victims of physical abuse, sexual abuse, neglect, or youth who have been adjudicated delinquent and committed and are emotionally disturbed; and
- Have a list of current (within the last two years) conferences, workshops attended, and Continuing Education Units (CEUs) earned, dedicated to relevant child and family treatment issues.

### Clinical Social Worker Qualifications
A clinical social worker must:

- Be licensed pursuant to the provisions of Chapter 491, Florida Statutes;
- Have a minimum of two years of direct experience working with children and families who are victims of physical abuse, sexual abuse, neglect, or youth who have been adjudicated delinquent and committed and are emotionally disturbed; and
- Have a list of current (within the last two years) conferences, workshops attended, and CEUs earned, dedicated to relevant child and family treatment issues.
### Staff Qualifications, continued

<table>
<thead>
<tr>
<th>Mental Health Counselor Qualifications</th>
<th>A mental health counselor must:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Be licensed pursuant to Chapter 491, Florida Statutes;</td>
<td></td>
</tr>
<tr>
<td>• Have a minimum of two years of direct experience working with children and families who are victims of physical abuse, sexual abuse, neglect, or youth who have been adjudicated delinquent and committed and are emotionally disturbed; and</td>
<td></td>
</tr>
<tr>
<td>• Have a list of current (within the last two years) conferences, workshops attended, and CEUs earned, dedicated to relevant child and family treatment issues.</td>
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<thead>
<tr>
<th>Marriage and Family Therapist Qualifications</th>
<th>A marriage and family therapist must:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Be licensed pursuant to Chapter 491, Florida Statutes;</td>
<td></td>
</tr>
<tr>
<td>• Have a minimum of two years of direct experience working with children and families who are victims of physical abuse, sexual abuse, neglect, or youth who have been adjudicated delinquent and committed and are emotionally disturbed; and</td>
<td></td>
</tr>
<tr>
<td>• Have a list of current (within the last two years) conferences, workshops attended, and CEUs earned, dedicated to relevant child and family treatment issues.</td>
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</tr>
</tbody>
</table>
**Staff Qualifications, continued**

### Mental Health Professional Qualifications

A non-licensed child welfare mental health professional must:

- Have a master’s degree in the field of counseling, social work, psychology, rehabilitation, special education, or a human services field. **(Effective October 1, 2014, graduate level coursework must have included at least four (4) of the following 13 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; or substance abuse.)**

- Have a minimum of five years full-time experience working directly with children and families who are victims of physical abuse, sexual abuse, neglect, or youth who have been adjudicated delinquent and committed and are emotionally disturbed;

- Have a minimum of two years experience working with foster parents; and

- Have a list of current (30 hours within the last two years) conferences and workshops attended, dedicated to relevant child and family treatment issues; and

- Have a supervisor who is a licensed practitioner of the healing arts.

To be in compliance with Department of Children and Families policy relating to assessment of children in the legal custody of the Department, comprehensive behavioral health assessments completed by a non-licensed person must be co-signed by a licensed professional. **By co-signing the assessment, the licensed professional assures that they have reviewed it for accuracy and completeness.**

### Psychologist Qualifications

A clinical psychologist must:

- Be licensed as a psychologist pursuant to the provisions of Chapter 490, Florida Statutes;

- **Have a specialty in pediatric clinical child psychology; or Have two years of employment experience working directly with children and families who are victims of physical abuse, sexual abuse, neglect, or youth who have been adjudicated delinquent and committed and are emotionally disturbed; and**

- Have a list of current (within the last two years) conferences, workshops attended, and CEUs earned, dedicated to relevant child and family treatment issues.
Staff Qualifications, continued

Psychiatrist Qualifications

A psychiatrist must:

- Be a medical practitioner licensed pursuant to Chapter 458 or 459, Florida Statutes;
- Have a specialty in child psychiatry;
- Have a minimum of two years employment experience working directly with children and families who are victims of physical abuse, sexual abuse, neglect, or youth who have been adjudicated delinquent, committed, and are emotionally disturbed; and
- Have a list of current (within the last two years) conferences, workshops attended, and CEUs earned, dedicated to relevant child and family treatment issues.
# SECTION 3
## SPECIALIZED THERAPEUTIC FOSTER CARE SERVICES

### Description and Service Goals

| **Specialized Therapeutic Foster Care** | Specialized therapeutic foster care services are intensive treatment services provided to children with **serious** emotional disturbances that reside in a state licensed foster home. Specialized therapeutic foster care services are appropriate for long-term treatment and short-term crisis intervention. Specialized therapeutic foster care services incorporate clinical treatment services, which are behavioral, psychological, and psychosocial in orientation. Services must include clinical interventions by the specialized therapeutic foster parent(s), a clinical staff person, and a psychiatrist. |
| **Level of Care** | Specialized therapeutic foster care services are offered at Level I or Level II intensity depending upon the needs of the child. Crisis intervention is available at both levels. The three specialized therapeutic foster care services are: • Specialized Therapeutic Foster Care, Level I; • Specialized Therapeutic Foster Care, Level II; and • Crisis Intervention. |
| **Goal of the Service** | The goal of specialized therapeutic foster care is to enable a child to manage and to work towards resolution of his or her emotional, behavioral, or psychiatric problems in a highly supportive, individualized, and flexible home setting. |
Provider Enrollment Requirements

In addition to the community behavioral health services provider enrollment requirements in Chapter 1 of this handbook, providers of specialized therapeutic foster care services who request enrollment in Medicaid must meet the following requirements:

- Be certified by the Substance Abuse and Mental Health office and the district or regional Child Welfare and Community Based Care program office and the Area Medicaid office or Juvenile Justice as a specialized therapeutic foster care services provider; and

- Be enrolled in Medicaid as a specialized therapeutic foster care provider.

- To bill Medicaid fee-for-service, the provider must be certified by the Medicaid Area office. The original certification must be sent to the Medicaid fiscal agent upon enrollment. A copy of the signed form must also be maintained by the provider.

- To bill the Child Welfare Prepaid Mental Health Plan, the provider must be certified by the Child Welfare Prepaid Mental Health Plan vendor or designee.

A provider may contract with the Child Welfare Prepaid Mental Health Plan (CW-PMHP) to provide this service. However, having a contractual relationship with the CW-PMHP vendor does not enroll the provider in Florida Medicaid.

Note: See Appendix D for a copy of the Specialized Therapeutic Foster Care Provider Agency Certification form.
Provider Enrollment Requirements, continued

Process for Provider Enrollment

To become enrolled in the Medicaid Community Behavioral Health Services Program as a provider of therapeutic services for children, a provider must submit a Specialized Therapeutic Foster Care Provider Agency Certification Form with a Florida Medicaid Provider Enrollment Application to the Medicaid fiscal agent. The Specialized Therapeutic Foster Care Provider Agency Certification Form must be completed and signed by:
- The designated Substance Abuse and Mental Health office
- The child welfare prepaid mental health plan vendor or designee.
- Area Medicaid staff, and the district Child Welfare and Community Based Care program office or Juvenile Justice.

Note: See Appendix D for a copy of the Specialized Therapeutic Foster Care Provider Agency Certification Form.

Provider Criteria for Certification

The following conditions must be met prior to a provider agency before the provider can being enrolled in Medicaid as a specialized therapeutic foster care services provider:

- The provider agency’s clinical staff, psychologists, psychiatrists, and foster parents delivering specialized therapeutic foster care services must meet the specific education and training requirements.
- The provider employs or contracts with clinical staff and foster care parents who provide the services. (The clinical staff and foster care parents are not individually enrolled in Medicaid.)
- The provider has an approved pre-service and in-service training plan for staff providing specialized therapeutic foster care services.
- The foster home is properly licensed in accordance with Chapter 409.175, F. S. and Chapter 64C-13, F. A. C. or 65C-14, F. A. C. by the district-circuit Child Welfare and Community Based Care program office.
- The foster parents have received basic training required of all licensed foster parents and meet all other licensing requirements.
- The provider agency has a financial agreement with the foster parents that adequately reimburses them for their services.
- The provider has sufficient administrative capacity to operate the program.
- The provider has policies and procedures that promote good therapeutic practice, ensure therapeutic foster parents are the primary therapeutic agent, provide for appropriate treatment plans and documentation, and protect the rights of children and families.
- The provider has a program evaluation system to review the process and outcomes on at least an annual basis.
Provider Enrollment Requirements, continued

Annual Certification

For providers under contract with the Child Welfare Prepaid Mental Health Plan vendor, the Child Welfare Prepaid Mental Health Plan vendor or designee, will certify providers annually if they continue to meet the specific qualifications to provide specialized therapeutic foster care services.

For providers enrolled in Medicaid, the Medicaid Area office or designee will certify providers annually if they continue to meet the specific qualifications to provide specialized therapeutic foster care services.

Providers must be certified annually by the designated Substance Abuse and Mental Health office, the district Child Welfare and Community Based Care program office or Juvenile Justice, and area Medicaid staff as meeting the specific qualifications to provide these specialized services.

Certification will be withdrawn if the provider fails to continue to meet the specific qualifications to provide these specialized services.

Recipient Eligibility for Specialized Therapeutic Foster Care

Who May Receive Services

In order to receive specialized therapeutic foster care services, a child-recipient must be authorized by a multidisciplinary team as meeting the following criteria:

- Be a child or adolescent under 18 years of age;
- Be experiencing serious emotional disturbance;
- Be a victim of abuse or neglect; and
- Have been determined by the Department of Children and Families, district Child Welfare and Community-Based Care program office lead agency to require out-of-home care.

OR the child-recipient must:

- Be a child or adolescent under 18 years of age;
- Have committed acts of juvenile delinquency;
- Be suffering from serious emotional disturbance; and
- Have been adjudicated delinquent and committed to the Department of Juvenile Justice, and the court must have ordered a low-risk residential community commitment setting for the child.
Recipient Eligibility for Specialized Therapeutic Foster Care, continued

Who Must Authorize

For children who reside in Medicaid Areas not covered by the Child Welfare Prepaid Mental Health Plan, the multidisciplinary team designated by each Medicaid Area office and Community-Based Care lead agency or Circuit Substance Abuse and Mental Health office or designee must authorize specialized therapeutic foster care services. If the Community-Based Care lead agency or Medicaid Area office or Circuit Substance Abuse and Mental Health office or designee team determines that the child requires specialized therapeutic foster care services, the multidisciplinary team must complete an Authorization for Specialized Therapeutic Foster Care Form.

OR

For children who reside in Medicaid Areas covered by the Child Welfare Prepaid Mental Health Plan, but who are not enrolled in the Plan, the Community-Based Care lead agency and the Medicaid Area office will coordinate with the multidisciplinary team. Both the Community-Based Care lead agency and the Medicaid Area office must authorize specialized therapeutic foster care services by completing an Authorization for Specialized Therapeutic Foster Care Form.

The Authorization for Specialized Therapeutic Foster Care form must be forwarded to the provider agency to be placed in the child’s clinical record.

Note: See Appendix E for a copy of the Authorization for Specialized Therapeutic Foster Care form

OR

For children who reside in Areas covered by the Child Welfare Prepaid Mental Health Plan and are enrolled in the CWPMHP, the vendor or designee of the plan must authorize specialized therapeutic foster care services.

The vendor's letter authorizing specialized therapeutic foster care services must be placed in the child’s clinical record.

The form must be forwarded to the provider agency to become part of the child's medical record.

Note: See Appendix E for a copy of the Authorization for Specialized Therapeutic Foster Care Form.
Recipient Eligibility for Specialized Therapeutic Foster Care, continued

Re-authorization

For children who reside in Medicaid Areas not covered by the Child Welfare Prepaid Mental Health Plan, the district designated multidisciplinary team designated by each Medicaid Area office, and Community-Based Care lead agency or Circuit Substance Abuse and Mental Health office must re-authorize specialized therapeutic foster care services no less than every six months. A new Authorization for Specialized Therapeutic Foster Care form must be completed and signed by the multidisciplinary team.

For children who reside in Medicaid Areas covered by the Child Welfare Prepaid Mental Health Plan, but who are not enrolled in the Child Welfare Prepaid Mental Health Plan, the Community-Based Care lead agency, and the Medicaid Area office will coordinate the multidisciplinary team and must re-authorize specialized therapeutic foster care services no less than every six months. A new Authorization for Specialized Therapeutic Foster Care form must be completed and signed.

The new Authorization for Specialized Therapeutic Foster Care form must be forwarded to the provider agency to be placed in the child’s clinical record.

For children who reside in Medicaid Areas covered by the Child Welfare Prepaid Mental Health Plan and are enrolled the plan, the vendor of this plan is responsible for the reauthorization of services.

The vendor’s letter reauthorizing Specialized Therapeutic Foster Care must be placed in the child’s clinical record.

The form must be forwarded to the provider agency to become part of the child’s medical record.
Recipient Eligibility for Specialized Therapeutic Foster Care, continued

Composition of the Multidisciplinary Team

For Medicaid Areas not covered in the Child Welfare Prepaid Mental Health Plan (CW-PMHP), or for children who reside in Medicaid Areas covered by the CW-PMHP but who are not enrolled in the plan, the multidisciplinary team must at a minimum consist of a representative from the Circuit Substance Abuse and Mental Health office, the Medicaid Area office, the Department of Children and Families district, Child Welfare and Community-Based Care lead agency program office or Juvenile Justice (when applicable). Additional members should be representatives who know or work with the child and family. When appropriate, members should include the child, the child’s case manager, a representative from the child’s school, the child’s biological or adoptive parents or relatives, the foster parents or emergency shelter staff, assigned counselors or case managers, and the child’s medical health care provider, e., and the area Medicaid office.

In districts in which Department of Children and Families has contracted with a lead agency(ies) to provide Child Welfare and Community-Based Care foster care and related services, the District or Regional Administrator, at the request of the lead agency, will designate the lead agency as the Child Welfare and Community-Based Care representative for the geographic area contractually served by the lead agency.

Additional members should be representatives who know or work with the child and family. When appropriate, members should include the child, a representative from the child’s school, the child’s biological or adoptive parents or relatives, the foster parents or emergency shelter staff, assigned counselors or case managers, the child’s health care provider. For children who reside in areas covered by the Child Welfare Prepaid Mental Health Plan, and are enrolled in the plan, the vendor shall meet the requirements of the CW-PMHP contract, or, and a member of the case review committee.

Role of the Multi-disciplinary Team

The multi-disciplinary team must assess whether or not the child requires specialized therapeutic foster care services or may be adequately served with less intensive services.

The multi-disciplinary team must also determine the level of specialized therapeutic foster care services required by the child, and review each child’s status to re-authorize services no less than every six months. For the CW-PMHP, the multidisciplinary team recommends a level of care, however, the recommendation goes through a clinical review process and the authorization decision may be made by the vendor.
Specialized Therapeutic Foster Care Levels of Service

Description and Purpose
There are two levels of specialized therapeutic foster care, which are differentiated by the type of supervision and training of the foster parents and intensity of programming required. Specialized therapeutic foster care levels are intended to support, promote competency, and enhance participation in normal age-appropriate activities of children who present moderate to severe emotional or behavioral management problems. Programming and interventions are tailored to the age and diagnosis of the child.

Placement Restrictions
Placement in a home certified as a Level I or Level II specialized therapeutic foster home is intended for children determined eligible for specialized therapeutic foster care services. Any exception to this requirement must be approved in writing by the multidisciplinary team. Exception requests must be re-reviewed on or before the date that the current specialized therapeutic foster care authorization expires. Reimbursement for the necessary level of service will only be made when the child receives that level of service.

Specialized Therapeutic Foster Care Service Requirements

Foster Home Capacity
No more than two specialized or regular foster care children or children committed to Juvenile Justice may reside in a home being reimbursed for specialized therapeutic foster care services.

Exceptions for Siblings
Only in the case of placement of a sibling(s) of the therapeutic foster care child may the two-child limit be exceeded and only when the specialized therapeutic foster home has the licensed capacity.

Specialized Therapeutic Foster Parents
The specialized therapeutic foster parent(s) serves as the primary agent in the delivery of therapeutic services to the child. Specialized therapeutic foster parents are specially recruited and trained in interventions designed to meet the individual needs of the child.
Specialized Therapeutic Foster Care Service Requirements, continued

Clinical Staff

One of the following individuals must serve in the role of a specialized therapeutic foster care clinical staff for each child:

- Psychiatric Nurse;
- Clinical Social Worker;
- Mental Health Counselor;
- Marriage and Family Therapist;
- Mental Health Professional; or
- Psychologist; or
- Psychiatrist.

Note: Refer to The specific education and training requirements for clinical staff can be referenced under Staff Qualifications for Comprehensive Behavioral Health Assessment in Chapter 2, Section 2 of this handbook, for the specific education and training requirements for these individuals.

Responsibilities of the Clinical Staff

Clinical staff are responsible for:

- Directly supervising and supporting the specialized therapeutic foster parents throughout the child’s length of stay;
- Evaluating and assessing children who are receiving services;
- Contributing to and participating in the preparation of a treatment plan;
- Providing in-service training to the therapeutic foster care parents, targeting skills needed to comply with treatment plan requirements;
- Supervising the performance of the specialized therapeutic foster care parent(s);
- Working with the Department of Children and Families, district Child Welfare and Community-Based Care lead agency program office, or Juvenile Justice counselor to coordinate other treatment initiatives, including school performance, permanency and reunification planning;
- Preparing and training the child’s biological or legal parents to resume care of their child when reunification is the goal;
- Working with the child’s targeted case manager, if one has been assigned;
- Conducting regularly scheduled face-to-face meetings with the specialized therapeutic foster parents in order to monitor the child’s progress and discuss treatment strategies and services; and
- Conducting monthly visits to other community settings where the child is demonstrating emotional or behavioral difficulties to observe the child’s behavioral, psychological, and psychosocial progress and to coordinate treatment intervention.
Specialized Therapeutic Foster Care Service Requirements, continued

**Caseload of Clinical Staff**

The maximum caseload for clinical staff may be less than, but must not exceed:

- Level I – eight children receiving specialized therapeutic foster care; or

The caseload of clinical staff who carry a combined caseload of Level I and Level II and Crisis Intervention children must not exceed six children.

These caseload requirements are based on full-time employment or a 40-hour employment week. The caseload of clinical staff employed or under contract for 20 hours a week should not exceed four Level I children, or three Level II children, or a combined caseload of three Level I and Level II children.

**Frequency of Home Visits by Clinical Staff**

Home visits will be conducted by clinical staff in accordance with the level of service designated in the child’s treatment plan, but no less than:

- Level I - once per week; or
- Level II and Crisis Intervention - twice per week.

Home visits will be conducted as often as necessary to support the foster parent(s) and child in making progress toward the treatment goals. A telephone call may not substitute for a home visit. Home visits must be individually documented to substantiate the service.

**Progress Notes**

The clinical staff person shall write progress notes summarizing the child’s status, program participation, and psychosocial and behavioral skills development as they relate to the treatment plan goals and objectives. Progress notes should be written as needed, but no less frequently than weekly for all levels of care.

**Required Signatures**

Clinicians must sign the summary progress notes as the person responsible for ensuring the provision of service and verification that services were provided in accordance with program policy.

The summary progress note shall be co-signed by the specialized therapeutic foster parent(s).
Specialized Therapeutic Foster Care Service Requirements, continued

### Responsibilities of the Psychiatrist
The psychiatrist assigned to the program must interview the child to assess progress toward meeting treatment goals. The psychiatrist must update the treatment plan on an as-needed basis, but at least:
- Level I - on a quarterly basis; or
- Level II and Crisis Intervention - on a monthly basis.

### School Notification Requirement
Within 10 business days after a child is placed in a specialized therapeutic foster care home, the clinical staff shall provide written notification of the placement to the school district where the student is currently counted for funding purposes and to the receiving school district.

### Level I Specialized Therapeutic Foster Care

#### Description of Level I
Level I is characterized by close supervision of the child within a specialized therapeutic foster home. Services must include clinical interventions by the specialized therapeutic foster parent(s), a clinical staff person, and a psychiatrist.
Level I Specialized Therapeutic Foster Care, continued

Level I Foster Care Child Eligibility Criteria

Level I is for a child with serious emotional disturbance, including a mental, emotional or behavioral disorder as diagnosed by a psychiatrist or other licensed practitioner of the healing arts. The child must meet the diagnostic eligibility criteria described in Number 1 or 2 in Section A, and the child must meet the eligibility criteria described in Number 1 or 2 in Section B.

Section A Criteria:
1. Without specialized therapeutic foster care, the child would require admission to a psychiatric hospital, the psychiatric unit of a general hospital, a crisis stabilization unit or a residential treatment center; or
2. The child has, within the last two years, been admitted to one of these settings.

The child must also meet one of the following criteria:

Section B Criteria:
1. The child has a history of abuse or neglect and serious emotional disturbance. The child’s emotional and behavioral patterns are marked by self-destructive acts, impaired self-concept, heightened aggression, or sexual acting out. Additional signs of social and emotional maladjustment such as lying, stealing, eating disorders, and emotional immaturity may also be identified.
2. The child has a history of delinquent acts and has a serious emotional disturbance. The child may exhibit maladaptive behaviors such as destruction of property, aggression, running away, use of illegal substances, lying, stealing, etc. The child may display impaired self-concept, emotional immaturity or extreme impulsiveness, and limited ability to delay gratification. The child’s social and emotional immaturity impairs decision-making and places the child at risk in a non-therapeutic community setting.

Level I Foster Parents

The treatment needs of the child require that a specialized therapeutic foster parent be available 24 hours per day to respond to crises or to the need for special therapeutic interventions. This may require that one of the foster parents not work outside of the home.

It is strongly recommended that specialized therapeutic foster homes have two parents. If a single parent wishes to become a therapeutic foster parent, special consideration must be given to his or her experience with parenting and the availability of a support network.

Role of Level I Foster Parents

Specialized therapeutic foster parents are considered the primary treatment agents for the implementation of treatment plans in the home. Foster parents must attend all multidisciplinary service planning or treatment plan meetings.
## Level II Specialized Therapeutic Foster Care

<table>
<thead>
<tr>
<th>Description of Level II</th>
<th>Level II is characterized by frequent and intense contact between the specialized therapeutic foster parents, the child, and the professional staff. Level II is intended to provide a high degree of structure, support, supervision, and clinical intervention.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level II Foster Care Child</td>
<td>Level II is for a child who meets the criteria for Level I and has also been diagnosed by a psychiatrist or other licensed health care practitioner of the healing arts as having a serious mental, emotional, or behavioral disorder and who exhibits more severe maladaptive behaviors such as destruction of property, physical aggression toward people or animals, self inflicted injuries and suicide indications or gestures, or an inability to perform activities of daily and community living due to psychiatric symptoms. The child requires more intensive therapeutic interventions and the availability of highly trained specialized therapeutic foster parents.</td>
</tr>
</tbody>
</table>
| Level II Foster Parents | Due to the potential for harm to self or others, a Level II child requires intense supervision from the specialized therapeutic foster parents. The treatment needs of the child require that the specialized therapeutic foster parent be available 24 hours per day to respond to crises or to the need for special therapeutic interventions.  

It is strongly recommended that specialized therapeutic foster homes have two parents. If a single parent wishes to become a specialized therapeutic foster parent, special consideration must be given to his or her experience with parenting and the availability of a support network.  

A Level II specialized therapeutic foster home must have at least one licensed parent who is not employed outside the home and is available 24 hours a day. |
| Role of Level II Foster Parents | Specialized therapeutic foster parents are considered the primary treatment agents for the implementation of treatment plans in the home. Foster parents must attend all multidisciplinary service planning or treatment plan meetings. |
**Crisis Intervention Services**

### Introduction

Specialized therapeutic foster care services may be used for crisis intervention for a child for whom placement must occur immediately in order to stabilize a behavioral, emotional, or psychiatric crisis. The child must be in foster care or commitment status and meet Level I or Level II criteria.

### Temporary Placement

A Level I and Level II specialized therapeutic foster home may be used as a temporary crisis intervention placement for a maximum of 30 days. Any exception to this length of stay must be approved in writing by the multidisciplinary team.

### Comprehensive Behavioral Health Assessment Requirement

A comprehensive behavioral health assessment must be initiated within 10 working days of crisis intervention placement for any child who has not been previously authorized for specialized therapeutic foster care Level I or II placement and has not had a comprehensive behavioral health assessment in the past year.

### Crisis Intervention Placement Decision

For children who reside in Areas not included in the Child Welfare Prepaid Mental Health Plan, approval for a placement must be determined by the Circuit Substance Abuse and Mental Health office and district or regional Child Welfare Community-Based Care lead agency or the Medicaid Area office or the Circuit Substance Abuse and Mental Health program offices or the Department of Juvenile Justice without the involvement of the full multidisciplinary team. An Authorization for Specialized Crisis Intervention Form must be completed and a copy placed in the child’s medical-clinical record.

For children who reside in Areas included in the Child Welfare Prepaid Mental Health Plan and who are not enrolled in the CW-PMHP, approval for placement must be determined by the Community-Based Care lead agency or the Medicaid Area office. An Authorization for Specialized Crisis Intervention Form must be completed and a copy placed in the child’s medical-clinical record.

An authorization form must be completed and placed in the child’s clinical record.

For children who reside in Areas covered by the Child Welfare Prepaid Mental Health Plan and are enrolled in the Child Welfare Prepaid Mental Health Plan, the vendor must authorize approval for crisis intervention services.

An authorization form must be completed and placed in the child’s medical record.

Note: See Appendix F in this chapter for a copy of the Authorization for Crisis Intervention Form.
### Specialized Therapeutic Foster Parent Qualifications and Training

#### Qualifications of Foster Parents

Specialized therapeutic foster care parents must have completed training required of all licensed foster parents and must receive 30 additional clock hours of pre-service, criterion-based training to prepare them to become treatment oriented foster care parents prior to having children placed in the home.

For all Medicaid Areas not included in the Child Welfare Prepaid Mental Health Plan, the district Substance Abuse and Mental Health program office, along with the Area Community-Based Care lead agency or Medicaid Area office enrolled provider, must assure that the therapeutic foster parents meet the qualifications and training requirements before a child is placed in the home and reimbursement is received from Medicaid.

The Child Welfare Prepaid Mental Health Plan is required to ensure that all network providers have met the qualifications and training requirements of this service.

For providers who have not contracted with the Child Welfare Prepaid Mental Health Plan vendor and reside in Medicaid Areas covered by the Plan, the Circuit Substance Abuse and Mental Health office and the provider are required to assure that they have met the qualifications and training requirements of this service.

#### Foster Parent Training Requirements

Foster home parents already licensed by the state must meet one of the following training requirements prior to the child being placed in the home:

- Have received the required 30 hour pre-service training from the provider agency that the parent is currently working with, and pre-service training, or
- Provide documentation of having received the required 30 hour pre-service or commensurate training. If this training was received from another provider agency, the foster parent must receive program orientation from their current provider prior to placement of any specialized therapeutic foster care children in their home commensurate training within the last two years.
Specialized Therapeutic Foster Parent Qualifications and Training, continued

<table>
<thead>
<tr>
<th>Pre-Service Training Components</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For Medicaid Areas covered by the Child Welfare Prepaid Mental Health Plan,</strong> the Child Welfare Prepaid Mental Health Plan vendor will approve the content of the pre-service training for network providers, as described below.</td>
</tr>
</tbody>
</table>

**For providers who reside in Medicaid Areas covered by the Child Welfare Prepaid Mental Health Plan, but have not contracted with the vendor of this plan, the Medicaid Area office must approve the content of the pre-service training.**

**For all Medicaid Areas not included in the Child Welfare Prepaid Mental Health Plan, the content of the pre-service training must be approved by the Substance Abuse and Mental Health program office Medicaid Area office and the Community-Based Care lead agency. The training must address at least the following areas:**

- Program orientation including the responsibilities of the treatment parent and provider agency;
- Normal childhood development;
- Emotional disturbances in children and common behavioral problems exhibited;
- Behavior management, theory and skills;
- Discipline, limit-setting, logical consequences, problem-solving, and relationship building skills;
- Communication skills;
- Permanency planning;
- Stress management;
- Crisis intervention and emergency procedures;
- Self-defense and passive physical restraint;
- Working with biological or adoptive families;
- Placement adjustment skills;
- Confidentiality;
- Cultural competency; and
- Behaviors and emotional issues of children who have been sexually abused.
**Specialized Therapeutic Foster Parent Qualifications and Training**, continued

**Other Care Providers**

Care providers other than the specialized therapeutic foster parents (e.g., baby sitters) must have the information and training necessary to properly care for the child and must be prior approved in writing by the clinical staff person. Information and training necessary to care for the child. In addition, clinicians must ensure that specialized therapeutic foster care services will not be compromised in any way as a result of receiving other care. Other care providers must be pre-approved in writing by the Clinical Staff person and approval documentation must be placed in the foster parents’ file, and in the child’s file.

**In-Service Training**

Specialized therapeutic foster parents must receive ongoing in-service training from clinical staff to support, enhance, and improve their treatment skills and strengthen their abilities to work with specific children. In-service training should be provided as often as needed, but not less than:

- **Level I** - 4-8 clock hours per quarter every 6 months; and
- **Level II** - 6-12 clock hours per quarter every 6 months.

If the minimum required training hours are exceeded in a given quarter, they cannot be carried over into the next quarter.

**Absences from the Specialized Therapeutic Foster Home**

**Absences from the Specialized Therapeutic Foster Home**

Medicaid reimbursement is not available for days a child is away from the delivery of specialized therapeutic foster care services, except for approved therapeutic visits, hospitalizations, or other crisis placements.

**Therapeutic Visits**

These are visits the child spends away from the specialized therapeutic foster family with the biological, adoptive or extended family, or potential placement setting.

Therapeutic visits must be prior authorized by the clinical staff person and recorded in the child’s medical record.

Therapeutic visits may include time spent away overnight with friends, school, or club activities. These visits are planned in conjunction with the child’s treatment goals and objectives. Specialized therapeutic foster parents must be accessible and must maintain a level of communication during such visits as determined by the clinical staff person.

**Reimbursement for Therapeutic Visits**

Medicaid can reimburse up to 10 days per calendar quarter (three months) except under the circumstances described in the next section. Medicaid will reimburse therapeutic visits only when the specialized therapeutic foster parents maintain a home for and contact with the child as described above.
### Absences from the Specialized Therapeutic Foster Home, continued

<table>
<thead>
<tr>
<th>Therapeutic Visits Prior to Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the last three months prior to a planned discharge to a child’s biological family or other permanent placement, Medicaid will reimburse for a graduated number of therapeutic visits.</td>
</tr>
<tr>
<td>Three months prior to discharge, Medicaid will reimburse up to a total of 5 therapeutic visits to the discharge placement setting.</td>
</tr>
<tr>
<td>Two months prior to discharge, Medicaid will reimburse for up to a total of 8 therapeutic visits to the discharge placement setting.</td>
</tr>
<tr>
<td>In the final month prior to discharge, Medicaid will reimburse for up to a total of 12 therapeutic visits to the discharge placement setting.</td>
</tr>
<tr>
<td>The schedule for graduated therapeutic visits with the biological family or other permanent placement setting must be prior approved by the multidisciplinary team and included in the child’s medical record.</td>
</tr>
<tr>
<td>The specialized therapeutic foster parents will maintain contact with the child and the receiving placement as determined by the child’s treatment team.</td>
</tr>
<tr>
<td>No other child may be placed in the bed of a child who is away on therapeutic visits.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vacations with Specialized Therapeutic Foster Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid will reimburse for specialized therapeutic foster care services during vacations provided that treatment continues during vacation and any special arrangements have been pre-approved in writing by the multidisciplinary team. Arrangements for contact with the child’s clinician during vacation must be made in advance. Every effort must be made to schedule the clinician’s home visits prior to the vacation. If this is not possible, the clinician must make telephone contact during the vacation. The cost of the phone calls is the responsibility of the provider agency. Documentation of any special arrangement must be maintained in the child’s medical record.</td>
</tr>
</tbody>
</table>
Absences from the Specialized Therapeutic Foster Home, continued

**Hospital and Crisis Stabilization Unit Placements**

Medicaid may reimburse for specialized therapeutic foster care services during a hospitalization or other crisis placement of no more than 14 days duration per hospitalization. Specialized therapeutic foster care services will be reimbursed during no more than a total of four hospitalizations or crisis stabilization unit placements per specialized therapeutic foster home placement.

Specialized therapeutic foster parents must be accessible and must maintain a level of communication during such placements as determined by the clinical staff person.

If a child experiences more than one crisis placement within a six-month period, the child’s multidisciplinary team must convene and complete a reassessment of the child’s plan to assure that the plan is meeting the child’s needs.

**Juvenile Detention Center Placements**

Medicaid will not reimburse a provider for days when a child is in a Juvenile Justice detention center.

**Unauthorized Absences**

Medicaid may reimburse for up to three days during times when a placement is being maintained for a child who has an unauthorized absence (i.e., runs away) from the therapeutic foster home.

**Reimbursement Restrictions**

**Public School and Summer Activities**

Medicaid may reimburse the following services in addition to specialized therapeutic foster care services only when provided as part of a public school program or summer activities program. These services may not be reimbursed when provided in the child’s foster home.

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Behavioral Onsite Services — Therapy</td>
<td>H2019</td>
<td>HO</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services — Behavior Management</td>
<td>H2019</td>
<td>HM</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services — Therapeutic Support Services</td>
<td>H2019</td>
<td>HN</td>
</tr>
<tr>
<td>Behavioral Health Day Services</td>
<td>H2012</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Day Services</td>
<td>H2012</td>
<td>HF</td>
</tr>
</tbody>
</table>

**Psychiatric Services**

Medicaid may reimburse medical or psychiatric services only when the treatment plan requires services by a psychiatrist more than once per month.
### Reimbursement Restrictions, continued

<table>
<thead>
<tr>
<th>Non-reimbursable Services</th>
<th>Psychosocial rehabilitative services will not be reimbursed as a separate service by Medicaid for children receiving specialized therapeutic foster care services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair Hearing Notices</td>
<td><strong>If the Agency for Health Care Administration must provide, if services are decreased or re-authorization is not provided, the multidisciplinary team lead will provide a fair hearing notice pursuant to 42 C.F.R. 431.206 will be provided.</strong> The notice will be sent at least 10 days prior to the service reduction or termination to the child, the child’s foster parents, the child’s attorney (if one exists), and the child’s guardian ad litem (if one exists).</td>
</tr>
</tbody>
</table>
SECTION 64
THERAPEUTIC GROUP CARE SERVICES

Description, Purpose and Goals of Therapeutic Group Care Services

Description
Therapeutic group care services are community-based psychiatric residential treatment services designed for children and adolescents with moderate to severe emotional disturbances. They are provided in a licensed residential group home setting serving no more than 12 children and adolescents. Treatment includes provision of psychiatric, psychological, behavioral and psychosocial services to Medicaid eligible children who meet the specified clinical criteria described in this section. Therapeutic group care is intended to provide a high degree of structure, support, supervision, and clinical intervention in a home-like setting.

Therapeutic group care services are a component within Florida Medicaid’s behavioral health system of care for children. They are appropriate for children and adolescents who are ready for step-down or transition from a more restrictive residential treatment program or for those who require more intensive community-based treatment to avoid placement in a more restrictive residential treatment setting.

The services are designed to provide a therapeutic framework of daily living for children and adolescents. The child’s primary diagnosis and level of functioning are the reasons for treatment and the focus of the interventions and services provided. Generally, these services include psychiatric and therapy services, therapeutic supervision and the teaching of problem solving skills, behavior strategies, normalization activities, and other treatment modalities, as authorized in the treatment plan.

Services are highly supportive, individualized, and flexible and are designed to maximize a child’s strengths and reduce behavior problems or functional deficits stemming from a mental health disorder. These services occur in a home-like setting, and include participation of family or guardian and appropriate involvement in the community and school. The young people being served spend a significant amount of time in the community, attending school, and engaging in school and community recreational or vocational activities. Generally, services cover a period of up to 12 months. Behavioral health overlay services (procedure code) are mental health and substance abuse services designed to meet the behavioral health treatment needs of recipients who are placed in the care of Medicaid enrolled, certified residential group care agencies under contract with the Department of Children and Families or a Community Based Care organization. Medicaid behavioral health overlay services enable providers to be reimbursed for medically necessary behavioral health services that are provided as an overlay to the residential care and supervision services that are reimbursed under contract with the Department of Children and Families or Community Based Care organization.

Purpose

Therapeutic group care services are intended to support, promote and enhance competency and participation in normal age-appropriate activities of children and adolescents who present moderate to severe psychiatric, emotional or behavioral management problems related to a psychiatric diagnosis. Programming and interventions are highly individualized and tailored to the age and diagnosis of the child. Generally, services cover a period of up to 12 months.

Description, Purpose and Goals of Therapeutic Group Care Services, continued

Goals and Anticipated Outcomes

The goal of therapeutic group care services is to enable a young person to self-manage, and work towards resolution of, emotional, behavioral or psychiatric problems towards the long-term goal of returning to a normalized living situation with a family, foster family, in a residential group care setting or an independent living situation.

Anticipated outcomes of therapeutic group care services are:

- Improved emotional, mental, and functional status;
- Increased ability to live safely, attend school, and be an active member in an inclusive community environment;
- Increased likelihood of a successful transition to a family or less restrictive community setting; and
- Increased capacity for independent living, if developmentally appropriate.
**Provider Requirements for Therapeutic Group Care Services**

<table>
<thead>
<tr>
<th>Provider Agency</th>
<th>Eligibility Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>In addition to</td>
<td>A provider of therapeutic group care services must first enroll in Medicaid as a community behavioral health services provider.</td>
</tr>
</tbody>
</table>

**Note:** The community behavioral health services provider enrollment requirements can be found in Chapter 1 of this handbook. These enrollment requirements include successfully completing the community behavioral health services provider pre-enrollment certification review. Provider enrollment requirements in Chapter 1 of this handbook including achieving compliance on the community behavioral health services provider pre-enrollment certification review, also:

- Be designated by the district or regional Department of Children and Families, Substance Abuse and Mental Health program office, as a therapeutic group care provider;
- Be properly licensed in accordance with Chapter 394, F.S., and Chapter 65E-9C-14, F. A. C., by the Agency for Health Care Administration, and
- Submit the Provider Agency Acknowledgement form for Therapeutic Group Care Services (Appendix J) to the Agency as specified on the form.

The Agency for Health Care Administration will send the provider a letter that acknowledges receipt of Appendix J the form and confirms initial certification.

- The provider’s executive director must complete the form. By signing the form, the executive director attests that the provider conducted a review of the site for which the certification is being requested, and meets the Medicaid criteria for providing therapeutic group care services. The Medicaid Area office will conduct an initial certification review at the site, before the provider can bill for therapeutic group care services.

**Note:** See Appendix J for a copy of the Provider Agency Acknowledgement form for Therapeutic Group Care Services. Send form to:

- Agency for Health Care Administration
- Medicaid Services
- Behavioral Health Unit TGC
- 2727 Mahan Drive, Mail Stop 20

- Tallahassee, Florida 32308 Be certified by the district or regional Department of Children and Families, district Substance Abuse and Mental Health and Child Welfare and Community Based Care program offices, and the area Medicaid office, as meeting specific criteria for providing therapeutic group care services and have a Therapeutic Group Care Provider Agency Certification Form completed and signed by the designated Substance Abuse and Mental Health program office, the Child Welfare and Community Based Care program office and area Medicaid field office.

Medicaid fee-for-service providers are subject to monitoring by the Agency for Health Care Administration.

For providers who contract with the Child Welfare Prepaid Mental Health Plan, the providers are subject to monitoring by the CWPMHP vendor.

**Note:** See Appendix K for a copy of the Therapeutic Group Care Provider Agency Certification Form.
**Provider Requirements for Therapeutic Group Home Services, continued**

**Provider Agency Certification in Areas Covered by CWPMHP**

**Therapeutic Group Home Services Certification Process**

For providers located in AHCA Areas covered by the Child Welfare Prepaid Mental Health Plan, the Agency for Health Care Administration representative and the Child Welfare Prepaid Mental Health Plan vendor or designee will initially certify the therapeutic group care providers within approximately 6 months. If the program site is in compliance, the provider will receive a Provider Agency Certification form signed by the Medicaid representative.

If the program is found to be non-compliant, the provider must complete a corrective action plan within 30 days in order to continue billing for services. If the program remains non-compliant with the certification criteria, certification will be withdrawn within six months from the date that the corrective action plan was requested. The providers must be recertified annually through the Medicaid Area office.

Note: See Appendix K for a copy of the Therapeutic Group Care Services Provider Agency Certification form. For Areas not covered by the Child Welfare Prepaid Mental Health Plan, the Agency for Health Care Administration will certify the therapeutic group care providers within approximately 6 months. The Medicaid provider must submit a Provider Agency Self-Study for Therapeutic Group Home Services form to:

Agency for Health Care Administration
Medicaid Services
Behavioral Health Unit-TGC
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308

The provider’s executive director must sign the form. By signing the form, the executive director is giving assurances that the provider conducted a review of the site for which the certification is being requested and that the site meets the provider qualifications, including current enrollment in Medicaid, and all other certification criteria (see Certification Criteria for Therapeutic Group Home Services in this section for a description of the requirements). Based on the provider’s assurances, district Substance Abuse and Mental Health program office, in coordination with the Child Welfare and Community Based Care program office and the area Medicaid office will conduct an initial certification review prior to implementation of billing for therapeutic group care services at the site.

Note: See Appendix J for a copy of the Provider Agency Self-Study for Therapeutic Group Care Services form.
Provider Requirements for Therapeutic Group Home Services, continued

**Provider Agency Certification Process**

Within approximately six months of the agency's initial certification, the district Substance Abuse and Mental Health program office, in coordination with the Child Welfare and Community-Based Care program office and the area Medicaid office, will survey each program to determine that it continues to meet the certification criteria (see Certification Criteria in this section for a description of the requirements).

The site must be in 90 percent compliance with program requirements in order to receive an annual certification form signed by the reviewing entity. If the site does not reach this level of 100 percent compliance for critical requirements, the agency must develop and implement a performance improvement plan for deficient items. These items must be corrected to bring the site into acceptable compliance with standards before a provider certification for therapeutic group care services can be granted.

**Provider Agency Certification in Areas Not Covered by CWPMHP**

For providers located in AHCA Areas not covered by the Child Welfare Prepaid Mental Health Plan, the Agency for Health Care Administration representative will initially certify the therapeutic group care providers within approximately 6 months. If the program site is in compliance, the provider will receive a Provider Agency Certification form signed by the Medicaid representative.

If the program is found to be non-compliant, the provider must complete a corrective action plan within 30 days in order to continue billing for services. If the program remains non-compliant with the certification criteria, certification will be withdrawn within six months from the date that the corrective action plan was requested.

Note: See Appendix K for a copy of the Therapeutic Group Care Services Provider Agency Certification form.

**Annual Certification of Providers**

Providers must be re-certified annually by the designated district or regional Substance Abuse and Mental Health, Child Welfare and Community Based Care and area Medicaid offices as meeting the specific qualifications to provide therapeutic group care services. Providers must complete performance improvement plans to correct deficiencies found during the review process. Certification will be withdrawn if the provider fails to meet the specific qualifications to provide these services.
Service Requirements Certification Criteria for Therapeutic Group Care Providers

To be certified to provide therapeutic group care, a provider must demonstrate the administrative and clinical capacity to operate as a therapeutic group care provider by meeting the criteria—service requirements listed in this section.

The criteria—service requirements cover the following areas, which are described in detail in the following sections:

- Required Capabilities of Therapeutic Group Care Services Providers
- Services to be Provided
- Quality Improvement Assurance Program Requirements
- Required Policies and Procedures
- Staff Qualifications and Training

Required Provider Capabilities of Therapeutic Group Care Services

The provider of therapeutic group care must be able to provide:

1. A home-like, therapeutic group care setting serving no more than 12 children and adolescents;
2. A therapeutic environment with an identified treatment orientation described and supported in the literature that is understood by all staff and by the children;
3. Psychiatric services and clinical assessment, treatment planning, and therapy services by qualified staff, per requirements in this section;
4. Consistent implementation of programmatic policy by administrative, clinical and direct care staff within the therapeutic group care program;
5. A range of age-appropriate indoor and outdoor recreational and leisure activities, including activities for nights and weekends, based on group and individual interests and developmental needs;
6. Access to, and coordination with, an accredited educational program for each child that complies with State Board of Education Rule 6A-15, F.A.C.;
7. Access to and coordination with primary care health care providers;
8. Behavioral programming that is individually designed and implemented and includes structured interventions and contingencies to support the development of adaptive, pro-social interpersonal behavior;
9. Psychiatric crisis management with demonstrated 24-hour response capability with access to acute care setting and behavioral health emergency management services.
Service Requirements for Therapeutic Group Care Providers, continued

Therapeutic group care providers must provide the following services:

1. Thorough psychiatric, psychological, substance abuse and biopsychosocial assessments including assessment of the child or adolescent’s strengths and needs, including the strengths and needs of involved family members and other natural supports;

2. Individualized treatment planning with services based on thorough assessments developed by the provider’s treatment team incorporating all components of a child’s treatment program, including psychiatry;

3. Assignment of each recipient to a primary clinician who is responsible for the overall coordination and monitoring of the recipient’s treatment;

4. Provision of individualized face-to-face therapeutic contact for each child with the primary clinician twice weekly with more frequent contacts per week as indicated by the child’s needs;

5. Individual and group therapy by the primary clinician, as prescribed in the treatment plan;

6. Family therapy or counseling with the clinician, or contact with the child’s guardian, at least weekly, based on the child’s treatment needs and permanency plan with documentation in the child’s record of the circumstances whenever this contact has not occurred;

7. Provision of substance abuse prevention, assessment and treatment services whenever indicated;

8. Provision of social and rehabilitative services when indicated and prescribed in the child’s individualized treatment plan;

9. Supportive and psycho-educational services that promote increased capacity for independent living for older adolescents; behavioral programming that is individually designed and implemented and includes structured interventions and contingencies to support the development of adaptive, pro-social interpersonal behavior;

10. Psychiatric crisis management with demonstrated 24-hour response capability with access to acute care setting and behavioral health emergency management services;

11. Services to integrate the child into the community including promoting and facilitating participation in extracurricular activities, such as community athletic leagues, Scouts, music lessons and other individualized activities based on the child’s strengths and interests, predicated on the child’s ability to self-manage behavior in order to participate;

12. Discharge and aftercare planning;

13. At least monthly review of a child’s treatment plan for effectiveness and appropriateness;

14. Review and re-authorization of each child’s needs for therapeutic group care services every six months by the designated circuit or regional district level multidisciplinary team; and

15. Coordination of care that includes linkages with the schools, primary medical care, and community services for children and adolescents.
Service Requirements for Therapeutic Group Care Providers, continued

<table>
<thead>
<tr>
<th>Quality Improvement Assurance Program Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider must have a quality improvement assurance program that evaluates the effectiveness and outcomes of the behavioral health services it provides. The quality improvement assurance policies and procedures must address:</td>
</tr>
<tr>
<td>1. Monitoring of behavioral health treatment planning and implementation;</td>
</tr>
<tr>
<td>2. Treatment plan review and assessment of progress at least monthly;</td>
</tr>
<tr>
<td>3. Ongoing review of treatment staff performance;</td>
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<tr>
<td>4. Review of medication administration and monitoring;</td>
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<tr>
<td>5. The interface with primary care providers;</td>
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<tr>
<td>6. Implementing and documenting pre-service and ongoing staff training that improves and supports the delivery of high level therapeutic service;</td>
</tr>
<tr>
<td>7. Maintaining procedures for gathering data and reporting on outcomes related to assessment of clinical status, behavioral functioning and the recipient's academic performance in school;</td>
</tr>
<tr>
<td>8. Quality and effectiveness of treatment services with children and their families;</td>
</tr>
<tr>
<td>9. Quality and effectiveness of aftercare planning; and</td>
</tr>
<tr>
<td>10. Quality and degree of involvement of children and adolescents in extracurricular activities in the community.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Policies and Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider must have policies and procedures that promote good therapeutic practice, provide for appropriate treatment plans and documentation, and protect the rights of children and families. Policies and procedures must be in place that address the following:</td>
</tr>
<tr>
<td>1. Thorough screening, evaluation, and diagnosis of symptoms, risks, functional status, and co-morbidity;</td>
</tr>
<tr>
<td>2. Therapeutic crisis intervention and procedures to transfer the recipient to a more restrictive level of care such as a hospital, crisis stabilization unit or an inpatient psychiatric program if clinically appropriate;</td>
</tr>
<tr>
<td>3. Treatment teams that are responsible for organizing the delivery of therapeutic services;</td>
</tr>
<tr>
<td>4. Individualized treatment plans that are integrated into the activities of daily living associated with therapeutic group care treatment;</td>
</tr>
<tr>
<td>5. Inclusion of the recipient’s family, guardian, or guardian agency in the clinical treatment process;</td>
</tr>
<tr>
<td>6. Documentation of services provided, including notes on each clinician’s therapeutic contact with a child; daily summary by direct care staff, and weekly notes by any ancillary staff on the child’s treatment. Documentation must relate to the recipient's progress in meeting individual goals and objectives as included in the treatment plan.</td>
</tr>
<tr>
<td>7. A monthly summary note is required to document the overall progress of the child in therapy and in the therapeutic milieu and report on contacts with the child’s family, community, school and activity program or include input from the child’s case manager relating to these entities;</td>
</tr>
</tbody>
</table>
Certification Criteria

Service Requirements for Therapeutic Group Care Providers, continued

Required Policies and Procedures, continued

8. Medical management of recipients who require psychotropic medical intervention;
9. Medication administration, training, monitoring and storage;
10. Prohibition of the use of mechanical restraints and seclusion;
11. The use of time out;
12. Clinical discharge and aftercare planning that are coordinated with the permanency plan and support development of independent living skills when developmentally appropriate;
13. An internal review process for determining the recipient’s continued eligibility and need for therapeutic group care services, on at least a monthly basis;
14. The clinical management of specific types of emotional and behavioral problems encountered by recipients served in the facility; and
15. A clinical supervision protocol that assures timely monitoring of services and modification of treatment as needed through at least weekly, documented supervision of non-licensed therapists.

16. **Within 10 business days after a recipient is placed in a therapeutic group care home, the facility shall provide written notification of the placement to the school district where the student is currently counted for funding purposes and the receiving school district.**

School Notification Requirement

Within 10 business days after a recipient is placed in a therapeutic group care home, the facility shall provide written notification of the placement to the school district where the student is currently counted for funding purposes and the receiving school district.

Focus and Intensity of Therapeutic Group Care Services

The focus of the services reimbursed under therapeutic group care services must be directly related to the recipient’s mental health or substance abuse condition.

The intensity and individual utilization of treatment services must be determined by, and must be directly related to, the child’s specific needs as identified in the individualized treatment plan. Services must be provided in accordance with the child’s individualized treatment plan and reflected in the clinical record.
### Staffing Requirements

<table>
<thead>
<tr>
<th>Staff Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider’s staffing roster must demonstrate that an adequate number of funded positions exist to meet the staff requirements for therapeutic group care services. Sufficient numbers and types of qualified staff shall be on duty and available at all times to provide necessary and adequate safety and care.</td>
</tr>
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<thead>
<tr>
<th>Management Staff Requirements</th>
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</thead>
<tbody>
<tr>
<td>The provider’s management staff must have appropriate experience and capability to administer effective, ongoing operations of therapeutic group services.</td>
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</table>

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<thead>
<tr>
<th>Program Director Qualifications</th>
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</thead>
<tbody>
<tr>
<td>The program director must have a master’s degree in a professional discipline such as social work, psychology, counseling, or special education and have at least two years’ administrative experience. Persons already in this position on October 1, 2002, were grandfathered in under these standards. Persons already in this position on October 1, 2002, may be grandfathered in under these standards.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Services Coordinator Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>A person in this position must meet the qualifications of a licensed mental health practitioner of the healing arts.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Services Coordinator’s Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The clinical services coordinator, in consultation with the program director, has lead responsibility for coordinating clinical services provided in the group home setting. The coordinator is responsible for oversight of planning and implementation of mental health services, including managing treatment team meetings, assessing clinical training needs and monitoring the quality of therapeutic and aftercare planning services.</td>
</tr>
</tbody>
</table>

This person may authorize treatment plans if individually enrolled in the Medicaid Behavioral Health Program.

If the clinical services coordinator serves as a program director, works less than full-time or provides supervision to non-licensed staff and carries a caseload, the caseload must be adjusted for appropriate coverage of these other duties. Documentation of responsibilities, allocation of contracted hours and caseload must be recorded in the personnel file. Each child must receive an average of 3.3 hours of clinical staff time allocated weekly for clinical, family and collateral work. |
## Clinical Staff Requirements, Qualifications and Responsibilities

### Psychiatrist

The provider must have a psychiatrist(s) on staff or under contract.

### Psychiatrist Qualifications

The psychiatrist must be a medical doctor or doctor of osteopathy, licensed pursuant to Chapter 458 or 459, F.S., and:

- Be board certified or board eligible and licensed pursuant to Chapter 458 or 459, F.S.;
- Have a specialty in child psychiatry;
- Have a minimum of two years employment experience working directly with children who are emotionally disturbed; and
- Have a list of current (within the past two years) conferences, workshops attended, and CEs earned, dedicated to relevant child and family treatment issues.

### Psychiatrist Responsibilities

Responsibilities of the psychiatrist include:

- Interviewing each child to assess progress toward meeting treatment goals monthly, or more often if medically necessary;
- Managing and authorizing services to recipients if this responsibility is not carried out by a licensed mental health practitioner;
- Supervising treatment for recipients who are on psychotropic medications, in coordination with the primary health care physician, when indicated by a child’s medical condition; and
- Serving as an active member on the multidisciplinary treatment team.

### Delegation of Responsibilities

The psychiatrist’s responsibilities may be carried out by a psychiatric ARNP who meets the qualifications in Chapter 1 of this handbook.

### Nursing Staff

The provider shall have a nurse on staff, under contract or have a definitive written agreement for nursing services to carry out responsibilities below.

### Nurse Qualifications

The nurse must be a Florida licensed registered nurse or a Florida licensed practical nurse with at least one year of experience who is working under the supervision of a registered nurse and performing duties as allowed under clinical protocol and licensure.
Clinical Staff Requirements, Qualifications and Responsibilities, continued

Responsibilities of the Nursing Staff

Responsibilities of nursing staff include:

- Monitoring the health and dental needs of children in care;
- Arranging for needed medical care and treatment;
- Monitoring monthly heights and weights for children;
- Monitoring for follow-up of doctor-ordered treatment and laboratory tests;
- Updating parents or guardian as needed regarding youth’s health status;
- Attending treatment team meetings, particularly for review of children with medically complex issues;
- Performing necessary nursing services and providing on-call services as necessary;
- Monitoring for compliance with infection control requirements;
- Monitoring that medications are properly stored, medication logs are properly completed, and only properly trained direct care staff administer medications, per program policy;
- Serving as resource person providing health information to children, family and legal guardians individually or in a group.

Behavior Analyst

The provider must have a behavior analyst on staff or under contract. If a staff person, such as the clinical coordinator, program director or clinician meets the qualifications of a behavior analyst, that person may serve in this capacity if these job responsibilities are included in his or her job description and time is allocated for carrying out these responsibilities.

Behavior Analyst Qualifications

The person serving in this position must have a master’s degree from an accredited college or university in counseling, social work, psychology, rehabilitation or special education or in a related human services field, and three years experience in behavior management program design and implementation or be certified in behavior analysis.

Behavior Analyst Job Responsibilities

Responsibilities of the behavior analyst include:

- Reviewing and approving the group home’s behavior management system;
- Reviewing and signing the behavior management components of the individualized treatment plan;
- Consulting with the staff who are implementing an individualized behavioral management program for a child or adolescent; and
- Training direct care staff, counselors, and administrators on behavioral management principles and application.

Clinical Staff Qualifications

All therapists, licensed practitioners, behavior analysts, and psychiatrists providing therapeutic group services must meet the specific education and training requirements described in this chapter.
Clinical Staff Requirements, Qualifications and Responsibilities, continued

<table>
<thead>
<tr>
<th>Primary Clinician</th>
<th>Recipients receiving therapeutic group care services must be assigned a primary clinician who is one of the following:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>• Licensed Psychologist;</td>
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<tr>
<td></td>
<td>• Licensed Psychiatric Nurse;</td>
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<tr>
<td></td>
<td>• Licensed Clinical Social Worker;</td>
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<td>• Licensed Mental Health Counselor;</td>
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<td></td>
<td>• Licensed Marriage and Family Therapist; or</td>
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<td></td>
<td>• Mental Health Professional.</td>
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</tbody>
</table>

**Note:** Refer to Staff Qualifications for Comprehensive Behavioral Health Assessment in Chapter 2, Section 2 of this handbook for the specific education and training requirements for these individuals.

**Note:** If a non-licensed mental health professional serves as a clinical staff person, this individual must receive documented weekly clinical supervision by a licensed mental health professional. A non-licensed mental health professional is not authorized to assign a diagnosis to a child or adolescent.

**Note:** Non-licensed professionals with a master’s degree and at least two years of experience working with emotionally disturbed children and their families, who are already in this position on October 1, 2002, were grandfathered in under these standards. On staff on October 1, 2002, may be grandfathered in as clinical staff under these standards.

| Caseload of Clinicians | The clinical staff person’s maximum caseload size may be less than but must not exceed 12 children. This caseload requirement is based on a 40-hour work week. |
Clinical Staff Requirements, Qualifications and Responsibilities, continued

<table>
<thead>
<tr>
<th>Responsibilities of the Clinician</th>
<th>The primary clinician is directly responsible for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Evaluating and assessing the children who are receiving services, on at least a monthly basis, documenting findings in the monthly note and arranging for further assessment when indicated;</td>
</tr>
<tr>
<td>2.</td>
<td>Contributing to and participating in the preparation of a treatment plan;</td>
</tr>
<tr>
<td>3.</td>
<td>Authorizing the treatment plan, if enrolled as a licensed mental health practitioner of the healing arts; if not licensed, reviewing and signing the treatment plan prior to the psychiatrist’s or other licensed professional’s authorization;</td>
</tr>
<tr>
<td>4.</td>
<td>Providing individual, group and family therapy;</td>
</tr>
<tr>
<td>5.</td>
<td>Providing in-service training to assist staff in developing the knowledge and skills necessary for the delivery of services authorized in the treatment plan;</td>
</tr>
<tr>
<td>6.</td>
<td>Supervising, if licensed, the performance of any non-licensed senior mental health professionals or mental health practitioners, including work with the Department of Children and Families, district or regional Child Welfare and Community Based Care office, to promote coordination of the group care services with other treatment initiatives, including school performance, permanency and reunification planning;</td>
</tr>
<tr>
<td>7.</td>
<td>Preparing and working with the child’s biological or legal parents through family therapy to resume or assume care of their child when reunification is the goal;</td>
</tr>
<tr>
<td>8.</td>
<td>Working with the child’s targeted case manager, if one has been assigned;</td>
</tr>
<tr>
<td>9.</td>
<td>Conducting visits to other community settings to observe the child’s behavioral, psychological, and psychosocial progress and to coordinate treatment intervention;</td>
</tr>
<tr>
<td>10.</td>
<td>Training of direct care staff in the implementation of the individualized treatment plan for services;</td>
</tr>
<tr>
<td>11.</td>
<td>Monitoring the overall course of treatment services and observing and documenting on a monthly basis, the direct care staff’s implementation of the recipient’s individualized treatment plan;</td>
</tr>
<tr>
<td>12.</td>
<td>Convening treatment team meetings as scheduled or as needed;</td>
</tr>
<tr>
<td>13.</td>
<td>Developing the recipient’s behavioral health discharge plan and aftercare plan; and</td>
</tr>
<tr>
<td>14.</td>
<td>Serving as a liaison with the district Substance Abuse and Mental Health program office and the district Child Welfare and Community Based Care program office, if indicated, multidisciplinary team lead.</td>
</tr>
</tbody>
</table>
# Direct Care Staff Requirements, Qualifications and Responsibilities

## Direct Care Staff Qualifications
Direct care staff employed to work directly with children in the therapeutic group home shall be of at least 18 years of age and have a high school diploma or GED certificate. Direct care staff must also receive pre- and in-service training as described below. Staff employed continuously by the provider since before October 1, 2002, who do not meet the above education criteria, may continue to work at their current place of employment.

## Responsibilities of Direct Care Staff
Direct care staff are responsible for:

- Providing support in activities of daily living, as appropriate;
- Implementation of individual treatment plans;
- Observation of children and adolescents for side effects of medication;
- Attending treatment team meetings and providing information on the adjustment of the child or adolescent in the group home;
- Interacting and sharing observations with clinicians on the child’s responses to the treatment plan; and
- Completing a daily progress note on each child.

## Direct Care Staff-to-Child Ratio
The provider must comply with the following direct care staff-to-child ratios:

- At a minimum, two direct care staff shall be awake and on duty at all times for therapeutic, safety and risk management purposes.
- If there are more than eight children in a home, a third direct care staff must be on duty during hours when children are normally awake.
- No less than two awake staff must be on duty for up to 12 children when children are normally asleep.
- Direct care staff shall not divide time on shifts between programs located in other areas or other buildings.
- At least one staff on duty at all times has been trained in CPR.
- Prior to a single staff person transporting one or more children in a motor vehicle, children must be assessed as being behaviorally in good control; otherwise additional staff must be assigned to ensure the safety of the children and staff.
Staff Orientation and Training

The provider must comply with the following staff and orientation and training requirements including all requirements of Chapter 65E-9, F.A.C.

- The provider shall have and regularly update a written plan for the orientation, ongoing training, and professional development of staff.
- The provider shall implement orientation and training programs for all new employees and ongoing staff training to increase knowledge and skills and improve quality of care and treatment services.
- The provider shall conduct orientation for each new employee during the first two weeks of employment. The orientation shall include specific job responsibilities, policies and procedures, care and supervision of children.
- Competency-based first aid and CPR training must be provided within the first month. At least one staff person on each shift must be trained in these procedures.
- The provider shall document training received by staff, including staff name and position, training subject, date completed and signature of instructor. The documented training shall be filed in the staff member’s personnel record.
- The provider shall implement a minimum of 40 hours of in-service training annually for all staff who work directly with children and a minimum of 20 for volunteers who work directly with children. This training shall cover all policies and procedures relevant to each position and shall, at a minimum, include:
  - Administrative issues:
    - Administrative policies and procedures and overall program goals;
    - Federal and state laws and rules governing the program;
    - Treatment plan development and implementation;
    - Discharge and aftercare planning;
    - Identification and reporting of child abuse and neglect; and
    - Protection of children’s rights.
  - Safety Issues:
    - Disaster preparedness and evacuation procedures;
    - Fire safety;
    - Group home safety;
    - Emergency procedures;
    - Violence prevention and suicide precautions;
    - Self-defense and passive physical restraint; and
    - First aid and CPR, with competency demonstrated annually.
Staff Orientation and Training Requirements, continued

Staff Orientation and Training, continued

- Child development
  - Child supervision skills;
  - Children's physical and emotional needs;
  - Developmental stages of childhood and adolescence;
  - Family relationships and the impact of separation;
  - Permanency planning;
  - Impact of trauma;
  - Substance abuse recognition and prevention; and
  - Principles and practices of child care.

- Treatment services
  - Individualized treatment that is culturally competent;
  - Treatment that addresses issues the child may have involving sexual or physical abuse, abandonment, domestic violence, separation, divorce, or adoption;
  - Treatment that supports the child's permanency goals.

Focus and Intensity of Service Requirement

Therapeutic Visits

Therapeutic visits are visits of more than 24 twenty-four consecutive hours away from the therapeutic group home with the child's biological, adoptive or extended family, or potential placement setting. Therapeutic visits must be prior authorized by the clinical staff person and recorded in the child's medical record. Therapeutic visits may include time spent away overnight with friends, school, or club activities. These visits are planned in conjunction with the child's treatment goals and objectives. Therapeutic group care staff must be accessible and must maintain a level of communication during such visits as documented and determined by the clinician.
Focus and Intensity of Service Requirement – continued

Reimbursement for Therapeutic Visits

Medicaid will reimburse the therapeutic group care provider for therapeutic visits up to 10 days per calendar quarter increasing up to 21 days during the last quarter prior to discharge as described below. Medicaid will reimburse therapeutic visits only when the therapeutic group home maintains a bed and contact with the child as described above.

During the last three months prior to a planned discharge to a child’s biological family or other placement, Medicaid will reimburse the therapeutic group care provider for a graduated number of therapeutic visits. Three months prior to discharge, Medicaid will reimburse up to a total of five therapeutic visits to the discharge placement setting. During the second to the last month and the last month of a child’s stay, Medicaid will reimburse for up to a total of eight therapeutic visits per month to the discharge placement setting.

The schedule for graduated therapeutic visits with the biological family or other placement setting must be prior approved by the child’s treatment team and included in the child’s medical record. The therapeutic group care staff will maintain contact with the child and the receiving placement as determined by the child’s treatment team. No other child may be placed in the bed of a child who is away on therapeutic visits.

Hospitalization

Medicaid will reimburse providers the daily rate for therapeutic group care services during a hospitalization or mental health inpatient or crisis stabilization placement of no more than seven (7) days duration, if the setting where the child resides is not an IMD. Therapeutic group care staff must be accessible and must maintain a therapeutic level of communication during such placements as determined necessary by clinical staff. If a child experiences more than one mental health crisis placement within a six-month period, the child’s clinician must request a multidisciplinary team meeting to complete a reassessment of the child’s plan to assure that the plan is meeting the child’s needs.

Juvenile Detention Center Placements

Medicaid will not reimburse a provider when a child is in secure detention for more than twenty-four hours.

Unauthorized Absences

Medicaid will reimburse for up to three days during times when a placement is being maintained for a child who has an unauthorized absence (i.e., runs away) from the therapeutic group home.
Recipieント Eligibility for Therapeutic Group Services

In order to receive therapeutic group care services, a child must **be under 18 years of age and** authorized by a multidisciplinary team as meeting 1, 2, if applicable, **and** 3(a) or 3(b) of the following criteria:

1. A child or adolescent, under 18 years of age, is diagnosed by a psychiatrist or other licensed practitioner of the healing arts as having a moderate to serious psychiatric, emotional, or behavioral disorder and, due to the emotional or psychiatric symptoms, is exhibiting severe maladaptive behaviors or an inability to perform activities of daily living. To be considered eligible for this service a child’s functional and behavioral problems may not be primarily related to cognitive or developmental disabilities. The child must require intensive, structured mental health interventions and the availability of highly trained therapeutic group care staff. The child or adolescent must have reached maximum benefit from a more restrictive setting or a less restrictive treatment option may have been tried or considered and found not sufficient to meet safely the child’s treatment needs;

2. For dependent children, placement in a therapeutic group home licensed under [Chapter 65E-9C:14, F.A.C.](#), must be determined appropriate by a qualified evaluator;

And

3. The child or adolescent must meet the diagnostic eligibility criteria described below in 3(a) or 3(b).

   (a) Have an ICD-9-CM diagnosis of 295.0 through 298.9 (schizophrenia or other psychotic disorder, major depression, or bipolar disorder)

   Or

   (b) Have an ICD-9-CM diagnosis in the following range: 294.8, 294.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; and 303.0 through 305.9;

   And

   Have been enrolled in a special education program for the seriously emotionally disturbed or emotionally handicapped;

   Or

   Have scored 50 or below on the Axis V Global Assessment of functioning Scale or CGAS within the past six months. The justification for the score must be well documented and detailed on the certification form.
Recipient Eligibility for Therapeutic Group Services, continued

Who Must Authorize Therapeutic Group Care Services in Areas Not Covered by CW-PMHP

A multidisciplinary team (MDT) with a representative from the district Substance Abuse and Mental Health program office, Child Welfare (CBC) program office and area Medicaid office with members from the Circuit Substance Abuse and Mental Health office or designee, the Community-Based Care lead agency, and the Medicaid Area office must authorize therapeutic group care services for each child or adolescent receiving this service. In districts with a CBC project, the Department of Children and Families district administrator may appoint a representative of the CBC to sit on this committee.

If the MDT team determines that the child requires therapeutic group care services, a member of the team must complete an Authorization for Therapeutic Group Care form. The form must be forwarded to the provider agency to become part of the child's clinical record. A suitability assessment by a qualified evaluator must be completed for children in the care and custody of the state, as recommended by the multidisciplinary team, pursuant to chapter 39.407 F.S. The suitability assessment must find the child suitable for therapeutic group care services before the team can authorize this level of care.

A child with a suitability assessment that recommends therapeutic group care services may be stepped down from a therapeutic group home if the treatment team makes that recommendation. Additionally, a child may be admitted to a therapeutic group care home when the child’s suitability assessment recommends Statewide Inpatient Psychiatric Program (SIPP) placement, if the SIPP treatment team makes the recommendation for a step down to therapeutic group care services.

For children in care and custody, a qualified evaluation that finds the child suitable for this level of care must be provided to the multidisciplinary team, before the team signs the Medicaid authorization for services.

Note: See Appendix L for a copy of the Authorization for Therapeutic Group Care Services form.

Who Must Authorize Therapeutic Group Care Services in Areas Covered by CW-PMHP

If the MDT determines that the child may require therapeutic group care services, the child will be referred for a suitability assessment. MDT must receive written approval from the Child Welfare Prepaid Mental Health Plan vendor. The approval documentation must be forwarded to the provider to become part of the child’s record. A suitability assessment by a qualified evaluator must be completed for children in the care and custody of the state, recommended by the multidisciplinary team, pursuant to chapter 39.407 F.S.

If the suitability assessment finds that the child is appropriate for therapeutic group care services, the team can authorize this level of care and forward documentation to the CW-PMHP vendor for utilization management review. The approval documentation must be forwarded to the provider and placed in the child’s clinical record.

If the MDT determines that the child requires therapeutic group care services and the child is not enrolled in the CW-PMHP, the Community-Based Care
**Re-authorization of Therapeutic Group Home Services**

The district designated multidisciplinary team must re-authorize therapeutic group care services no less than every six months. A new Authorization for Therapeutic Group Care form must be completed and signed by the appropriate representative of the multidisciplinary team. For children in care and custody, a qualified evaluation that finds the child suitable for this level of care must be provided to the multidisciplinary team, before the team signs the Medicaid authorization for services.

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**Recipient Eligibility for Therapeutic Group Services, continued**

**Composition of the Multi-disciplinary Team**

For providers located in AHCA Areas not covered by the Child Welfare Prepaid Mental Health Plan (CW-PMHP), or for children who reside in Areas covered by the CW-PMHP but who are not enrolled in the plan, the multidisciplinary team must consist of a representative from:

- The Medicaid Area office, or
- The Community-Based Care lead agency, or
- The Circuit Substance Abuse and Mental Health office or their designee, or The Department of Juvenile Justice (when applicable).

Additional members should be representatives who know or work with the child and family. When appropriate, members should include the child, case manager, a representative from the child’s school, the child’s biological or adoptive parents or relatives, the foster parents or emergency shelter staff, assigned counselors or case managers, the child’s health care provider.

For children who reside in areas covered by the Child Welfare Prepaid Mental Health Plan, and are enrolled in the plan, the vendor shall meet the requirements of the CW-PMHP contract. The multidisciplinary team must at a minimum comprise at least one representative from the district Substance Abuse and Mental Health program office, a district Child Welfare and Community Based Care program office and the area Medicaid office. Additional members should be people who know or work with the child and family. When appropriate, members should include the child, the child’s biological or adoptive parents or relatives, the foster parents or emergency shelter staff, assigned counselors or case managers, a representative from the child’s current mental health service provider, a school representative, the child’s health care provider, and a member of the case review committee.
Role of the Multidisciplinary Team

For children in the custody of their parents, the multidisciplinary team must assess whether the child requires therapeutic group care services or may be adequately served with less intensive services. The multidisciplinary team must also review each child’s status to re-authorize services no less than every six months.

For children in care and custody, a qualified evaluation must find that child is suitable for this level of care. Such findings must be provided to the multidisciplinary team prior to authorizing the placement.

Absences from the Therapeutic Group Care Home

Medicaid reimbursement is not available for any consecutive 24-hour period when a child is away from the therapeutic group care home, except for approved therapeutic visits, hospitalizations, and crisis placements in which the child maintains Medicaid eligibility. Up to three days may be reimbursed for holding a bed in the case of a runaway child.

Clinical Record and Documentation Requirements

Clinical Record Requirements

The following components must be documented in the recipient’s clinical record:

- The name of the primary clinician who coordinates implementation of the recipient’s treatment plan;
- The recipient’s completed and signed Authorization for Therapeutic Group Care Services (Appendix L) for each six-month period that the recipient received services;
- A signed copy of the psychosocial assessment and evaluation of the recipient’s symptoms, risks, and functional status that was completed by, or signed by, a licensed practitioner prior to the development of the treatment plan;
- An individualized treatment plan for both the child and family that meets the criteria for treatment plans as specified in this section and in Chapter 2, Section 1, of this handbook, that is completed within 14 days of admission rather than 45 days; the treatment plan must have individualized measurable goals and objectives;
- Treatment plan reviews conducted and documented periodically including assessments to determine progress or lack of progress in meeting treatment goals;
- A discharge and aftercare plan with specified discharge criteria; and
- Daily and monthly progress notes as described on the following page.
**Clinical Record and Documentation Requirements**, continued

<table>
<thead>
<tr>
<th>Additional Individualized Treatment Plan Requirements</th>
<th>The provider must comply with the following additional individualized treatment plan requirements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The recipient’s individualized treatment plan must specify the therapeutic activities that will be provided under the therapeutic group care services code, including <strong>the amount, frequency, and duration, and amount</strong> of timed activities.</td>
<td></td>
</tr>
<tr>
<td>Examples: If a recipient will receive individual or group therapy, the plan should specify the number of sessions each week and the length of the session(s) and the clinician responsible for providing this service. If a goal is relationship building through consistent informal contacts with staff throughout each day, this daily intervention should be specified in the plan.</td>
<td></td>
</tr>
<tr>
<td>2. If the treatment plan contains an individualized behavior management component, the behavior analyst must review and sign the component. The behavior management plan must be consistent with treatment outcomes and objectives.</td>
<td></td>
</tr>
<tr>
<td>3. Treatment plans must be developed in conjunction with discharge planning and include input from the child, the child’s family or guardian, psychiatrist, therapist, direct care staff, direct care supervisors, case managers, behavioral analysts, ancillary services and school personnel, as indicated by signature on the treatment plan and by a summary of the treatment team meeting in the clinician’s monthly note.</td>
<td></td>
</tr>
<tr>
<td>4. If a parent or guardian, team member or school personnel are not at the treatment team meeting, the record must reflect that a staff person contacted them for their input.</td>
<td></td>
</tr>
</tbody>
</table>

| Documentation Requirements for the Direct Care Staff | Direct care staff must complete a daily summary of a child or adolescent’s progress each day on working towards his measurable goals and objectives. The note should contain interventions and the child’s responses to interventions as well as significant contacts with family, at school or in the community. This daily note will be an important tool and source of information for other direct care staff and for the clinical staff person to reference during therapeutic contacts with the child. |

<table>
<thead>
<tr>
<th>Quality of Care Monitoring</th>
<th>For Medicaid Areas not included in the Child Welfare Prepaid Mental Health Plan, providers will be subject to Quality of Care monitoring of these requirements by the local Medicaid Area office or designee.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For Medicaid Areas covered by the Child Welfare Prepaid Mental Health Plan, providers will be subject to Quality of Care monitoring of these requirements by the Child Welfare Prepaid Mental Health Plan vendor or designee and the Medicaid Area office or designee.</td>
</tr>
</tbody>
</table>
Clinical Record and Documentation Requirements, continued

**Documentation Requirements for Clinical Staff**

Clinicians must complete a brief progress note following each of the two face-to-face weekly contacts with a child or adolescent (at least two contacts per week) to provide clinical observations and inform the other staff of the child’s current status.

The clinician must complete a monthly treatment summary in the progress notes. These progress notes must include the following information:

1. A summary of the treatment interventions delivered, the child’s response to the interventions, including any individualized behavior management plan, and progress toward reaching individualized goals, significant events, occurring during the month, and contacts with family and other agencies.
2. Documentation that interventions authorized in the treatment plan are being delivered in accordance with the plan.
3. Observations of the direct care staff’s implementation of the treatment plan, i.e., does the direct care staff demonstrate knowledge of the child’s individualized treatment plan and carry out recommended interventions, e.g., praise, rewards, timeout, consequences, consistently during supervision and interactions with the child?
4. Summary of the treatment team meetings related to the child and information to reflect that the recipient’s individualized goals, progress, and identified treatment needs were discussed and revised whenever necessary.
5. The clinician must document that the family members are involved in the treatment planning and treatment processes and must include the goals and objectives for family counseling, or justification if family is not involved. If the child is in the care and custody of the state, the record must document how the treatment plan is supporting the permanency plan.

**Documentation of Services Billed Fee-For-Service**

The provider who provides a service on a fee-for-service basis must document the service in accordance with Medicaid policy.

**Note:** Please see Chapter 2 in the Florida Medicaid Provider General Handbook for documentation requirements.
Recipient Absences from Therapeutic Group Care

**Therapeutic Visits**
Therapeutic visits are visits of more than 24 consecutive hours away from the therapeutic group home with the child’s biological, adoptive or extended family, or potential placement setting. Therapeutic visits must be prior authorized by the clinical staff person and recorded in the child’s clinical record. Therapeutic visits may include time spent away overnight with friends, school, or club activities. These visits are planned in conjunction with the child’s treatment goals and objectives. Therapeutic group care staff must be accessible and must maintain a level of communication during such visits as documented and determined by the clinician.

**Reimbursement for Therapeutic Visits**
Medicaid will reimburse the therapeutic group care provider for therapeutic visits up to 10 days per calendar quarter increasing up to 21 days during the last quarter prior to discharge as described below. Medicaid will reimburse therapeutic visits only when the therapeutic group home maintains a bed and contact with the child as described above.

During the last three months prior to a planned discharge to a child’s biological family or other placement, Medicaid will reimburse the therapeutic group care provider for a graduated number of therapeutic visits. Three months prior to discharge, Medicaid will reimburse up to a total of five therapeutic visits to the discharge placement setting. During the second to the last month and the last month of a child’s stay, Medicaid will reimburse for up to a total of eight therapeutic visits per month to the discharge placement setting.

The schedule for graduated therapeutic visits with the biological family or other placement setting must be prior approved by the child’s treatment team and included in the child’s clinical record. The therapeutic group care staff will maintain contact with the child and the receiving placement as determined by the child’s treatment team. No other child may be placed in the bed of a child who is away on therapeutic visits.

**Hospitalization**
Medicaid will reimburse providers the daily rate for therapeutic group care services during a hospitalization or mental health inpatient or crisis stabilization placement of no more than seven (7) days duration, if the setting where the child resides is not an IMD. Therapeutic group care staff must be accessible and must maintain a therapeutic level of communication during such placements as determined necessary by clinical staff. If a child experiences more than one mental health crisis placement within a six-month period, the child’s clinician must request a multidisciplinary team meeting to complete a reassessment of the child’s plan to assure that the plan is meeting the child’s needs.
Recipient Absences from Therapeutic Group Care, continued

**Juvenile Detention Center Placements**  Medicaid will not reimburse a provider when a child is in secure detention for more than twenty-four hours.

**Unauthorized Absences**  Medicaid will reimburse for up to three days during times when a placement is being maintained for a child who has an unauthorized absence (i.e., runs away) from the therapeutic group home.

## Reimbursement Requirements

### Allowable Reimbursement
Certified providers may bill the per diem rate for up to 365 days a year for services delivered to a child who has been certified as meeting the eligibility criteria.

Children and adolescents receiving therapeutic group care services in community-based group homes of fewer than 16 beds retain their Medicaid eligibility for other medical and dental benefits under the Medicaid program.

Targeted case management reimbursement is limited to eight hours of billable services per month, excluding travel time, for children placed in therapeutic group care services.

### Services that May be Reimbursed in Conjunction with Therapeutic Group Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Behavioral Health Assessment (if not previously provided and if indicated during an admission to therapeutic group care services)</td>
<td>H0031</td>
<td>HA</td>
</tr>
<tr>
<td>Medication Administration</td>
<td>T1015</td>
<td></td>
</tr>
<tr>
<td>Review of records</td>
<td>H2000</td>
<td></td>
</tr>
<tr>
<td>Brief Mental Status Examination (if needed more than once a month, as documented in the clinical record)</td>
<td>H2010</td>
<td>HO</td>
</tr>
<tr>
<td>Brief Individual Psychotherapy Mental Health Substance Abuse</td>
<td>H2010</td>
<td>HE</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>H2019</td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric evaluation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By an MD/DO</td>
<td>H2000</td>
<td>HP</td>
</tr>
<tr>
<td>By a Non MD/DO</td>
<td>H2000</td>
<td>HO</td>
</tr>
</tbody>
</table>
Reimbursement Requirements, continued

Public School and Summer Activities

Medicaid may reimburse the following services in addition to therapeutic group care services only when provided as part of a public school program or summer activities program. These services may not be reimbursed when provided in the child’s group home.

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Based Wrap Around Services, Therapy</td>
<td>H2019</td>
<td>HO</td>
</tr>
<tr>
<td>Community Based Wrap Around Services, Behavior Management</td>
<td>H2019</td>
<td>HMN</td>
</tr>
<tr>
<td>Community Based Wrap Around Services, Therapeutic Support Services</td>
<td>H2019</td>
<td>HNM</td>
</tr>
<tr>
<td>Behavioral Health Day Services, mental health</td>
<td>H2012</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Day Services, substance abuse</td>
<td>H2012</td>
<td>HF</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation Services</td>
<td>H2017</td>
<td></td>
</tr>
</tbody>
</table>
## Reimbursement Requirements, continued

### Services that may not be Reimbursed with Therapeutic Group Care

The following No other community behavioral health services procedure codes may not be billed in conjunction with therapeutic group care services, with the exceptions as noted in previous pages for school-related programs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-depth Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New patient</td>
<td>H0031</td>
<td>H0001</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td>HQ</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Established patient</td>
<td>H0031</td>
<td>TS</td>
</tr>
<tr>
<td>Mental Health</td>
<td>H0001</td>
<td>TS</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bio-Psychosocial Evaluation</td>
<td>H0001</td>
<td></td>
</tr>
<tr>
<td>Limited Function Assessment</td>
<td>H0031</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>H0001</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment Plan Development and Modification</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Dev.</td>
<td>H0032</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>T1007</td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Rev.</td>
<td>H0032</td>
<td>TS</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>T1007</td>
<td>TS</td>
</tr>
<tr>
<td><strong>Medical/Psychiatric Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Medical Therapy</td>
<td>H2010</td>
<td>HQ</td>
</tr>
<tr>
<td>Behavioral Health Screening</td>
<td>T1023</td>
<td>HE</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>T1023</td>
<td>HF</td>
</tr>
<tr>
<td><strong>Behavioral Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specimen Collection</td>
<td>T1015</td>
<td>HE</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>T1015</td>
<td>HF</td>
</tr>
<tr>
<td>Verbal Interaction</td>
<td>H0046</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
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<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>H0047</td>
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</tr>
<tr>
<td>Methadone Administration</td>
<td>H0020</td>
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</tr>
<tr>
<td><strong>Behavioral Health Therapy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/Family Therapy</td>
<td>H2019</td>
<td>HR</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>H2019</td>
<td>HQ</td>
</tr>
<tr>
<td>Behavioral Health Day Services</td>
<td>H2012</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Day Services</td>
<td>H2012</td>
<td></td>
</tr>
<tr>
<td><strong>Community Support and Rehabilitative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial Rehabilitative Services</td>
<td>H2017</td>
<td></td>
</tr>
<tr>
<td>Club House</td>
<td>H2030</td>
<td></td>
</tr>
</tbody>
</table>
### Reimbursement Requirements, continued

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services Limited to Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-Based Wrap-Around Services—Therapeutic Behavioral on-site services, Master’s degree level</td>
<td>H2019</td>
<td>HO</td>
</tr>
<tr>
<td>Community-Based Wrap-Around Services—Behavior Management Therapeutic behavioral on-site services, behavior management</td>
<td>H2019</td>
<td>HMHN</td>
</tr>
<tr>
<td>Community-Based Wrap-Around Services—Therapeutic Support Services Therapeutic behavioral on-site services, therapeutic support</td>
<td>H2019</td>
<td>HNHM</td>
</tr>
<tr>
<td><strong>Specialized Therapeutic Foster Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level I Specialized Therapeutic Foster Care Services</td>
<td>S5145</td>
<td>HE</td>
</tr>
<tr>
<td>Level II Specialized Therapeutic Foster Care Services</td>
<td>S5145</td>
<td>HK</td>
</tr>
<tr>
<td>Crisis Intervention Specialized Therapeutic Foster Care Services</td>
<td>S5145</td>
<td>HK</td>
</tr>
<tr>
<td>Behavioral Health Wrap-Around Overlay Services/per diem/Juvenile Justice</td>
<td>H2020</td>
<td>HK</td>
</tr>
<tr>
<td>Behavioral Health Wrap-Around Overlay Services/per diem/Child Welfare</td>
<td>H2020</td>
<td>HA</td>
</tr>
</tbody>
</table>

### Non-Duplication of Services

A provider may not be reimbursed for therapeutic group home services or any other community behavioral health service if the provider has been paid for the provision of the same service or type of service by another purchasing entity.

### Room and Board

Neither therapeutic group care services nor any other Medicaid community behavioral health care service cover reimbursement for room and board expenses.

### Fair Hearing Notices

If services are decreased or re-authorization is not provided for the child welfare prepaid mental health plan enrollee, the vendor will provide a fair hearing notice pursuant to 42 C.F.R. 431.206. The notice will be sent at least 10 days prior to the service reduction or termination to the child, the child’s foster parents, the child’s attorney (if one exists applicable), and the child’s guardian ad litem (if one exists applicable).
SECTION 5
SERVICES FOR CHILDREN AGES 0 THROUGH 5 YEARS

Service Requirements

| Introduction | Services for children ages 0 through 5 years are subject to additional policy requirements outlined in this section. Medicaid does not pay for community behavioral health services for treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation. Medicaid may reimburse for community behavioral health services provided for recipients who have one or more of the preceding conditions, and who also have behavioral health needs. (The presence of one of these conditions does not prohibit the recipient from receiving services for behavioral health needs.) |

In order to receive community behavioral health services the infant or child age 0 through 5 years must:

1. Have an ICD-9-CM diagnosis in the following range: 290 through 298.9, 300 through 301.9, 302.7, 303 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9. Diagnosis codes are found in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

2. Be exhibiting symptoms of an emotional or behavioral nature that are atypical for the child’s age and development.

For children 0 through 3 years of age, Medicaid encourages use of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0–3) for assistance in determining the infant or child’s ICD-9-CM diagnosis.

| Assessment Requirement | Prior to receiving any community behavioral health services, infants and children ages 0 through 5 years must have a current assessment (within a year) that meets the requirements listed below. |
### Service Requirements, continued

<table>
<thead>
<tr>
<th>Assessment Components</th>
<th>For children ages 0-5 years, the assessment must include the following components:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Presenting symptoms and behaviors;</td>
</tr>
<tr>
<td></td>
<td>• Developmental and medical history - history of pregnancy and delivery, past and current medical conditions and developmental milestones;</td>
</tr>
<tr>
<td></td>
<td>• Family psychosocial and medical history (may be as reported or based upon collateral information);</td>
</tr>
<tr>
<td></td>
<td>• Family functioning, cultural and communication patterns and current environmental conditions and stressors;</td>
</tr>
<tr>
<td></td>
<td>• Clinical interview with the primary caretaker and observation of the caregiver-infant (child) relationship and interactive patterns;</td>
</tr>
<tr>
<td></td>
<td>• Provider’s observation and assessment of the child including affective, language, cognitive, motor, sensory, self-care and social functioning.</td>
</tr>
</tbody>
</table>

The assessment must include the elements outlined above and must be written in narrative form and provide detailed, individualized information on the components listed above. The sole use of checklists or fill in the blank forms is prohibited.

| Integrated Summary | The integrated summary is developed after the assessment has been completed. The integrated summary is written to evaluate and interpret from a broader perspective, the history and assessment information collected. The summary identifies and prioritizes the infant or child’s needs, establishes a diagnosis, provides an evaluation of the efficacy of past interventions, and helps to determine the care and services to be provided. |

| Reimbursement for the Assessment | The assessment may be billed using procedure code H0001-HO, H0001-TS, H0031-HO, or H0031-TS. |

**Note:** See Chapter 2, Section 1 for reimbursement restrictions for assessment procedure codes.
### Service Requirements, continued

<table>
<thead>
<tr>
<th><strong>Comprehensive Behavioral Health Assessment</strong></th>
<th>A comprehensive behavioral health assessment may serve in lieu of the assessment described above.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who Must Provide</strong></td>
<td>A master’s level mental health practitioner must, at a minimum, personally render the assessment and complete the integrated summary.</td>
</tr>
</tbody>
</table>

### Authorization of Services

| **Service Authorization** | Services for children ages 0 through 5 years must be medically necessary and must be authorized by a treating physician or treating licensed practitioner of the healing arts in an individualized treatment plan.  

Providers must obtain consent for treatment from the parent, guardian, or legal custodian.  
**Note:** See Chapter 2, Section 1 of this handbook for exceptions to obtaining consent. |

### Behavioral Health Day Services for Children Ages 24 Months through 5 Years

| **Behavioral Health Day Services** | Behavioral health day services are appropriate early childhood therapeutic services for children age 24 months and older who are experiencing emotional problems and who meet the eligibility criteria described below. Services are designed to strengthen individual and family functioning, prevent more restrictive placement of children, and provide an integrated set of interventions to promote behavioral and emotional adjustment.  

Services must be provided in a therapeutic milieu that allows for a broad range of therapeutic activities designed for the treatment of specific social, emotional, and behavioral problems. Services must be delivered in a coordinated manner and must be appropriate for the developmental age of the child. Services must be individualized and directly related to the treatment plan goals and the long-term goal of returning the child to regular day care, preschool, or the least restrictive environment possible. |
<p>| <strong>Service Restrictions</strong> | Medicaid does not reimburse for basic childcare programs for developmental delays, preschool, or enrichment programs. The purpose of the behavioral health day services must be to address the young child’s emotional problems. |</p>
<table>
<thead>
<tr>
<th>Eligibility Criteria</th>
<th>In order to receive behavioral health day services, a child must:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Be 24 months of age or older;</td>
</tr>
<tr>
<td>2.</td>
<td>Have an ICD-9-CM diagnosis in the following range: 294.8, 294.9,</td>
</tr>
<tr>
<td></td>
<td>298.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0</td>
</tr>
<tr>
<td></td>
<td>through 312.4, and 312.81 through 314.9; and</td>
</tr>
<tr>
<td>3.</td>
<td>Score in at least the moderate impairment range on a behavior and</td>
</tr>
<tr>
<td></td>
<td>functional rating scale developed for this age group.</td>
</tr>
</tbody>
</table>

**Behavioral Health Day Services for Children Ages 24 Months through 5 Years, continued**

<table>
<thead>
<tr>
<th>Program Requirements</th>
<th>Behavioral health day services for children age 24 months through 5 years must meet the following requirements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Services must be provided for a minimum of two to a maximum of four hours within the day. This need not be a continuous time period, but must be provided in one day.</td>
</tr>
<tr>
<td>2.</td>
<td>Therapeutic activities, as listed in the child’s treatment plan, must be interwoven throughout the child’s scheduled activities.</td>
</tr>
<tr>
<td>3.</td>
<td>The day treatment program must have a parent or caregiver component. At a minimum, there should be a monthly face-to-face contact at the day treatment center or at the child’s home.</td>
</tr>
<tr>
<td>4.</td>
<td>If the provider is unable to involve the parent or caregiver or meet the requirement for the face-to-face contact, a telephone contact is allowable but is not reimbursable as part of day treatment. Written justification of why the face-to-face intervention could not occur must be provided in the child’s medical record.</td>
</tr>
<tr>
<td>5.</td>
<td>The group size during therapeutic activities must not exceed ten (10) children.</td>
</tr>
<tr>
<td>6.</td>
<td>The behavioral health day services staff to child ratio during therapeutic activities may not exceed 1:5. Aides may be used to meet these staffing requirements.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who Must Provide</th>
<th>The behavioral health day services program must have, per group of 10, a full time bachelor’s level practitioner. The bachelor’s level practitioner must be supervised by a master’s level practitioner with two years experience with children ages 0 through 5 years or by a licensed practitioner of the healing arts.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aides must, at a minimum, have a high school diploma or equivalent with at least two years’ experience with infants and toddlers or a Child Development Aide (CDA) certificate.</td>
</tr>
</tbody>
</table>
Behavioral Health Day Services for Children Ages 24 Months through 5 Years, continued

Training Requirements for Bachelor’s Level Practitioners

A bachelor’s level practitioner providing behavioral health day services to children ages 0 through 5 years must have received training or receive 20 hours of training prior to work with the 0-5 population.

Bachelor’s level practitioners must have documented training in the following areas: early childhood development, behavior observation, developmental screening, parent and child interventions and interactions, functional assessment, developmentally appropriate practices for serving infants, young children and their families, psychosocial assessment and diagnosis of the young child, and crisis intervention training.

Bachelor’s level practitioners who have had the above training through conferences, workshops, continuing education credits (CEUs), academic training are not required to repeat the training. However, training must be documented in the employee’s personnel record.

Written Certification for Behavioral Health Day Services

Prior to receipt of behavioral health day services, a physician or other licensed practitioner of the healing arts experienced in the diagnosis of mental disorders must provide written certification that:

- The child meets the eligibility criteria listed above;
- The services are medically necessary for the treatment of the recipient’s mental health;
- The services can be expected to retard deterioration, maintain, or improve the child’s condition and functional level; and
- The child’s condition or functional level cannot be improved in a less restrictive level of care.

Written justification that supports the certification of the child’s eligibility for services must be provided in the recipient’s medical record by the physician or other licensed practitioner of the healing arts.

Discharge Criteria

Each recipient must, within 45 days of admission to behavioral health day services, have a written plan containing specific criteria for discharge from behavioral health day services.
Behavioral Health Day Services for Children Ages 24 Months through 5 Years, continued

**Continued Stay Criteria**
Within at least six months of the original authorization and every six months thereafter, the members of the child’s treatment team must provide written documentation that, based upon an assessment of the child’s status, the child continues to meet the eligibility criteria stated above.

Services may be authorized for less than six months.

If a reassessment is done any time during the course of treatment and the child is found to no longer meet eligibility criteria, Medicaid will no longer reimburse for behavioral health day services.

**Reimbursement for In-Home Services**
In-home services with the infant or child’s parent or caregiver may be billed as part of the day services program. If provided on a day when no behavioral health day services are billed, an in-home service may be billed as individual or family therapy or therapeutic behavioral on-site therapy services.

**Documentation Requirements**

**Documentation Requirements**
Documentation of behavioral health day services for children 24 months through 5 years must include the following:

1. The child’s name;
2. The exact dates and times the child attended (e.g., 3/26/01 8am to 12pm);
3. Identification of the setting(s) in which the service was rendered;
4. A weekly summary note signed by the master’s level practitioner. The weekly summary note must include:
   - The specific therapeutic activities rendered during the week;
   - The child’s response to therapeutic activities;
   - Updates regarding the child’s progress or lack of progress toward meeting treatment plan goals; and
   - Any changes required.
Documentation Requirements, continued

Reimbursement Limitations of Behavioral Health Day Services

Medicaid can reimburse day treatment services 190 hour units per recipient, per state fiscal year (July 1 through June 30). Medicaid will not reimburse for provision of behavioral health day services where there is a per diem reimbursement being paid by Medicaid for Medicaid recipients.

Medicaid will not reimburse for behavioral health day services when the same service or any component of the service is already being paid for by another source.

Combinations of Services That Cannot Be Reimbursed

The following services may not be reimbursed in conjunction with behavioral health day services for the same recipient on the same day.

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial Rehabilitative Services</td>
<td>H2017</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services – Therapy</td>
<td>H2019</td>
<td>HO</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services – Behavior Management</td>
<td>H2019</td>
<td>HM</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services – Therapeutic Support</td>
<td>H2019</td>
<td>HN</td>
</tr>
</tbody>
</table>

**Specialized Therapeutic Foster Care**

<table>
<thead>
<tr>
<th>Level</th>
<th>Procedure Code</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>S5145</td>
<td></td>
</tr>
<tr>
<td>Level II</td>
<td>S5145</td>
<td>HE</td>
</tr>
<tr>
<td>Crisis</td>
<td>S5145</td>
<td>HE</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite – Juvenile Justice</td>
<td>H2020</td>
<td>HK</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite – Child Welfare</td>
<td>H2020</td>
<td>HA</td>
</tr>
</tbody>
</table>
**Therapeutic Behavioral Onsite Services for Children Ages 0 Through 5 Years**

<table>
<thead>
<tr>
<th>Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipients ages 0 through 5 who meet the criteria described below, may receive therapeutic behavioral on-site services as described in Chapter 2, Section 1 of this handbook.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligibility Criteria for Ages 0 Through 23 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order to receive therapeutic behavioral on-site services an infant or child age 0 through 23 months must:</td>
</tr>
</tbody>
</table>

1. Have an ICD-9-CM diagnosis in one of the following categories: 294.8, 294.9, 298.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; and

2. Have experienced:
   (a) Trauma such as physical abuse, sexual abuse, severe neglect; witnessed life threatening violence; or death of the caretaker; or
   (b) Failure to thrive (due to emotional or psychosocial causes, not solely medical issues); or
   (c) Atypical development of temperament or behavior that interferes with social interaction and relationship development.

The above conditions must be clearly supported by written documentation of the 0-5 assessments.

<table>
<thead>
<tr>
<th>Eligibility Criteria Ages 24 Months Through 5 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order to receive therapeutic behavioral on-site services recipients age 24 months through five years of age must:</td>
</tr>
</tbody>
</table>

1. Have an ICD-9 diagnosis in the following range: 294.8, 294.9, 298.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; and

2. Score in at least the moderate impairment range on a behavior and functional rating scale developed for the specific age group.

<table>
<thead>
<tr>
<th>Written Certification</th>
</tr>
</thead>
</table>
| Written justification that supports the certification of the child’s eligibility for services must be provided in the recipient’s medical record by the physician or other licensed practitioner of the healing arts. Prior to receipt of services, a physician or other licensed practitioner of the healing arts experienced in the diagnosis of mental health disorders must provide written certification that:

- The child meets the criteria defined above;
- There is adequate evidence to indicate that the child is at risk for a more intensive, restrictive and costly mental health placement; and
- There is adequate evidence to indicate the child’s condition cannot be improved with less intensive services (e.g., individual/family therapy, group therapy). |
### Therapeutic Behavioral Onsite Services for Children Ages 0 Through 5 Years, continued

#### Who Must Provide

A person meeting the qualifications as specified in Chapter 2, Section 1, must deliver therapeutic behavioral on-site services for this population. In addition staff must meet the training requirements listed earlier in this section and further, a bachelor’s level practitioner must receive supervision from a master’s level practitioner and a master’s level practitioner must receive supervision from a licensed practitioner of the healing arts.

#### Reimbursement Limitations

Therapeutic behavioral on-site therapy services are limited to 36 units per month, per recipient. Exceptions to the limits may be requested when medically necessary.

#### Discharge Criteria

Within 45 days of admission, each child must have specific, written discharge criteria.

If a reassessment is done at any time during the course of treatment and the recipient is found to no longer meet eligibility criteria, the recipient must be discharged from therapeutic behavioral on-site services.
SECTION 64
BEHAVIORAL HEALTH OVERLAY SERVICES FOR YOUTH IN JUVENILE JUSTICE SETTINGS

Description and Purpose

Description
Behavioral health overlay services for youth in juvenile justice settings are a set of services and natural supports for children with serious emotional disturbance who are placed in the care of Medicaid enrolled, certified residential programs under contract with the Department of Juvenile Justice. Included are mental health, substance abuse and social services, based on an individualized treatment recipient plan designed to achieve specific outcomes.

Medicaid behavioral health overlay services enable providers to deliver medically-necessary behavioral health and social services on-site, in addition to room and board, along with delinquency programming and training, which are reimbursed under contract with the Department of Juvenile Justice.

Purpose
The purpose of behavioral health overlay services is:

1. To provide on-site mental health and, substance abuse treatment and social services to recipients placed in Department of Juvenile Justice residential settings; and
2. To provide support to the recipient in the current residential setting in order to avoid a more intensive level of care.

Goals
The goals of behavioral health overlay services are to provide the recipient with:

- Improved emotional, mental, and functional status;
- Reduction in unplanned placement changes;
- Increased ability to live safely, attend school, and be a productive member in an inclusive community environment;
- Increased likelihood of a successful transition to the home, community and family, if possible; and
- If developmentally appropriate, increased capacity for independent living.
Provider Requirements for Behavioral Health Overlay Services

Provider Agency Eligibility Requirements

To enroll as a Medicaid provider of behavioral health overlay services, a residential care agency must meet all of the following criteria:

1. Be enrolled as a Medicaid community mental health services provider (including monitoring by First Health Services, the Agency for Health Care Administration (AHCA), or its designee and approval of Pre-Certification).
2. Be under contract with the Department of Juvenile Justice as a Medicaid-approved residential group care provider.
3. Have as a primary mission the provision of an alternative living situation for children who have been adjudicated delinquent.
4. Be designated by the Department of Juvenile Justice as an essential behavioral health care provider.
5. Be self-certified to provide behavioral health overlay services pending an on-site survey or be certified to provide behavioral health overlay services, following an on-site survey conducted by the Substance Abuse and Mental Health (SAMH) program office or the Agency for Health Care Administration’s (AHCA) utilization management organization, or its designee.

Provider Agency Self-Certification Process

To be certified, a provider must submit a Provider Agency Self-Certification Behavioral Health Overlay Services form to:

AHCA, Medicaid Services
Behavioral Health Unit-DJJ/Overlay
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308

The provider’s executive director must sign the form. By signing the form, the executive director is giving assurances that the provider conducted a review of the site for which the certification is being requested and that the site meets the certification criteria. (see Certification Criteria for Behavioral Health Overlay Services in this section for a description of the requirements).

Based on the provider’s assurances, Medicaid will send a letter to the provider that grants temporary certification for billing behavioral health overlay services at the site.

Note: See Appendix G in this chapter for a copy of the Provider Agency Self-Certification Behavioral Health Overlay Services form.
Provider Agency Certification Process

Within six months of the effective date of the self-certification, the district Substance Abuse and Mental Health program office or Agency for Health Care Administration’s utilization management organization, or designee will survey the site to determine if it meets the certification criteria. (see Certification Criteria for Behavioral Health Overlay Services in this section for a description of the requirements).

If the program site is in compliance, the provider will receive a Provider Agency Certification form signed by the reviewing entity AHCA and the provider.

If the program is found to be non-compliant, the provider must complete a corrective action plan within 60 days in order to continue billing for services. Certification will be withdrawn within six months if the program continues to be found non-compliant with the certification criteria.

Providers of behavioral health overlay services to both juvenile justice and child welfare populations require agency behavioral health overlay services certification for both juvenile justice and child welfare populations.

Note: See Appendix H in this chapter for a copy of the Provider Agency Certification Form for Behavioral Health Overlay Services Certification form for Youth in Juvenile Justice Settings.

Certification Criteria for Behavioral Health Overlay Services Provider Agencies

Certification Criteria

To be certified or self-certified to provide behavioral health overlay services, a provider must demonstrate the administrative capability to operate as a designated residential facility by meeting the criteria listed in this section. The criteria cover the following areas:

- Services to be provided;
- Community mental health services to be provided;
- Provider capabilities;
- Behavior therapy criteria;
- Behavioral health crisis intervention and management support;
- Quality assurance program;
- Required policies and procedures;
- Staff requirements;
- Clinical staffing requirements and responsibilities; and
- Clinical supervision.

The criteria are described in detail in the following sections.
Community Behavioral Health Services Coverage and Limitations Handbook

The provider must offer the following array of on-site clinical and supportive services when medically necessary:

Behavioral health crisis management including referral procedures when the recipient needs to be placed in a crisis stabilization unit or acute psychiatric inpatient care:

1) Individualized behavior management services (including design, consultation, and supervision), when indicated:
   - Individual, family, and group therapy
   - Therapeutic support services

2) Therapeutic support services, Individual, group, and family therapy and supportive services:
   - Individual, family, and group therapy;
   - Individualized behavior management services (including design, consultation, and supervision), when indicated; and,
   - Therapeutic support services.

3) Clinical social rehabilitation and counseling;
4) Individualized behavioral programming (including design, consultation, and supervision), if indicated;
5) Provision of clinical expertise in reunification activities with family;
6) Supportive counseling;
7) Identification of behavioral and substance abuse support services needed for successful transition into the community; and

Clinical and support services that promote increased capacity for independent living for older adolescents.

8) Therapeutic visits

Behavioral Health Overlay Services - Therapy

Individual and family therapy services include the provision of insight oriented, cognitive-behavioral, or supportive therapy to an individual or family. Individual and family therapy may involve the recipient, the recipient’s family (without the recipient present), or a combination of therapy with the recipient and the recipient’s family.

Group therapy services include the provision of cognitive-behavioral or supportive therapy to individuals or families; and, consultation with family or other responsible persons for sharing of clinical information. Also included is education, counseling, or advising family or other responsible persons on how to assist the recipient.

Behavioral Health Overlay Services - Behavior Management

Behavior management services include the following:

- Assessment of behavior problems, and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the client’s behaviors and the interactions that motivate, maintain or improve behavior;
- Development of an individual behavior plan with measurable goals and objectives;
- Training caregivers and other involved persons in the implementation of the behavior plan;
- Monitoring the child and caregiver progress and revise as needed; and
- Coordinating services on the treatment plan with the treatment team.
Behavioral Health Overlay Services - Therapeutic Support

Therapeutic support services are interventions and direct care service contacts that must be related to the child’s or adolescent’s treatment plan goals and objectives and must include one or more of the following services:

- One-to-one supervision and intervention with the child or adolescent during therapeutic activities in accordance with the child’s treatment plan;

- Skill training of the child or adolescent for restoration of those basic living and social skills necessary to function in the child or adolescent’s own environment; or

- Assistance to the child or adolescent and caregiver in implementing the behavioral goals identified through assessments, therapy, and development of the treatment plan.

Certification Criteria for Behavioral Health Overlay Services Provider Agencies, continued

Community Behavioral Health Services to Be Provided

The provider must offer the following Medicaid community behavioral health services:

1) Assessment Services;
2) Treatment Plan Development and Modification; and
3) Medical and Psychiatric Services.

The provider may bill for these services on a fee-for-service basis in addition to billing for behavioral health overlay services. The services must be provided in accordance with Medicaid policy and be medically necessary.

Provider Capabilities

The provider must have the capability to provide:

- Behavioral health services and supports, bio-psychosocial assessments, and individual and group therapy with the availability of multiple sessions per week as indicated by the recipient’s needs and reflected in the treatment plan.

- Family counseling for recipients with their families, when clinically indicated, with goals and objectives of such counseling specified in the treatment plan and conducted in conjunction with the recipient’s performance plan.

- A therapeutic environment with an identified behavioral health treatment orientation, which is supported and implemented consistently across components of the program.

- Behavioral health care coordination and linkages with the delinquency program, schools, primary medical care, and community services.
Behavior Therapy

Behavior therapy is defined as a type of therapy that seeks to change abnormal or maladaptive behavior patterns by the use of extinction and inhibitory processes and positive and negative re-enforcers. The focus of therapy is on the behavior itself rather than engaging in analytical or dynamic analysis or exploration of underlying conflicts or other root causes. Treatment interventions include behavior programming that is aimed at behavior modification of current behaviors.

If the provider uses behavior therapy as a treatment modality, the behavioral programming must be individually designed and implemented and include structured interventions and contingencies designed to support the development of adaptive, pro-social interpersonal behavior.

Behavioral Health Crisis Intervention and Management Support

The provider must demonstrate that crisis intervention and support are available twenty-four hours per day, seven days per week. Crisis services include facilitating access to acute care settings or other behavioral health emergency management services. The provider must demonstrate 24-hour response capability with access to an acute care setting and behavioral health emergency management services.

Quality Assurance Program

The provider must have a quality assurance program that evaluates the effectiveness and outcomes of all the behavioral health services it provides. The quality assurance policies and procedures must include:

- Monitoring behavioral health treatment planning and implementation;
- Monitoring behavioral health outcomes against treatment objectives and the youths’ Global Assessment of Functioning scales and academic progress;
- Evaluating and submitting behavioral health outcomes to the Department of Children and Families using the Children’s Functional Assessment Rating Scale; Note: See http://outcomes.fmhi.usf.edu/ for approved DCF training;
- Ongoing review of behavioral health staff performance;
- Reviewing behavioral health medication administration and monitoring;
- Interfacing with primary caregivers;
- Implementing and documenting pre-service and ongoing staff training agendas that improve and support the delivery of behavioral overlay services; and
- Maintaining procedures for gathering data and reporting on outcomes related to the recipient’s academic performance in school and assessment of functioning.
Certification Criteria for Behavioral Health Overlay Services Provider Agencies, continued

<table>
<thead>
<tr>
<th>Required Policies and Procedures</th>
</tr>
</thead>
</table>

The provider agency must have policies and procedures in place that address the following:

1. Thorough screening, evaluation, and diagnosis of symptoms, risks, functional status, and co-morbidity.
2. Therapeutic crisis intervention in compliance with applicable Centers for Medicare and Medicaid Services rules and Department of Juvenile Justice requirements, including transfer of the recipient to a more restrictive level of care (hospital, crisis stabilization unit).
3. Treatment teams that are responsible for organizing the delivery of behavioral health overlay services.
4. Behavioral health overlay services that are integrated into the daily activities associated with structured residential care.
5. Inclusion of the recipient’s family in the clinical treatment process or documented justification if the recipient’s family is not involved.
6. Documentation, on at least a weekly basis, on the recipient’s behavioral health treatment that directly relates to the recipient’s progress in meeting his or her individual clinical goals and objectives as included in the treatment plan.
7. In programs using behavior therapy, individualized behavior management plans that are consistent with the recipient’s treatment plan and Department of Juvenile Justice performance plan.
9. Clinical aftercare planning and discharge planning that support development of independent living skills and are coordinated with the delinquency discharge plan, when developmentally appropriate.
10. An internal review process of the recipient’s eligibility for behavioral health overlay services.
11. A clinical supervision protocol that assures timely monitoring of services and modification of treatment as needed.
12. Policies and procedures for the clinical management of specific types of emotional and behavioral problems encountered by recipients served in the facility.
<table>
<thead>
<tr>
<th>Certification Criteria for Behavioral Health Overlay Services Provider Agencies, continued</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Services Supervisor</strong></td>
</tr>
<tr>
<td>The provider must have a clinical services supervisor who has lead</td>
</tr>
<tr>
<td>responsibility for the overall coordination and provision of behavioral health</td>
</tr>
<tr>
<td>overlay services.</td>
</tr>
<tr>
<td><strong>Management Staff Requirements</strong></td>
</tr>
<tr>
<td>The provider’s management staff must have appropriate experience and</td>
</tr>
<tr>
<td>capability to administer effective, ongoing operations of behavioral health</td>
</tr>
<tr>
<td>overlay services.</td>
</tr>
<tr>
<td><strong>Adequate Number of Staff</strong></td>
</tr>
<tr>
<td>The provider’s budget must indicate that there are an adequate number of</td>
</tr>
<tr>
<td>funded positions to meet the staff requirements for behavioral health overlay</td>
</tr>
<tr>
<td>services.</td>
</tr>
<tr>
<td><strong>Psychiatrist</strong></td>
</tr>
<tr>
<td>The provider must have a psychiatrist(s) on staff or under contract.</td>
</tr>
<tr>
<td><strong>Behavior Analyst</strong></td>
</tr>
<tr>
<td>When a provider uses behavior therapy, the provider must have a behavior</td>
</tr>
<tr>
<td>analyst on staff or under contract.</td>
</tr>
<tr>
<td><strong>Clinical Staff Credentials</strong></td>
</tr>
<tr>
<td>All counselors, licensed practitioners, behavior analysts, and psychiatrists</td>
</tr>
<tr>
<td>providing behavioral health overlay services must meet the specific education</td>
</tr>
<tr>
<td>and training requirements described in this chapter.</td>
</tr>
<tr>
<td><strong>Counselor Staffing Ratio</strong></td>
</tr>
<tr>
<td>The ratio of counselors to youth must not exceed one counselor to 16 youths.</td>
</tr>
</tbody>
</table>
Clinical Staff Qualifications and Responsibilities

Counselor Qualifications

To provide behavioral health overlay services, a counselor must meet one of the following qualifications:

1. Hold a master’s degree from an accredited university or college in the field of counseling, social work, psychology, rehabilitation, special education, or in a related human services field. (Effective October 1, 2014, graduate level coursework must include at least four (4) of the following 13 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 abuse); or

2. Hold a bachelor’s degree from an accredited university or college in the field of counseling, social work, psychology, rehabilitation, special education, or in a related human services field and have two years experience in working with children with serious emotional disturbances or substance abuse problems; or

3. Hold a bachelor’s degree and have 52 hours of pre-service training (as described below) prior to working with children and adolescents and be directly supervised for one year by a staff person who meets the minimum criteria of a bachelor’s degree, 88 hours of training in the areas outlined above with additional training in therapeutic techniques, and at least 18 months experience in the program.

Counselors with bachelor’s degrees are restricted to providing face-to-face therapeutic support services and group therapy. They may not provide individual or family therapy. Only counselors with a minimum of a master’s degree may provide individual and family therapy.

Counselors who do not meet the requirement of two years of experience are restricted to providing one-on-one therapeutic intervention as a part of the daily routine, managing therapeutic group activities, and providing supportive therapeutic interventions throughout the day. They may not provide family therapy or individual therapy.

Pre-Service Training

The pre-service training must cover at a minimum the following components: basic counseling skills, basic group skills, program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, early intervention and de-escalation, documentation requirements, normal and abnormal adolescent development, typical behavior problems, and introduction to the Department of Juvenile Justice.
### Counselor Job Responsibilities

Counselors must be supervised by licensed professionals. Counselors are responsible for:

- Completing or requesting required assessments;
- Providing therapeutic support services and interventions;
- Providing individual, group and family therapy, when indicated;
- Coordinating and implementing behavioral health programming associated with the treatment plan and with the recipient’s performance plan;
- Training of direct care staff in the implementation of the individualized treatment plan for behavioral health overlay services;
- Monitoring the overall course of treatment services and observing and documenting direct care staff’s implementation of the recipient’s individualized treatment plan;
- Convening treatment team meetings as scheduled or as needed to discuss behavioral health overlay services;
- Developing the recipient’s behavioral health discharge plan and aftercare plan; and
- Serving as a liaison with the Department of Juvenile Justice, the district or regional Substance Abuse and Mental Health program office, the Department of Children and Families, and the district Child Welfare and Community-Based Care program office lead agency, if indicated, to address continuity of care issues.

### Licensed Practitioner Qualifications

Licensed practitioners include: psychiatrists, physician assistants, psychiatric nurses or ARNP’s, clinical social workers, mental health counselors, psychologists, and marriage and family therapists. For recipients with a primary diagnosis of a substance abuse disorder, licensed practitioners also include certified addictions professionals with a master’s degree. In addition, for recipients with primary substance abuse diagnoses, licensed practitioners include master’s certified addictions professionals.

To provide behavioral health overlay services, the licensed practitioner must meet the specific qualifications described in Chapter 1 and Chapter 2, Section 2 of this handbook.
Clinical Staff Qualifications and Responsibilities, continued

The licensed practitioner’s responsibilities include:

- Conducting face-to-face interviews with recipients to develop an individualized behavioral health treatment plan that is in accordance with the policies in this handbook;

- Reviewing and signing the recipient’s:
  - Certification for Eligibility for Behavioral Health Overlay Services;
  - Clinical psychosocial assessment, after it is prepared by the counselor;
  - Individualized behavioral health treatment plan. **Note:** If the licensed practitioner is enrolled in Medicaid as a treating provider, this signature may serve to authorize the treatment plan, and an additional authorization by signature and date from the psychiatrist is not required; and

- Providing documented weekly clinical supervision to the counselors.

Licensed practitioners may conduct behavioral health assessments and provide direct treatment services.
Clinical Staff Qualifications and Responsibilities, continued

Clinical Supervision

A licensed practitioner must provide at least one hour of supervision per week for each unlicensed counselor. Licensed staff must be available to provide emergency consultation services. A licensed practitioner must provide and document at least four hours of clinical supervision per month for each unlicensed counselor. The documentation should include the name of the participants, length of the meeting, and a list of the clinical topics discussed. Licensed staff must be available by phone to provide emergency consultation services. The supervision may be individual or group supervision. Treatment team meetings and treatment plan reviews may not be substituted for supervision.

Behavior Analyst Qualifications

A behavior analyst must have a master’s degree from an accredited college or university in counseling, social work, psychology, rehabilitation or special education or in a related human services field, and three years experience in behavior management or be certified in behavior analysis. Certified behavior analysts must meet the specific qualifications described in Chapter 1.

Behavior Analyst Job Responsibilities

A behavior analyst responsibilities include:

- Reviewing and signing the behavior modification components of the individualized behavioral health treatment plan;
- Consulting with the staff who are implementing an individualized behavioral management program for a recipient with behavioral health issues; and
- Training direct care staff, counselors, and administrators on behavioral management principles and application.

Psychiatrist Qualifications

The psychiatrist must be a medical doctor or doctor of osteopathy, licensed pursuant to Chapter 458 or 459, Florida Statutes, and board eligible or certified in psychiatry.

Psychiatrist Responsibilities

The psychiatrist’s responsibilities include:

- Oversight of the recipient’s psychiatric services; and
- Supervising the treatment for recipients who are on psychotropic medications, in coordination with the primary health caregiver, when indicated by a recipient’s medical condition.

The psychiatrist may serve as the treating physician if he is enrolled in the Medicaid program as a physician provider (provider types 25 or 26).
Recipient Eligibility for Behavioral Health Overlay Services

Who May Receive Services

To receive behavioral health overlay services, a recipient must:
- be a child or adolescent under 18 years of age;
- be placed in a Medicaid-enrolled residential program that has been self-certified or certified to provide behavioral health overlay services; and
- be certified as meeting the clinical criteria listed below.

Clinical Criteria

The recipient must meet the diagnostic eligibility criteria described in Number 1 or 2 in Section A and one of the four risk factors in Section B.

Section A: Diagnostic Criteria

1. Has an ICD-9-CM diagnosis of 295.0 through 298.9 (psychotic disorder, major depression or bipolar disorder).
   OR
2. Has an ICD-9-CM diagnosis in the following range: 294.8, 294.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; and
   a) Has been enrolled in a special education program for the seriously emotionally disturbed or emotionally handicapped; or
   b) Has scored a 60 or below on the Axis V Global Assessment of Functioning Scale or CGAS within the last six months. The justification for the score must be well documented and detailed on the certification form.

Section B: Risk Factors

The recipient must be at risk due to one of the following factors:

1. Within the past 12 months, recipient has exhibited a history of suicidal gestures, attempts or self-injurious behaviors, or current ideation related to suicidal or self-injurious behavior, though not be currently in need of acute care.
2. Within the past 12 months, recipient has exhibited a history of physical aggression or violent behavior towards people, animals, or property. This risk may also be evidenced by current threats of such aggression.
3. Within the past 12 months, recipient has a history of running away from home or placements or current verbal threatened to run away on one or more occasions.
4. Within the past 12 months, recipient has exhibited problems with substance abuse.
5. Recipient has a history or recent occurrences of sexual aggression.
6. Recipient has a history of victimization.

The recipient's risk factor(s) must be documented and detailed on the certification form and reflected in the recipient's treatment plan.
**Recipient Eligibility for Behavioral Health Overlay Services**, continued

| Recipient Certification for Services | A Certificate of Eligibility for Behavioral Health Overlay Services in Juvenile Justice Settings form verifying eligibility for behavioral health overlay services must be completed and signed by a licensed practitioner within 72 hours of provision of services and prior to billing for such services. Prior to the provision of behavioral health overlay services, a licensed practitioner must complete and sign a Certification of Eligibility for Behavioral Health Overlay Services. Documentation must be present in the recipient clinical record to support the certification. 

Note: See Appendix I in this chapter for a copy of the Certification of Eligibility for Behavioral Health Overlay Services in Juvenile Justice Settings form. |
| Authorization and Effective Date of Certification | Medicaid will reimburse for behavioral health overlay services up to 72 hours prior to the authorization date. The Certificate of Eligibility becomes effective on the date it is authorized (i.e., signed and dated) by the licensed practitioner. |
| Recipient Re-Certification for Services | Every six months, a licensed practitioner must complete and sign a new Certification of Eligibility for Behavioral Health Overlay Services in Juvenile Justice Settings form verifying the recipient’s continued eligibility. Documentation must be present in the recipient’s clinical record to support the recertification. |
Service Requirements

Required Components

Behavioral health overlay services must include the following components:

- An initial screening by a counselor or licensed clinician within 72 hours of provision of services at the time of admission to the residential program (or prior to admission, if possible) to determine if the recipient meets the criteria for behavioral health overlay services. If a counselor completes the screening, a licensed clinician must also sign the Certification of Eligibility for Behavioral Health Overlay Services in Juvenile Justice Settings.
- A face-to-face interview by a licensed clinician as part of the treatment planning process.
- Assignment of a counselor to serve as a recipient’s primary counselor who will complete a psychosocial assessment or provide the clinical component of a comprehensive delinquency psychosocial.
- Behavioral health treatment team meeting within 30 days of admission to develop the individualized treatment plan, in conjunction with delinquency performance plan development.
- Behavioral health treatment team meetings that include input from the recipient’s family, psychiatrist, licensed practitioners, counselors, direct care staff, direct care supervisors, any involved case managers, behavioral analyst, ancillary services and school personnel, and Department of Juvenile Justice juvenile probation officers.
- Review and sign off by the treating psychiatrist (or other physician) or treating licensed practitioner of the healing arts.
- The behavior analyst’s review and sign off on the behavior management section of the plan, if indicated.
- Provision of individualized treatment interventions for each youth as authorized in the treatment plan.
- The recipient’s primary counselor’s planning, coordinating and monitoring responsibilities that are listed under Counselor Responsibilities in this section.
- A treatment plan review at least every six months, in accordance with Medicaid policy contained in Chapter 2, Section 1.
- Provision of transition, discharge, and aftercare planning for successful transition into inclusive community environment.
- Recipient re-certification for behavioral health overlay services.
- Evaluation and submission of behavioral health outcomes to the Department of Children and Families using the Children's Functional Assessment Rating Scale.

Intensity of Services

The intensity and individual utilization of treatment services is governed by the recipient’s individualized treatment plan. Each recipient must receive at least one behavioral health service intervention each day for which behavioral health overlay services are billed.
The following components must be documented in the recipient’s medical record:

- The name of the primary counselor who coordinates implementation of the recipient’s behavioral health treatment plan.
- The recipient’s completed and signed Certification of Eligibility for Behavioral Health Overlay Services form(s) for each six-month period that the recipient received services.
- A signed copy of the psychosocial assessment and evaluation of the recipient’s behavioral health symptoms, risks, and functional status that was completed and signed off on by a licensed practitioner prior to the development of the treatment plan.
- An individualized treatment plan that meets the criteria for treatment plans as specified in Chapter 2, Section 1 of this handbook and the additional treatment plan requirements that are listed below.
- A behavioral health aftercare plan for any child receiving behavioral health overlay services at the time of release from the Department of Juvenile Justice program.
- Treatment plan review conducted at least every six months, and documented according to Medicaid policy as specified in Chapter 2, Section 1.
- Daily or weekly progress notes as described on the following page.

The following requirements are in addition to those found in Chapter 2, Section 1, Treatment Planning and Review.

The recipient’s individualized treatment plan must be completed and signed by a treating practitioner within 30 days of initiation of behavioral health overlay services. The recipient’s individualized treatment must specify the therapeutic activities that will be provided under the behavioral health overlay services code, including the amount, frequency, and duration, and amount of timed activities.

Examples: If a recipient will receive individual or group therapy, the plan should specify the number of sessions each week and the length of time that the recipient will need the session(s). If a goal is relationship building through consistent informal contacts with staff throughout each day, this daily intervention should be specified in the plan.

If the behavioral health treatment plan contains an individualized behavior management component, the behavioral analyst must review and sign the component. The behavior management plan must be consistent with treatment outcomes and objectives.
Upon enrollment as a BHOS provider, and once per state fiscal year, providers may choose to document services in either daily progress notes or weekly progress notes. The provider’s choice of documentation frequency must be clearly identified in the provider’s policy.

For each recipient, the primary counselor must dictate or complete and sign the behavioral health overlay services weekly progress notes. For each day that BHOS is billed, the weekly progress notes must include the following information:

1. **Summary** Documentation of the behavioral health overlay services delivered, the recipient’s corresponding responses to the services, and the recipient’s progress toward reaching individualized goals, significant events occurring during the week, and contacts with family and other agencies.

2. **Information** Documentation that the interventions services authorized in the treatment plan were delivered in accordance with the plan.

3. **Observations** of the direct care staff’s implementation of the treatment plan.

4. **Summary** Documentation of the treatment team meetings related to the recipient. Include information to reflect that the recipient’s individualized goals, progress, and identified treatment needs were discussed.

5. Substantiation that behavioral health overlay services were delivered each day that these services are billed by documenting the therapeutic interventions and interactions that the primary counselor or the direct care staff provided to the recipient based on the recipient’s treatment plan. (Include specific responses/actions by counselor or direct care staff)

6. Documentation of any significant events, and documentation of contacts and visits with family and other agencies.

For each recipient, the primary counselor must complete and sign behavioral health overlay services daily progress notes. For each day that BHOS is billed, the daily progress notes must include the following information:

1. Documentation of the behavioral health overlay services delivered, the recipient’s corresponding responses to the services, and the recipient’s progress toward reaching individualized goals.

2. Documentation that the services authorized in the treatment plan were delivered in accordance with the plan.

3. Documentation of any treatment team meetings related to the recipient. Include information to reflect that the recipient’s individualized goals, progress, and treatment needs were discussed.

4. Documentation of any significant events, and documentation of contacts and visits with family and other agencies.
<table>
<thead>
<tr>
<th>Documentation of Family Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The medical clinical record must document that the family members were involved in the behavioral health treatment plan development and treatment processes and must include the goals and objectives for family counseling, or justification if family is not involved.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Weekend Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct care staff or counselors may document daily service when provided and interventions or counselors may gather information on the recipient's activities, adjustment, mood, and response to staff interventions and interactions to include in the progress notes summary to substantiate that the services were provided on each weekend day.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation of Services Billed Fee-For-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider who provides a service on a fee-for-service basis must document the service in accordance with Medicaid policy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation of Case Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation must reflect coordination and linkages with family, the program's school, primary medical care providers, community services, and Department of Juvenile Justice probation officers in accordance with a recipient's treatment plan.</td>
</tr>
</tbody>
</table>
Recipient Absences from the Behavioral Health Overlay Services Provider

Recipient Absences
Medicaid reimbursement is not available for the days a recipient is away from the residential provider agency, except for approved therapeutic visits, hospitalizations, or other crisis placements.

Therapeutic Visits
Therapeutic visits are visits the recipient spends with his or her biological, adoptive or extended family or potential placement setting. Therapeutic visits must be planned in accordance with the recipient’s Department of Juvenile Justice performance plan and authorized in the behavioral health overlay services treatment plan. The visitation schedule must be individualized to the specific needs of the child or adolescent. Visitation must not be dependent on the provider’s holiday and leave schedule for staff. The home visitation schedule must be individualized to the specific needs of the child or adolescent. Home visitation must not be dependent on the provider’s holiday and leave policy.

The recipient’s behavioral health overlay services provider must be accessible and must maintain a level of communication during such visits as determined by the counselor and his or her clinical supervisor. Documentation in the recipient's clinical record must substantiate the contact and on-going communication with the child or adolescent recipient during the visits or placement. Documentation of phone conversations between the provider and recipient constitutes substantiation of on-going communication. Voicemail or e-mail messages are not reimbursable modes of contact.

Reimbursement During Therapeutic Visits
Medicaid reimburses for behavioral health overlay services when the recipient is absent for a therapeutic visit for up to 10 days per calendar quarter (three months).

During the last three months of placement and if the visits are in accordance with the recipient’s treatment plan, Medicaid can reimburse for behavioral health overlay around services when the recipient is absent up to 20 therapeutic visit days to allow for gradual therapeutic re-integration into the discharge setting and community. The visits must be authorized in the recipient’s treatment plan.

Reimbursement During Hospital and Crisis Stabilization Unit Placements
Medicaid can reimburse for behavioral health overlay services during a recipient’s absence due to hospitalization or other crisis placement for up to 14 six days duration per hospitalization once every six months state fiscal year.

Behavioral health overlay services counselors must be accessible and must maintain a level of communication during such placements as determined by the recipient’s clinical needs and hospital staff.

If a recipient experiences more than one psychiatric crisis placement within a six-month period, the recipient’s treatment team must convene and complete a reassessment of the recipient’s plan to ensure that the plan is meeting the recipient’s needs.
<table>
<thead>
<tr>
<th>Juvenile Detention Center Placements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid will not reimburse for behavioral health overlay services if a recipient is absent because he or she is in a detention center placement.</td>
</tr>
</tbody>
</table>

**Recipient Absences from the Behavioral Health Overlay Services Provider**, continued

<table>
<thead>
<tr>
<th>Unauthorized Absences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid can reimburse for behavioral health overlay services for up to three days when a placement is being maintained for a recipient who has an unauthorized absence (i.e., runs away) from the provider's residential program.</td>
</tr>
</tbody>
</table>

**Reimbursement Requirements**

<table>
<thead>
<tr>
<th>Allowable Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified providers may bill the per diem rate for behavioral health overlay services for services delivered to a recipient who has been certified as meeting the eligibility criteria for up to 365 days a year.</td>
</tr>
</tbody>
</table>
Services that May be Reimbursed in Conjunction with Behavioral Health Overlay Services

The following community behavioral health services are reimbursable in conjunction with behavioral health overlay services. The services must be medically necessary and delivered in accordance with this handbook.

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment Services</strong></td>
<td></td>
<td></td>
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<tr>
<td>Psychiatric evaluation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By an MD or DO</td>
<td>H2000</td>
<td>HP</td>
</tr>
<tr>
<td>By a Non MD or DO</td>
<td>H2000</td>
<td>HO</td>
</tr>
<tr>
<td>Review of records</td>
<td>H2000</td>
<td></td>
</tr>
<tr>
<td>Brief mental status examination</td>
<td>H2010</td>
<td>HO</td>
</tr>
<tr>
<td><strong>In-depth Assessment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New patient</td>
<td>H0031</td>
<td>HO</td>
</tr>
<tr>
<td>Est. patient</td>
<td>H0031</td>
<td>TS</td>
</tr>
<tr>
<td>Bio-Psychosocial Evaluation:</td>
<td>H0031</td>
<td>TS</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>H2019</td>
<td></td>
</tr>
<tr>
<td>Limited Functional Assessment</td>
<td>H0031</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Behavioral Health</td>
<td>H0031</td>
<td>HA</td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
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<tr>
<td><strong>Treatment Plan Development and Modification</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Development</td>
<td>H0032</td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Review</td>
<td>H0032</td>
<td>TS</td>
</tr>
<tr>
<td><strong>Medical and Psychiatric Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td>T1015</td>
<td></td>
</tr>
<tr>
<td>Individual Medical Psychotherapy</td>
<td>H2010</td>
<td>HE</td>
</tr>
<tr>
<td>Group Medical Therapy</td>
<td>H2010</td>
<td>HF</td>
</tr>
<tr>
<td>Behavioral Health Screening</td>
<td>T1023</td>
<td>HE</td>
</tr>
<tr>
<td>Medical/Clinic Service</td>
<td>T1015</td>
<td>HE</td>
</tr>
<tr>
<td>Verbal Interaction</td>
<td>H0046</td>
<td>HF</td>
</tr>
<tr>
<td>Methadone Administration</td>
<td>H0020</td>
<td></td>
</tr>
</tbody>
</table>
Reimbursement Requirements, continued

If a Medicaid recipient does not meet the clinical criteria for behavioral health overlay services but has behavioral health needs, the provider may be reimbursed on a fee-for-service basis for providing the following community mental health services. The services must be medically necessary and provided in accordance with this handbook.

<table>
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<td>Brief mental status examination</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>New patient</td>
<td>H0031</td>
<td>HO</td>
</tr>
<tr>
<td>Est. patient</td>
<td>H0001</td>
<td>HO</td>
</tr>
<tr>
<td>Bio-Psychosocial Evaluation</td>
<td>H0001</td>
<td>TS</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>H2019</td>
<td></td>
</tr>
<tr>
<td>Limited Functional Assessment</td>
<td>H0031</td>
<td>TS</td>
</tr>
<tr>
<td>Comprehensive Behavioral Health Assessment</td>
<td>H0031</td>
<td>HA</td>
</tr>
<tr>
<td><strong>Treatment Plan Development and Modification</strong></td>
<td></td>
<td></td>
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<tr>
<td>Treatment Plan Development</td>
<td>H0032</td>
<td></td>
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<tr>
<td>Treatment Plan Review</td>
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<td>TS</td>
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<td></td>
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<tr>
<td>Individual Medical Psychotherapy</td>
<td>H2010</td>
<td>HE</td>
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<tr>
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<td>H2010</td>
<td>HF</td>
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<tr>
<td>Behavioral Health Screening</td>
<td>T1023</td>
<td>HE</td>
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<tr>
<td>Methadone Administration</td>
<td>H0020</td>
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<tr>
<td><strong>Behavioral Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical or Clinic Service</td>
<td>T1015</td>
<td>HE</td>
</tr>
<tr>
<td>Verbal Interaction</td>
<td>H0046</td>
<td>HF</td>
</tr>
<tr>
<td>Methadone Administration</td>
<td>H0020</td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health Therapy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual or Family Therapy</td>
<td>H2019</td>
<td>HR</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>H2019</td>
<td>HQ</td>
</tr>
<tr>
<td><strong>Community Support and Rehabilitative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial Rehabilitative Services</td>
<td>H2017</td>
<td></td>
</tr>
</tbody>
</table>
### Reimbursement Requirements, continued

**Residential group care providers under contract with the Department of Juvenile Justice may not bill for the following community mental health services procedure codes for recipients in their care.**

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
<th>Modifier (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Day Services</td>
<td>H2012</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Day Services (substance abuse)</td>
<td>H2012 HF</td>
<td></td>
</tr>
<tr>
<td><strong>Services Limited to Children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services – Therapy</td>
<td>H2019 HO</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services – Behavior Management</td>
<td>H2019 HM</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services – Therapeutic Support</td>
<td>H2019 HN</td>
<td></td>
</tr>
<tr>
<td><strong>Specialized Therapeutic Foster Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level I</td>
<td>S5145 HE</td>
<td></td>
</tr>
<tr>
<td>Level II</td>
<td>S5145 HK</td>
<td></td>
</tr>
<tr>
<td>Crisi</td>
<td>S5145 HK</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Overlay – Child Welfare</td>
<td>H2020 HA</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Group Care Services</td>
<td>H2020</td>
<td></td>
</tr>
</tbody>
</table>

Mental health targeted case management for children under age 18 cannot be billed in conjunction with behavioral health overlay services except for 90 days prior to a planned and documented discharge date.
Combinations of Services that Cannot be Billed

The following community behavioral health services procedure codes cannot be billed in conjunction with behavioral health overlay services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code</th>
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</thead>
<tbody>
<tr>
<td>Behavioral Health Therapy Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual or Family Therapy</td>
<td>H2019</td>
<td>HR</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>H2019</td>
<td>HQ</td>
</tr>
<tr>
<td>Community Support and Rehabilitative Services</td>
<td></td>
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<tr>
<td>Psychosocial Rehabilitative Services</td>
<td>H2017</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Day Services</td>
<td>H2012</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Day Services (substance abuse)</td>
<td>H2012</td>
<td>HF</td>
</tr>
<tr>
<td>Club House</td>
<td>H2030</td>
<td></td>
</tr>
<tr>
<td>Services Limited to Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services — Therapy</td>
<td>H2019</td>
<td>HO</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services — Behavior Management</td>
<td>H2019</td>
<td>HM</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services — Therapeutic Support Services</td>
<td>H2019</td>
<td>HN</td>
</tr>
<tr>
<td>Behavioral Health Overlay — Child Welfare</td>
<td>H2020</td>
<td>HA</td>
</tr>
<tr>
<td>Therapeutic Group Care Services</td>
<td>H0019</td>
<td></td>
</tr>
</tbody>
</table>

Specialized Therapeutic Foster Care

<table>
<thead>
<tr>
<th>Level</th>
<th>Procedure Code</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>S5145</td>
<td></td>
</tr>
<tr>
<td>Level II</td>
<td>S5145</td>
<td>HE</td>
</tr>
<tr>
<td>Crisis</td>
<td>S5145</td>
<td>HK</td>
</tr>
</tbody>
</table>

Mental health targeted case management for children under age 18 cannot be billed in conjunction with behavioral health overlay services except for 90 days prior to discharge.

Room and Board

Behavioral health overlay services or any other Medicaid community behavioral health service does not cover room and board expenditures.

Non-Duplication of Services

Medicaid will not reimburse a provider for behavioral health overlay services or any other community mental health service if the provider has been paid for the provision of the same type of services by another purchasing entity.
SECTION 7
BEHAVIORAL HEALTH OVERLAY SERVICES

CHILD WELFARE SETTINGS

Description and Purpose

Description of Behavioral Health Overlay Services in Child Welfare Settings

Behavioral health overlay services in child welfare settings are mental health, substance abuse, and supportive services designed to meet the behavioral health treatment needs of recipients who are placed in the care of Medicaid enrolled, certified residential group care agencies under contract with the Department of Children and Families, Child Welfare and Community Based Care organization.

Medicaid behavioral health overlay services in child welfare settings enable providers to be reimbursed for medically necessary behavioral health services that are provided as an overlay to the residential care and supervision services that are reimbursed under contract with the Department of Children and Families, Child Welfare and Community Based Care organization.

Purpose

The purpose of behavioral health overlay services in child welfare settings are to address, on-site and on a child specific basis, medically necessary mental health and substance abuse treatment needs of children who are placed in a residential group care setting that is under contract with Department of Children and Families or its agent.

Goals

The goals of behavioral health overlay services in child welfare settings are to provide the recipient with:

- Improved mental status, emotional and social adjustment;
- Reduction in unplanned placement changes;
- Enhanced ability to attend and be productive in school and engage in age appropriate activities;
- Increased likelihood of a child’s successful return to family or successful implementation of a permanency plan; and
- If developmentally appropriate, increased capacity for independent living.
Provider Requirements for Behavioral Health Overlay Services in Child Welfare Settings

Provider Agency Eligibility Requirements

To enroll as a Medicaid provider of behavioral health overlay services in child welfare settings, a residential care agency must meet all of the following criteria:

1. Be enrolled as a Medicaid community behavioral health services provider (includes monitoring by the Agency for Health Care Administration (AHCA), or its designee First Health Services and approval of Pre-Certification);
2. Have the capacity to provide assessments, treatment planning, individual and group therapy and behavioral health overlay services in child welfare settings to eligible children;
3. Be licensed by a district or regional Department of Children and Families, Child Welfare and Community Based Care office, under Chapter 65 C-14, F.A.C. as a child caring agency and under contract with the child welfare or a community based care organization to provide group shelter care or residential group care to dependent children;
4. Have as a primary mission to provide an alternative living situation for children who have been placed in the care of the Department of Children and Families. The provider may not be a residential treatment facility;
5. Be designated by the district Department of Children and Families, Child Welfare and Community Based Care office as an essential behavioral health care provider;
6. Have completed a successful pre-operational self-survey and been self-certified as indicated by a letter from the Agency for Health Care Administration authorizing a billing start date, followed within approximately six months by an on-site survey by the area Agency for Health Care Administration office and district Substance Abuse Mental Health and Child Welfare and Community Based Care office. The agency must meet criteria to receive an Agency Certification form signed and approved by representatives from those offices; and
7. Be accredited by the Council on Accreditation (COA); the Council on Accreditation of Rehabilitation Facilities (CARF); or the Joint Commission on Accreditation of Health Organizations (JCAHO); the National Committee for Quality Assurance (NCQA); or any other accreditation organization approved by Medicaid or earn accreditation by 2005. The provider must be fully accredited within two years of enrollment as a Medicaid provider of behavioral health overlay services.

Provider Agency Behavioral Health Overlay Services Self Certification Process

To be certified to provide behavioral health overlay services in child welfare settings, an enrolled Medicaid provider must submit a Provider Agency Self-Certification Behavioral Health Overlay Services-Child Welfare form to:

Agency for Health Care Administration
Medicaid Services
Behavioral Health Unit- C/Overlay
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308
Provider Requirements for Behavioral Health Overlay Services in Child Welfare Settings, continued

**Provider Agency Behavioral Health Overlay Services Self Certification Process, continued**

The provider’s executive director must sign the form. By signing the form, the executive director is giving assurances that the provider conducted a review of the site for which the certification is being requested and that the site meets the provider qualifications, including current enrollment in Medicaid, and all other certification criteria (see Certification Criteria for Behavioral Health Overlay Services — Child Welfare in this section for a description of the requirements).

Based on the provider’s assurances, Medicaid Behavioral Health unit will send a letter to the provider that grants temporary certification for billing behavioral health overlay services-child welfare at the site.

**Note:** See Appendix N in this chapter for a copy of the Provider Agency Self-Certification Behavioral Health Overlay Services-Child Welfare form.

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**Provider Agency Certification Process**

Within approximately six months of the effective date of the self-certification, the district Substance Abuse and Mental Health program office, with the area Medicaid office, will survey the site to determine if it meets the certification criteria (see Certification Criteria for Behavioral Health Overlay Services - Child Welfare in this section for a description of the requirements).

If the program site is in compliance, the provider will receive a Provider Agency Certification form signed by the reviewing entity AHCA and the provider.

If the program is found to be non-compliant, the provider must complete a corrective action plan within 60 days. If a provider does not earn a score of 70 percent or above, the site will be re-reviewed. The provider’s certification will be withdrawn within 6 months if a program continues to be non-compliant with the certification criteria.

Providers of behavioral health overlay services to both juvenile justice and child welfare populations require agency behavioral health overlay services certification for both juvenile justice and child welfare populations.

**Note:** See Appendix O in this chapter for a copy of the Provider Agency Behavioral Health Overlay Services Certification form.
Certification Criteria for Behavioral Health Overlay Services Provider Agencies

Certification Criteria

To be certified or self-certified to provide behavioral health overlay services — child welfare, a provider must demonstrate the administrative capability to operate as a designated residential shelter or group care setting by meeting the criteria listed in this section. The criteria cover the following areas:

- Services to be provided;
- Community behavioral health services to be provided;
- Provider capabilities;
- Behavioral health crisis management;
- Quality assurance program;
- Required policies and procedures;
- Staff requirements;
- Clinical staffing requirements and responsibilities; and
- Clinical supervision.

The criteria are described in detail in the following sections.

Services to be Provided

The provider must have the capacity to provide the following therapeutic and supportive array of services, when medically necessary, to be reimbursed under the behavioral health overlay services-child welfare procedure code:

1. Screening to determine eligibility for behavioral health overlay services child welfare;
2. Crisis management up to the need for acute level of a crisis stabilization unit or inpatient care, including referral procedures when the recipient needs to be placed in a crisis stabilization unit or acute psychiatric inpatient care;
3. Individual, group, and family counseling — therapeutic support services;
4. Individual, group, and family therapy, when indicated;
5. Integrated therapeutic interventions such as assistance in anger management, problem resolution, and social interaction;
6. Individualized behavioral programming (including design, consultation, and supervision), if when indicated;
7. Provision of clinical expertise in reunification activities with family;
8. Supportive counseling during transitions;
9. Discharge and aftercare planning that includes identification of behavioral and substance abuse support services needed for successful discharge from behavioral health overlay services-child welfare and transition into the next level of care or placement;
10. Therapeutic visits;
11. Clinical services that promote increased capacity for independent living for older adolescents; and
12. Coordination of behavioral health overlay services — child welfare interventions across components of the program.
Certification Criteria for Behavioral Health Overlay Services Provider Agencies, continued

**Community Behavioral Health Services**

The provider must have the capacity to provide the following Medicaid community behavioral health services:

1) Assessment services;
2) Treatment planning development and modification; and
3) Medical and psychiatric services.

The provider may bill for these services on a fee-for-service basis in addition to billing for behavioral health overlay services. The services must be provided in accordance with Medicaid policy and be medically necessary.

**Provider Capabilities**

The provider must have the capability to provide:

- Behavioral health, bio-psychosocial assessments, and individual and group therapy with the availability of multiple sessions per week as indicated by the needs of the individual and reflected in the treatment plan.
- The clinical therapeutic and therapeutic supportive services array as listed in the above paragraphs: Services to be Provided and Community Behavioral Health Services.
- Family counseling for individuals and their family when the individual's family is willing to participate in reintegration with the family is a goal. When appropriate, family counseling should be specified in the treatment plan and conducted in conjunction with the recipient's permanency plan.
- A therapeutic environment with an identified treatment orientation, which is supported and implemented consistently across components of the program.
- Behavioral health care coordination and linkages with the schools, primary medical care, and community services.
- If the provider uses behavior therapy as a treatment modality, the behavioral programming must be individually designed and implemented and include structured interventions and contingencies designed to support the development of adaptive, pro-social interpersonal behavior.
- Behavior therapy is defined as a type of therapy that seeks to change abnormal or maladaptive behavior patterns by the use of extinction and inhibitory processes and positive and negative reinforcements. The focus of therapy is on the behavior itself rather than engaging in analytical or dynamic analysis or exploration of underlying conflicts or other root causes. Treatment interventions include behavior programming that is aimed at behavior modification of current behaviors. A certified behavior analyst or a certified associate behavior analyst who is under the supervision of a certified behavior analyst must render all behavior therapy.
### Behavioral Health Crisis Management

The provider must demonstrate 24-hour response capability with access to acute care settings and behavioral health emergency management services.

### Quality Improvement Assurance Program

The provider must have a quality improvement assurance program that includes evaluation of the effectiveness and outcomes of all the behavioral health services provided. The quality improvement policies and procedures must include:

- Monitoring behavioral health treatment planning and implementation;
- Tracking the child’s use of services to assure the intensity of services is appropriate for the child’s assessment, risk factors and clinical characteristics;
- **Evaluating and submitting behavioral health outcomes to the Department of Children and Families using the Children’s Functional Assessment Rating Scale**;
- Review of effectiveness of services per recipient through monitoring behavioral health outcomes against treatment objectives;
- Ongoing review of behavioral health staff performance in implementing behavioral health services;
- Monitoring of behavioral health critical incidents; and
- Implementing and documenting pre-service and ongoing staff training agendas that improve and support the delivery of behavioral health overlay service – child welfare.
Certification Criteria for Behavioral Health Overlay Services Provider Agencies, continued

Required Policies and Procedures

The provider agency must have policies and procedures in place that address the following:

1. Thorough screening, evaluation, and diagnosis of symptoms, risks, functional status, and co-morbidity.

2. Policies and procedures that address therapeutic crisis intervention, including the use of time out, in compliance with applicable requirements and generally accepted standards of care. The policies and procedures must address transfer to a restrictive level of care if a recipient is a danger to him or herself or others and cannot be safely managed in the residential group care setting. The use of mechanical restraint is not allowed.

3. Treatment teams that are responsible for organizing the delivery of behavioral health overlay services – child welfare that are integrated into the daily activities of daily living associated with structured residential care, including the revision of treatment plans if the child is not making progress.

4. Inclusion of the recipient’s family in the clinical treatment process or documented justification if the recipient’s family is not involved.

5. Prompt enrollment and disenrollment procedures for recipients in managed care plans.

6. Each child must receive at least one documented behavioral health intervention each day the service is billed, with the intensity and individual use of treatment services directly related to the child’s specific needs as addressed in the treatment plan.

7. At least a weekly documentation on the course of treatment that directly addresses the child’s progress toward meeting individual clinical goals and objectives as included in the individual treatment plan.


9. Clinical aftercare planning and discharge planning that support development of independent living skills when developmentally appropriate and are coordinated with the child’s permanency plan.

10. An internal review process of the recipient’s eligibility for behavioral health overlay services – child welfare.

11. A clinical supervision protocol that assures timely monitoring of services and modification of treatment as needed.

### Certification Criteria for Behavioral Health Overlay Services Provider Agencies, continued

<table>
<thead>
<tr>
<th>Required Policies and Procedures, continued</th>
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</thead>
<tbody>
<tr>
<td>12. At least a weekly documentation on the course of treatment that directly addresses the child’s progress toward meeting individual clinical goals and objectives as included in the individual treatment plan.</td>
</tr>
<tr>
<td>14. Clinical aftercare planning and discharge planning that support development of independent living skills when developmentally appropriate and are coordinated with the child’s permanency plan.</td>
</tr>
<tr>
<td>15. An internal review process of the recipient’s eligibility for behavioral health overlay services — child welfare.</td>
</tr>
<tr>
<td>16. A clinical supervision protocol that assures timely monitoring of services and modification of treatment as needed.</td>
</tr>
<tr>
<td>17. Best practice guidelines for the clinical management of specific types of emotional and behavioral problems encountered by recipients served in residential child care settings.</td>
</tr>
</tbody>
</table>

### Staff Requirements

<table>
<thead>
<tr>
<th>Clinical Services Supervisor</th>
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<tbody>
<tr>
<td>The provider must have a clinical services supervisor, identified on the program’s organizational chart, who has lead responsibility for the overall coordination and provision of behavioral health overlay services in child welfare settings.</td>
</tr>
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<table>
<thead>
<tr>
<th>Management Staff Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider’s management staff must have appropriate experience and capability to administer effective, ongoing operations of behavioral health overlay services in child welfare settings.</td>
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</table>

<table>
<thead>
<tr>
<th>Adequate Number of Staff</th>
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<tbody>
<tr>
<td>The provider’s budget must indicate that there are an adequate number of funded positions to meet the staff requirements for behavioral health overlay services in child welfare settings.</td>
</tr>
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<thead>
<tr>
<th>Psychiatrist</th>
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<tbody>
<tr>
<td>The provider must have a psychiatrist(s) on staff or under contract.</td>
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</tbody>
</table>
**Staff Requirements, continued**

<table>
<thead>
<tr>
<th>Clinical Staff Credentials</th>
<th>All counselors, licensed practitioners, and psychiatrists providing behavioral health overlay services in child welfare settings must meet the specific education and training requirements described in this chapter.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Counselor Staffing Ratio</strong></td>
<td>The ratio of counselors to youth must not exceed one counselor to 20 youths.</td>
</tr>
</tbody>
</table>

**Clinical Staff Qualifications and Responsibilities**

<table>
<thead>
<tr>
<th>Counselor Qualifications</th>
<th>To provide behavioral health overlay services in child welfare settings, a counselor must meet one of the following qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Hold a master’s degree from an accredited university or college in the field of counseling, social work, psychology, rehabilitation, special education, or in a related human services field (Effective October 1, 2014, graduate level coursework must have included at least four (4) of the following 13 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 abuse); or</td>
</tr>
<tr>
<td>Or</td>
<td>Hold a bachelor’s degree from an accredited university or college in the field of counseling, social work, psychology, rehabilitation, special education, health education or in a human services field and have two years experience in working with children with serious emotional disturbances or substance abuse problems. Counselors with bachelor’s degrees are restricted to providing face-to-face behavioral support services and group therapy. They may not provide individual or family therapy. Only counselors with a minimum of a master’s degree may provide individual and family therapy.</td>
</tr>
</tbody>
</table>
Counselor Job Responsibilities

Counselors must be supervised by a licensed practitioner of the healing arts, as defined in this handbook.

Counselors are responsible for:

- Completing or requesting required assessments;
- Providing therapeutic support services and interventions;
- Providing individual, group and family therapy when indicated and in accordance with qualifications; supportive counseling;
- However, whenever a child or his family is assessed as needing more intensive therapy than supportive counseling, a master's level practitioner, as defined in Chapter 1 of this handbook, must provide these individual or family services.
- Overseeing behavioral health treatment services associated with the treatment plan and with the recipient's permanency plan;
- Training direct care staff in the implementation of the individualized treatment plan for behavioral health overlay services — child welfare, including any behavioral management components;
- Overseeing behavioral health treatment services associated with the treatment plan and with the recipient’s permanency plan;
- Training direct care staff in the implementation of the individualized treatment plan for behavioral health overlay services — child welfare, including any behavioral management components;
- Monitoring the overall course of treatment services and observing and documenting direct care staff’s implementation of the recipients individualized treatment plan.
- Participating in and convening and participating in treatment team meetings as scheduled or as needed to discuss behavioral health overlay services — child welfare;
- Developing the recipient’s behavioral health discharge plan and aftercare plan; and
- Providing serving as a liaison with between the BHOS provider and the Substance Abuse and Mental Health Program, Office of Children and Families, the Department of Juvenile Justice, other involved agencies, and the Child Welfare and Community-Based Care organization's case managers, lead agency, and other involved agencies, if indicated, to address continuity of care issues.

Licensed Practitioner Qualifications

Licensed practitioners must be licensed by the State of Florida under Chapters 458, 459, 490, 491, 464, F.S., providing for licensure of psychiatrists, physician assistants, psychiatric nurses or ARNP’s, clinical social workers, mental health counselors, psychologists, and marriage and family therapists. In addition, for recipients with a primary substance abuse diagnosis, licensed practitioners include masters prepared certified addictions professionals with a master’s degree.

To provide behavioral health overlay services — child welfare, the licensed practitioner must meet the specific qualifications described in Chapter 1 and Chapter 2, Section 2 of this handbook.
### Clinical Staff Qualifications and Responsibilities, continued

<table>
<thead>
<tr>
<th>Licensed Practitioner Responsibilities</th>
<th>The licensed practitioner’s responsibilities include:</th>
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<tbody>
<tr>
<td></td>
<td>• Conducting interviews with recipients to develop individualized behavioral health treatment plans which must be in accordance with the policies in this handbook;</td>
</tr>
<tr>
<td></td>
<td>• Reviewing and signing the recipient’s:</td>
</tr>
<tr>
<td></td>
<td>✓ Certification for Eligibility for Behavioral Health Overlay Services — Child Welfare.</td>
</tr>
<tr>
<td></td>
<td>✓ Psychosocial assessment if it is prepared by an unlicensed counselor.</td>
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<tr>
<td></td>
<td>✓ Individual behavioral health treatment plan. If the Licensed practitioner is enrolled in Medicaid as a treating provider, this signature may serve to authorize the treatment plan, without additional sign off by the psychiatrist,</td>
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<tr>
<td></td>
<td>• Providing documented weekly clinical supervision to the counselors.</td>
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</tbody>
</table>

Licensed practitioners may provide assessments, and individual or family therapy if a child or family is assessed as needing specialized or more intensive treatment services than can be provided by a bachelor’s level staff.

<table>
<thead>
<tr>
<th>Behavior Analyst</th>
<th>If behavior therapy is utilized by a provider, consultation with a certified behavior analyst or person with specialized training in behavior therapy is encouraged to:</th>
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<tbody>
<tr>
<td></td>
<td>• Review the behavior modification components of the treatment plan;</td>
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<tr>
<td></td>
<td>• Consult with staff implementing behavior management plans; and</td>
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<tr>
<td></td>
<td>• Provide training to direct care staff, counselors and administrators on behavior management principles and application.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatrist Qualifications</th>
<th>The psychiatrist must be a medical doctor or doctor of osteopathy, licensed pursuant to Chapter 458 or 459, F.S., and board eligible or certified in psychiatry.</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Psychiatrist Responsibilities</th>
<th>The psychiatrist's responsibilities include:</th>
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<tbody>
<tr>
<td></td>
<td>• Managing the delivery of psychiatric services to recipients;</td>
</tr>
<tr>
<td></td>
<td>• Supervising the treatment for recipients who are on psychotropic medications, in coordination with the primary health caregiver, when indicated by a recipient's medical condition; and</td>
</tr>
<tr>
<td></td>
<td>• Authorizing the delivery of services to recipients that are not authorized by a licensed practitioner of the healing arts.</td>
</tr>
</tbody>
</table>
Clinical Staff Qualifications and Responsibilities, continued

Clinical Supervision
A licensed practitioner must provide and document at least four hours of clinical supervision per month for each unlicensed counselor. The documentation should include the name of the participants, length of the meeting, and a list of the topics discussed. Licensed staff must be available by phone to provide emergency consultation services through a posted on-call schedule. The supervision may be individual or group supervision. Treatment team meetings and treatment plan reviews may not be substituted for supervision.

Recipient Eligibility for Behavioral Health Overlay Services

Who May Receive Services
To receive behavioral health overlay services, a recipient must be placed in a Medicaid-enrolled residential program that has been self-certified or certified to provide behavioral health overlay services in child welfare settings and must be certified as meeting the clinical criteria listed below.

Recipient Eligibility for Behavioral Health Overlay Services

Who May Receive Services
To receive behavioral health overlay services, a recipient must:

- be a child or adolescent under 18 years of age;
- be placed in a Medicaid-enrolled residential program that has been self-certified or certified to provide behavioral health overlay services in child welfare settings; and
- be certified as meeting the clinical criteria listed below.

Eligibility Criteria
The recipient must meet both diagnostic eligibility criteria described in Section A and one of the eight risk factors in Section B.

Section A: Diagnostic Criteria

1. Has an ICD-9-CM diagnosis of 294.8, 294.9, 295.0 through 298.9; 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; and 303.0 through 305.9; and
2. The child or adolescent demonstrates significant impairment of age-appropriate, developmental progression and psychosocial functioning as a result of the ICD-9-CM diagnosis, in one or more of the following areas: family, social and peer relationships, educational or vocational.
Recipient Eligibility for Behavioral Health Overlay Services, continued

Eligibility Criteria

The recipient must meet both diagnostic eligibility criteria described in Section A and one of the eight risk factors in Section B.

Section A: Diagnostic Criteria

1. Have an ICD-9-CM diagnosis of 294.8, 294.9, 295.0 through 298.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; and 303.0 through 305.9; and

2. The child or adolescent demonstrates significant impairment of age-appropriate, developmental progression and psychosocial functioning as a result of the ICD-9-CM diagnosis, in one or more of the following areas: family, social and peer relationships, educational or vocational.

Section B: Risk Factors

The recipient must be at risk due to one of the following factors and such risk is documented and detailed on the certification form:

1. Within the past 12 months, recipient has exhibited a history of suicidal gestures or suicide attempts, or self-injurious behavior, or current ideation related to suicidal or self-injurious behavior, though and not be currently in need of acute care;

2. Within the past 12 months, recipient has exhibited a history of physical aggression or violent behavior toward people, animals, or property. This risk may also be evidenced by current threats of such aggression;

3. Within the past 12 months, recipient has a history of running away from home or placements or current verbal threats to run away on one or more occasions;

4. Within the past 12 months, recipient has received multiple placements;

5. Recipient has recently been removed from home because of abuse or neglect and placed in a group shelter setting;

6. Recipient has a history, or recent occurrences, of sexual aggression, or

7. Recipient has a history of victimization trauma;

8. Within the past 12 months, recipient has exhibited a history of criminal or delinquent behavior;

9. Within the past 12 months, recipient has exhibited a history of or current psychoactive chemical use substance abuse; or

10. A history of disrupted out of home placements; or

Recipient has been discharged from a higher level of care and is in need of post stabilization services.
Recipient Eligibility for Behavioral Health Overlay Services, continued

Recipient Certification for Services

A Certification of Eligibility for Behavioral Health Overlay Services – Child Welfare form verifying eligibility for behavioral health overlay services in child welfare settings must be completed and signed by a licensed practitioner within 72 hours of provision of services and prior to billing for such services. Documentation must be present in the recipient clinical record to support the certification.

Note: See Appendix M in this chapter for a copy of the Certification of Eligibility for Behavioral Health Overlay Services – Child Welfare form.

Recipient Re-Certification for Services

Every six months, a licensed practitioner must complete and sign a new Certification of Eligibility for Behavioral Health Overlay Services – Child Welfare form verifying the recipient’s continued eligibility. Documentation must be present in the recipient’s clinical record to support the recertification.

Service Requirements

Required Components

Behavioral health overlay services in child welfare settings must include the following components:

- An initial screening by a counselor or licensed clinician within 72 hours of provision of services to determine that the recipient meets the criteria for behavioral health overlay services in child welfare settings. If a counselor completes the screening, a licensed clinician must also sign the Certification of Eligibility for Behavioral Health Overlay Services – Child Welfare.

- An face to face interview by a licensed clinician as part of the treatment planning process.

- Assignment of a counselor, documented in the recipient’s record, to serve as a recipient’s primary counselor who will complete a psychosocial assessment and perform job responsibilities as listed in this section.

- Treatment team meeting within 30 days of admission to develop the individualized treatment plan, in conjunction with the child’s permanency plan.

- Treatment team meetings that include input from the recipient’s family, case worker, psychiatrist, licensed practitioners, counselors, direct care staff, direct care supervisors, any involved case managers, behavior analyst, ancillary services and school personnel, and if applicable Department of Juvenile Justice juvenile probation officers, Child Welfare and Community Based Care organization.

- The psychiatrist’s or licensed practitioner’s review and signature, with certification that services are medically necessary for the recipient, on the treatment plan.
Service Requirements, continued

Required Components, continued

- Provision of individualized treatment interventions for each youth as authorized in the treatment plan.
- A treatment plan review at least every six months, in accordance with Medicaid policy contained in Chapter 2, Section 1.
- Recipient review and re-certification, if indicated, for behavioral health overlay services – child welfare.
- Evaluation and submission of behavioral health outcomes to the Department of Children and Families using the Children’s Functional Assessment Rating Scale.

Focus and Intensity of Behavioral Health Overlay Services

The focus of the services reimbursed under behavioral health overlay services in child welfare settings must be directly related to the recipient’s behavioral health or substance abuse condition.

The child’s specific needs as identified in the individualized treatment plan shall determine the intensity and individual utilization of treatment services available under behavioral health overlay.

Medical RecordClinical Record and Documentation Requirements

The following components must be documented in the recipient’s medical record:

- The name of the primary counselor who coordinates implementation of the recipient’s behavioral health treatment plan.
- The recipient’s initial Certification of Eligibility for Behavioral Health Overlay Services – Child Welfare form(s), and a new Certification of Eligibility each six months the recipient remains eligible for Behavioral Health Overlay Services – Child Welfare. A licensed practitioner must sign each eligibility form.
- A signed copy of the psychosocial assessment and evaluation of the recipient’s behavioral health symptoms, risks, and functional status that was completed and signed by a licensed practitioner prior to the development of the treatment plan.
- An face to face interview by a licensed practitioner completed prior to completion and signing of the individualized treatment plan.
- An individualized treatment plan that meets the criteria for treatment plans as specified in Chapter 2, Section 1 of this handbook and the additional treatment plan requirements that are listed below.
- A behavioral health aftercare plan for any child receiving behavioral health overlay services – child welfare when moved or placed in another setting.
Medical Record Clinical Record and Documentation Requirements, continued

- A detailed discharge and aftercare plan with specified criteria.
- Treatment plan reviews to determine the effectiveness of the current plan or the need for revision if the child is not making progress. Reviews should be conducted at least every six months and documented according to Medicaid policy as specified in Chapter 2, Section 1 of this handbook.
- Written substantiation in the clinical record that a behavioral health overlay service—child welfare intervention, as detailed and authorized on the treatment plan, was provided to the child on each day this service was billed, including the name of the staff person providing the service.
- Daily or weekly progress notes as described on the following page.

Additional Individualized Treatment Plan Requirements

The recipient's individualized treatment plan must be completed and signed by a treating practitioner within 30-days of initiation of behavioral health overlay services. The individualized treatment plan must specify the therapeutic therapy or therapeutic support activities services that will be provided under the behavioral health overlay services—child welfare code, including the amount, frequency, and duration of timed activities.

Examples: If a recipient will receive individual or group therapy, the plan should specify the number of sessions each week, and the length of time that the recipient will need the session(s). If a goal is relationship building through consistent informal contacts with staff throughout each day, this daily intervention should be specified in the plan. If the individualized treatment plan contains a behavior management component, the behavioral analyst must review and sign the component. The behavior management plan must be consistent with treatment outcomes and objectives.
The primary counselor must complete and sign the behavioral health overlay services – child welfare weekly progress notes. The notes must include the following information:

1. Summary of the treatment interventions delivered, the recipient’s response to the interventions and progress toward reaching individualized goals.
2. Information that the interventions authorized in the treatment plan were delivered in accordance with the plan treatment.
3. Summary of the treatment team meetings related to the recipient and information to reflect that the recipient’s individualized goals, progress, and identified treatment needs were discussed.
4. Review of the documentation that substantiates the daily intervention(s) billed to this service to determine that behavioral health overlay services – child welfare were delivered each day that these services are billed and that the therapeutic interventions and interactions of the primary counselor or the direct care staff are being provided to the recipient based on the recipient’s treatment plan.

Summary of significant events occurring with the child during the week, and information on contacts and visits with family and other agencies.
Upon enrollment as a BHOS provider, and once per state fiscal year, providers may choose to document services in either daily progress notes or weekly progress notes. The provider’s choice of service documentation frequency must be clearly identified in the provider’s policy.

Documentation Requirements for Weekly Progress Notes

For each recipient, the primary counselor must complete and sign behavioral health overlay services weekly progress notes. For each day that BHOS is billed, the weekly progress notes must include the following information:

1. Documentation of the behavioral health overlay services delivered, the recipient’s corresponding responses to the services, and the recipient’s progress toward reaching individualized goals.
2. Documentation that the services authorized in the treatment plan were delivered in accordance with the plan.
3. Documentation of the treatment team meetings related to the recipient. Include information to reflect that the recipient’s individualized goals, progress, and treatment needs were discussed.
4. Documentation of significant events, and contacts and visits with family and other agencies.
5. Documentation of any services provided on Saturday or Sunday to substantiate that services were provided on a weekend day.

Documentation Requirements for Daily Progress Notes

For each recipient, the primary counselor must complete and sign behavioral health overlay services daily progress notes. For each day that BHOS is billed, the daily progress notes must include the following information:

1. Documentation of the behavioral health overlay services that were delivered, the recipient’s corresponding responses to the services, and the recipient’s progress toward reaching individualized goals.
2. Documentation that the services authorized in the treatment plan were delivered in accordance with the plan.
3. Documentation of treatment team meetings related to the recipient. Include information to reflect that the recipient’s individualized goals, progress, and treatment needs were discussed.
4. Documentation of any significant events, and documentation of contacts and visits with family and other agencies.
Medical Record and Documentation Requirements, continued

**Documentation of Family Involvement**
The clinical record must document that the family members were involved in the behavioral health treatment plan development and treatment interventions and must include the goals and objectives for family counseling, or justification if family is not involved.

**Weekend Documentation**
Direct care staff may document interventions or counselors may gather information on the recipient’s activities, adjustment, mood, and response to staff interventions and interactions to include in the progress notes summary to substantiate that the services were provided on each weekend day.

**Documentation of Services Billed Fee-For-Service**
Allowable service provided on a fee-for-service basis must be documented in accordance with Medicaid policy.

**Documentation of Case Coordination**
Documentation must reflect coordination and linkages with family, the child’s school, primary medical care providers, community services, child welfare caseworker, and if indicated, Department of Juvenile Justice probation officers in accordance with the recipient’s treatment and permanency plan.

**Recipient Absences from the Behavioral Health Overlay Services Provider**

**Recipient Absences**
Medicaid reimbursement is not available for the days a recipient is away from the residential provider agency, except for approved therapeutic visits, hospitalizations, or other crisis placements.

**Therapeutic Visits**
Therapeutic visits are visits the recipient spends with his or her biological, adoptive or extended family or in a potential residential placement setting. Therapeutic visits must be planned in accordance with the recipient’s permanency plan and authorized in the behavioral health overlay services – child welfare treatment plan. The visitation schedule must be individualized to the specific needs of the child or adolescent. Visitation must not be dependent on the provider’s holiday and leave schedule for staff.

The recipient’s behavioral health overlay services – child welfare provider must be accessible and must maintain a level of communication during such visits as determined by the counselor and his or her clinical supervisor. Documentation in the child’s clinical record must substantiate the contact and on-going communication with the child or adolescent during the placement. Documentation of phone conversations between the provider and recipient constitutes substantiation of on-going communication. Voicemail or email messages are not reimbursable modes of contact.
Recipient Absences from the Behavioral Health Overlay Services Provider, continued

| Reimbursement During | Medicaid reimburses behavioral health overlay services – child welfare when the recipient is absent up to 10 therapeutic visit days per calendar quarter (three months).
| Therapeutic Visits   | During the last three months of placement and if the visits are in accordance with the recipient’s permanency plan, Medicaid can reimburse for behavioral health overlay services – child welfare when the recipient is absent up to 20 therapeutic visit days to allow for gradual therapeutic integration into the next residential placement. The visits must be authorized in the behavioral health overlay services – child welfare treatment plan.

| Reimbursement During | Medicaid will reimburse for behavioral health overlay services – child welfare during a recipient’s absence due to a psychiatric hospitalization or other crisis placement for up to six days per state fiscal year, duration per hospitalization once every six months.
| Hospital and Crisis Stabilization Unit Placements | Behavioral health overlay services – child welfare counselors must be accessible and must maintain a level of communication during such placements as determined by the recipient’s clinical needs and hospital staff. Documentation in the recipient’s clinical record must substantiate the contact and on-going communication with the child or adolescent recipient during the placement.
| | If a recipient experiences more than one psychiatric crisis placement within a six-month period, the recipient’s treatment team must convene and complete a reassessment of the recipient’s plan to ensure that the plan is meeting the recipient’s needs.
### Recipient Absences from the Behavioral Health Overlay Services Provider, continued

<table>
<thead>
<tr>
<th><strong>Juvenile Detention Center Placements</strong></th>
<th>Medicaid will not reimburse for behavioral health overlay services when a recipient is absent because he or she is in a Department of Juvenile Justice detention center placement.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unauthorized Absences</strong></td>
<td>Medicaid will reimburse for behavioral health overlay services – child welfare for up to three days when a placement is being maintained for a recipient who has an unauthorized absence (i.e., runs away) from the provider’s residential program. If a recipient is formally discharged from the behavioral health overlay services – child welfare program and readmitted at a later date, a new treatment plan is required.</td>
</tr>
</tbody>
</table>

### Reimbursement Requirements

<table>
<thead>
<tr>
<th><strong>Allowable Reimbursement</strong></th>
<th>Certified providers may bill the per diem rate for behavioral health overlay services – child welfare for services delivered to a recipient who has been certified as meeting the eligibility criteria, for up to 365 days a year.</th>
</tr>
</thead>
</table>
## Reimbursement Requirements

### Services that May be Reimbursed in Conjunction with Behavioral Health Overlay Services

The following community mental health services are reimbursable in conjunction with behavioral health overlay services – child welfare. The services must be medically necessary and delivered in accordance with this handbook.

<table>
<thead>
<tr>
<th>Services</th>
<th>Procedure Code</th>
<th>Modifier (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric Evaluation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By an MD or DO</td>
<td>H2000</td>
<td>HP</td>
</tr>
<tr>
<td>By a Non MD or DO</td>
<td>H2000</td>
<td>HO</td>
</tr>
<tr>
<td>Review of records</td>
<td>H2000</td>
<td></td>
</tr>
<tr>
<td>Brief mental status examination</td>
<td>H2010</td>
<td>HO</td>
</tr>
<tr>
<td><strong>In-Depth Assessment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New patient</td>
<td>H0031</td>
<td>HO</td>
</tr>
<tr>
<td>Est. patient</td>
<td>H0031</td>
<td>TS</td>
</tr>
<tr>
<td>Bio-Psychosocial Evaluation</td>
<td>H0031</td>
<td>TS</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>H2019</td>
<td></td>
</tr>
<tr>
<td>Limited Functional Assess.</td>
<td>H0031</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Behavioral Health Assessment</td>
<td>H0031</td>
<td>HA</td>
</tr>
<tr>
<td><strong>Treatment Plan Development and Modification</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Development</td>
<td>H0032</td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Review</td>
<td>H0032</td>
<td>TS</td>
</tr>
<tr>
<td><strong>Medical and Psychiatric Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td>T1015</td>
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</tr>
<tr>
<td>Indiv. Medical Psychotherapy</td>
<td>H2010</td>
<td>HE</td>
</tr>
<tr>
<td>Group Medical Therapy</td>
<td>H2010</td>
<td>HQ</td>
</tr>
<tr>
<td>Behavioral Health Screening</td>
<td>T1023</td>
<td>HE</td>
</tr>
<tr>
<td><strong>Behavioral Health Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical or Clinic Service</td>
<td>T1015</td>
<td>HE</td>
</tr>
<tr>
<td>Verbal Interaction</td>
<td>H0046</td>
<td></td>
</tr>
<tr>
<td>Methadone Administration</td>
<td>H0020</td>
<td></td>
</tr>
</tbody>
</table>
Reimbursement Requirements, continued

Reimbursement for a Recipient Who is Not Eligible For Behavioral Health Overlay Services

If a Medicaid recipient does not meet the clinical criteria for behavioral health overlay services – child welfare but has behavioral health needs, the provider may be reimbursed on a fee-for-service basis for providing the following community mental health services. The services must be medically necessary and provided in accordance with this handbook.

<table>
<thead>
<tr>
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<td>HO</td>
</tr>
<tr>
<td><strong>In-depth Assessment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New patient</td>
<td>H0031</td>
<td>HO</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>H0001</td>
<td></td>
</tr>
<tr>
<td>Est. patient</td>
<td>H0031</td>
<td>TS</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>H0001</td>
<td>TS</td>
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<tr>
<td>Bio-Psychosocial Evaluation</td>
<td>H0001</td>
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<tr>
<td>Psychological Testing</td>
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<td></td>
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<tr>
<td>Limited Functional Assess.</td>
<td>H0031</td>
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<tr>
<td>Substance Abuse</td>
<td>H0001</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Behavioral Health Assessment</td>
<td>H0031</td>
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<tr>
<td><strong>Treatment Plan Development and Modification</strong></td>
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</tr>
<tr>
<td>Treatment Plan Development</td>
<td>H0032</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>T1007</td>
<td></td>
</tr>
<tr>
<td>Treatment Plan Review</td>
<td>H0032</td>
<td>TS</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>T1007</td>
<td>TS</td>
</tr>
<tr>
<td><strong>Medical and Psychiatric Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indiv. Medical Psychotherapy</td>
<td>H2010</td>
<td>HE</td>
</tr>
<tr>
<td>Mental Health</td>
<td>H2010</td>
<td>HF</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Medical Therapy</td>
<td>H2010</td>
<td>HQ</td>
</tr>
<tr>
<td>Behavioral Health Screening</td>
<td>T1023</td>
<td>HE</td>
</tr>
<tr>
<td>Mental Health</td>
<td>T1023</td>
<td>HF</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Services Medical or Clinic Service</td>
<td>H0046</td>
<td></td>
</tr>
<tr>
<td>Verbal Interaction</td>
<td>H2010</td>
<td>HE</td>
</tr>
<tr>
<td>Mental Health</td>
<td>H2010</td>
<td>HF</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone Administration</td>
<td>H0020</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Therapy Services Individual or Family Therapy</td>
<td>H2019</td>
<td>HR</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>H2019</td>
<td>HQ</td>
</tr>
<tr>
<td>Psychosocial Rehabilitative Services</td>
<td>H2017</td>
<td></td>
</tr>
</tbody>
</table>
**Reimbursement Requirements, continued**

**Reimbursement Restrictions** Residential group care providers under contract with the Department of Children and Families, Child Welfare and Community Based Care organization may not bill for the following community behavioral health services procedure codes for recipients in their care:

<table>
<thead>
<tr>
<th>Services</th>
<th>Procedure Code</th>
<th>Modifier (if required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Behavioral Onsite Services – Therapy</td>
<td>H2019</td>
<td>HO</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite – Behavior Management</td>
<td>H2019</td>
<td>HM</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite – Therapeutic Support Services</td>
<td>H2019</td>
<td>HN</td>
</tr>
<tr>
<td>Behavioral Health Day Services</td>
<td>H2012</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Day Services Substance Abuse</td>
<td>H2012</td>
<td>HF</td>
</tr>
</tbody>
</table>

Mental health targeted case management for children under age 18, except for 90 days prior to a planned and documented discharge, cannot be billed in conjunction with behavioral health overlay services:
Reimbursement Requirements, continued

<table>
<thead>
<tr>
<th>Combinations of Services that Cannot be Billed</th>
<th>The following community behavioral health services procedure codes cannot be billed in conjunction with behavioral health overlay services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>Procedure Code</td>
</tr>
<tr>
<td>Behavioral Health Therapy Services</td>
<td></td>
</tr>
<tr>
<td>Individual or Family Therapy</td>
<td>H2019</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>H2019</td>
</tr>
<tr>
<td>Behavioral Health Day Services</td>
<td>H2012</td>
</tr>
<tr>
<td>Behavioral Health Day Services (Substance Abuse)</td>
<td>H2012</td>
</tr>
<tr>
<td>Community Support and Rehabilitative Services (unless provided as a part of a public school program or summer activities program. These services may not be reimbursed when provided in the residential care setting)</td>
<td></td>
</tr>
<tr>
<td>Psychosocial Rehabilitative Services</td>
<td>H2017</td>
</tr>
<tr>
<td>Club House</td>
<td>H2030</td>
</tr>
<tr>
<td>Services Limited to Children</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services – Therapy</td>
<td>H2019</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services – Behavior Management</td>
<td>H2019</td>
</tr>
<tr>
<td>Therapeutic Behavioral Onsite Services – Therapeutic Support Services</td>
<td>H2019</td>
</tr>
<tr>
<td>Behavioral Health Overlay Services – Juvenile Justice</td>
<td>H2020</td>
</tr>
<tr>
<td>Specialized Therapeutic Foster Care Services</td>
<td></td>
</tr>
<tr>
<td>Level I</td>
<td>S5145</td>
</tr>
<tr>
<td>Level II</td>
<td>S5145</td>
</tr>
<tr>
<td>Crisis</td>
<td>S5145</td>
</tr>
<tr>
<td>Therapeutic Group Care Services</td>
<td>H0019</td>
</tr>
</tbody>
</table>

Mental health targeted case management for children under age 18, except for 90 days prior to discharge, cannot be billed in conjunction with behavioral health overlay services.

Room and Board

Behavioral health overlay services in child welfare settings or any other Medicaid community behavioral health service does not cover room and board expenditures.

Non-Duplication of Services

Medicaid will not reimburse a provider for behavioral health overlay services – child welfare or any other community behavioral health service if the provider has been paid for the provision of the same type of services by another purchasing entity.
CHAPTER 3
COMMUNITY-BASED SUBSTANCE ABUSE SERVICES

Overview

Introduction
This chapter describes the services covered under the community-based substance abuse services program, the requirements for service provision, the service limitations, and service exclusions.

Services described in this chapter are restricted to providers under contract with a participating Florida county. Under this program the county will contract with providers to offer these services. The county will directly reimburse the providers in full, and then submit claims to Medicaid for reimbursement of the federally funded portion.

In This Chapter
This chapter contains:

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Purpose</td>
<td>3-1</td>
</tr>
<tr>
<td>Program Components</td>
<td>3-2</td>
</tr>
<tr>
<td>Alcohol and Drug Intervention Services</td>
<td>3-4</td>
</tr>
<tr>
<td>Comprehensive Community Support Services for Substance Abuse</td>
<td>3-6</td>
</tr>
</tbody>
</table>

Program Purpose

Purpose
The purpose of the community-based substance abuse services program is to provide reimbursement to Florida counties for arranging medically necessary substance abuse services for Medicaid-eligible individuals.

This chapter is intended for use by Florida counties who are enrolled in Medicaid under the community-based substance abuse services program. It contains specific policies for each substance abuse service that is reimbursable by Medicaid under this program.

Background
These substance abuse services are available to counties who have agreed to commit local, public dollars to the delivery of three additional services.
Program Components

Components of County Agreement with AHCA

The county will enter into an agreement with the Agency for Health Care Administration (AHCA) to reimburse these select substance abuse services delivered by substance abuse providers that:

- Are under contract with the county;
- Are a Medicaid enrolled provider;
- Are appropriately licensed through the Department of Children and Families; and
- Have the administrative and staffing capacity to provide these services in line with Medicaid requirements.

The county will develop an agreement with providers to provide covered services and to seek reimbursement from counties.

Counties must certify quarterly to AHCA that they have reimbursed providers 100 percent of expenditures with public tax dollars in order to collect the federal portion of reimbursement for the services.

AHCA will reconcile county certification with filed claims to assure local tax dollars have been utilized for all expenditures reimbursed with federal Medicaid funds.

AHCA Agreement Terms

AHCA agrees to:

- Develop a list and description of services;
- Reconcile claims with county’s certification of expenditures;
- Reimburse counties for their federal portion of certified expenditures;
- Develop procedures for recoupment of funds, if necessary, following an audit;
- Monitor participating providers for compliance with service and documentation requirements, and qualifications of staff;
- Produce any Medicaid specific reports;
- Notify participating counties of changes in match percentages; and
- Designate an employee to act as liaison for counties and providers under the Medicaid match program.
Program Components, continued

County Agreement Terms

The county agrees to:
- Reimburse providers for 100 percent of the rate for delivery of services;
- Use only locally generated, unmatched, tax revenues for reimbursement of services;
- Enroll in the Medicaid program as a Community Behavioral Health Services Provider;
- Maintain an ongoing management information system to ensure accountability of paid and reimbursed claims;
- Maintain accurate records of payment and monitor services delivery;
- Submit quarterly certification reports;
- Maintain, and require providers to maintain, records relevant to these services;
- Provide any county or provider records to the Centers for Medicare and Medicaid Services (CMS) and to AHCA, or their designees, when requested for audit purposes;
- Void or otherwise pay back any claims that are found to be ineligible for match due to an audit, deferral of denial as deemed appropriate;
- Designate an employee to act as liaison with AHCA for issues related to this agreement.

Components of County Agreement with Providers

Providers must agree to:
- Maintain Medicaid enrollment and have the appropriate substance abuse license by the Department of Children and Families;
- Have the staff and programmatic capacity to provide services to Medicaid recipients;
- Adhere to all Medicaid services standards and documentation requirements, including confidentiality;
- Provide adequate supervision to staff;
- Have services authorized by a Medicaid enrolled treating provider;
- Submit claims for services to the county and not bill Medicaid directly; and
- Cooperate with county, AHCA, and CMS audits and monitorings.

Certification and Billing Procedures

Providers will bill the county for services delivered and the provider will receive 100 percent reimbursement with allowable non-matched public tax dollars.

The county will provide certification to AHCA on a quarterly basis.


Alcohol and Drug Intervention Services

Introduction

This service is designed to detect alcohol or other drug problems and to provide a brief intervention for the purpose of arresting the progression of such problems, thereby obviating the need for more intensive levels of treatment as described in the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC – 2R). These intervention services are provided prior to treatment and are delivered in community-based settings on an outpatient basis. Sites include: substance abuse treatment centers, schools, Juvenile Assessment Centers, work sites, community centers, homes, etc. The goal is to identify current or potential risk factors for substance abuse and then identify and provide the medically necessary clinical services to minimize and ameliorate those factors as an alternative to a more restrictive level of treatment. Intervention services are provided for the purpose of early identification of substance abuse problems and rapid linkage to needed services.

Description of the Service

Intervention services include the following:

- Clinical Screening and Evaluation;
- Identifying medically necessary treatment needs;
- Clinical and therapeutic intervention with family and peer involvement;
- Supportive counseling;
- Referral to clinically indicated services; and
- Ensuring referral appointments are met.

Who May Receive Services

Recipients must meet the following criteria to be eligible for intervention services:

- Individuals who meet the ASAM PPC-2R Level 0.5 Dimensions 4, 5, or 6 under Early Intervention;
- Individuals at risk for substance abuse or dependence.

Recipients are NOT eligible for Intervention services if they:

- Fail to meet Dimension 4, 5, or 6 under ASAM PPC – 2R level 0.5;
- Are currently receiving a residential or inpatient level of substance abuse treatment; or
- Are not considered at risk for substance abuse or dependence.
## Alcohol and Drug Intervention Services, continued

### Who Must Provide Services

Services must be delivered, at a minimum, by a substance abuse counselor under the supervision of a licensed practitioner of the healing arts or a master's level C.A.P.

Note: For specific education and training requirements, see Staff Qualifications in Chapter 1 of this handbook.

### Reimbursement Limitations

Reimbursement for this service is limited to 120 units per state fiscal year per recipient. Each unit of intervention services must last 15 minutes in order to claim Medicaid reimbursement.

This service may not be reimbursed for the same recipient on the same day as any of the following:

- Behavioral Health Overlay Services – Juvenile Justice (H2022 HK)
- Behavioral Health Overlay Services – Child Welfare (H2020 HA)
- Methadone Administration (H0020)
- Comprehensive Community Support Services (H2015; H2015 HQ; H2015 HN)
Comprehensive Community Support Services for Substance Abuse (Bachelor's Degree Level) (Aftercare Services)

Introduction

Comprehensive community support services are a set of medically necessary clinical aftercare services that are directed toward individuals who have received substance abuse treatment within a correctional or other institutional setting (jails) or a community-based program, and need continued therapeutic services to maintain recovery as they re-enter the community.

The principle purpose of comprehensive community support services is to provide integrative therapeutic supports and aftercare in collaboration with available and relevant ancillary medical and behavioral support services in the community and to ensure the receipt and effectiveness of those services. This service follows a recovery support services model that addresses interpersonal and coping skills and assists in symptom monitoring through therapeutic service provision. Identifying barriers that impede the development of skills necessary for independent functioning in the community will also be an integral part of these services. These services may be provided in a variety of community-based settings on an outpatient basis.

Description of Service

Comprehensive community support services include the following:

- Supportive counseling;
- Specific recovery support services such as locating housing, vocational counseling, psycho-educational counseling, pre-vocational counseling;
- Aftercare planning;
- Relapse prevention;
- Ensuring and monitoring recipient progress toward meeting goals of the aftercare plan; and
- Coordinating any necessary services with other sources and subsequently making any referrals for medically necessary services.

Who May Receive

Recipients must meet the following criteria to be eligible for comprehensive community support services:

- Successful completion of substance abuse treatment in a jail, correctional or institutional facility or community-based setting;
- Have an ICD-9-CM diagnosis of 291.0 through 292.9, 303.0 through 305.09 or 305.2 through 305.9; and
- Be motivated to participate in the program.
Comprehensive Community Support Services for Substance Abuse (Bachelor’s Degree Level), (Aftercare Services) continued

Clinical Exclusions

Recipients are NOT eligible for comprehensive community support services if they:

- Have not successfully completed a substance abuse treatment program;
- Exhibit clinical symptoms that require a more restrictive level of care than can be provided through comprehensive community support services; or
- Are not motivated to participate in comprehensive community support services.

Who Must Provide

Services must be provided by a substance abuse counselor (minimum of a bachelor’s degree) who has knowledge of existing support services within the community. Services shall be supervised by a licensed practitioner of the healing arts or a master’s level C.A.P.

Note: For specific education and training requirements, see Staff Qualifications in Chapter 1 of this handbook.

Reimbursement Limitations

Reimbursement for this service is limited to 120 units per state fiscal year per recipient. Each unit must be 15 minutes in duration.

This service may not be reimbursed for the same recipient on the same day as any of the following:

- Behavioral Health Overlay Services – Juvenile Justice (H2020 HK) [BHOS-JJ]
- Therapeutic Group Care Services (H0019) [TGCS]
- Behavioral Health Overlay Services – Child Welfare (H2020 HA) [BHOS-CW]
- Specialized Therapeutic Foster Care (All Levels) [STFC] (S5145, S5145-HE; S5145-HK)
- Alcohol and/or Drug Intervention Services (H0022)

Medicaid will not reimburse for provision of Community Support Services where there is a per diem reimbursement being paid by Medicaid for recipients (e.g., Nursing homes, Statewide Inpatient Psychiatric Programs, etc).

Medicaid will not reimburse for any component of Community Support Services, including medical interventions and counseling, when the same services are already being paid for by another source.
Comprehensive Community Support Services for Substance Abuse (Therapeutic Support) (Peer Recovery Support)

Introduction

Comprehensive community support services are a set of medically necessary services designed to be delivered individually or in a group setting. Individual or group recovery supports allow for a combination of services related to substance abuse education; life skills training; medical or health education; employment and educational skills; family, marital, parenting guidance; anger and stress management; and support counseling. The recovery support services could occur in conjunction with treatment, after an individual is discharged from treatment or has had a screening and assessment and is waiting for services.

This service allows for “client choice” in developing natural supports by non-traditional treatment providers such as in schools, churches, clubs, etc.

These services may be provided in a variety of community-based settings on an outpatient basis.

Description of Services

Comprehensive community support services for individuals include the following:

• Services designed to strengthen and regain the individual’s skills;
• Develop the environmental support necessary to help the individual thrive in the community and meet life goals which promote recovery and resiliency;
• Specific recovery support services such as substance abuse education, coordination of medical or health issues; employment or educational coordination and support; family, marital, parenting guidance; life skills; anger and stress management coping skills;
• Supportive counseling; and
• Ensuring and monitoring recipient progress toward meeting goals of the aftercare plan.

Comprehensive community support services for groups include the following:

• Groups providing peer support to facilitate problem solving, communication skills development, and personal growth; and
• Support groups focused on recovery and relapse prevention including substance abuse education; coordination of medical or health issues; employment or educational coordination and support; family, marital, parenting guidance, life skills, anger and stress management coping skills; and support counseling.

Who May Receive

Recipients must meet the following criteria to be eligible for comprehensive community support services:

• Have an ICD-9-CM diagnosis of 291.0 through 292.9, 303.0 through 305.09 or 305.2 through 305.9; and
• Be motivated to participate in the program.
**Comprehensive Community Support Services for Substance Abuse (Therapeutic Support), continued**

**Clinical Exclusions**

Recipients are NOT eligible for comprehensive community support services if they:

- Exhibit clinical symptoms that require a more restrictive level of care than can be provided through comprehensive support services; or
- Are not motivated to participate in comprehensive community support services.

**Who Must Provide**

Services must be provided, at a minimum, by a Certified Recovery Support Specialist or Substance Abuse Technician.

Note: For specific education and training requirements, see Staff Qualifications in Chapter 1 of this handbook.

**Reimbursement Limitations**

Reimbursement for this service is limited to 600 units per state fiscal year per recipient. Each unit must be 15 minutes in duration.

This service may not be reimbursed for the same recipient on the same day as any of the following:

- Behavioral Health Overlay Services – Juvenile Justice (H2020 HK) [BHOS-JJ]
- Therapeutic Group Care Services (H0019) [TGCS]
- Behavioral Health Overlay Services – Child Welfare (H2020 HA) [BHOS-CW]
- Specialized Therapeutic Foster Care (All Levels) [STFC] (S5145, S5145-HE; S5145-HK)
- Alcohol or Drug Intervention Services (H0022)

Medicaid will not reimburse for provision of Community Support Services where there is a per diem reimbursement being paid by Medicaid for recipients (e.g. Nursing homes, Statewide Inpatient Psychiatric Programs, etc).

Medicaid will not reimburse for any component of Community Support Services, including interventions and counseling, when the same services are already being paid for by another source. These services do not include Alcoholics Anonymous or Narcotics Anonymous meetings.
CHAPTER 34
PROCEDURE CODES AND FEE SCHEDULE

Overview

Introduction
This chapter identifies the community behavioral health procedure codes and the maximum fees that Medicaid reimburses.

In This Chapter
This chapter contains:

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<th>TOPIC</th>
<th>PAGE</th>
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</thead>
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<td>Reimbursement Information</td>
<td>34-1</td>
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<td>Procedure Code Modifiers</td>
<td>34-3</td>
</tr>
<tr>
<td>Appendix P: Procedure Codes and Fee Schedule</td>
<td>P-1</td>
</tr>
</tbody>
</table>

Reimbursement Information

Procedural Codes
The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. CPT copyright 2009 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. CPT codes and descriptions are copyrighted in 2003 by the American Medical Association. All rights reserved.

Effective October 1, 2003—In compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.

All previously used “local codes” can no longer be processed by the Florida Medicaid claims processing system for Medicaid payment for dates of service after October 1, 2003. For dates of services prior to October 1, 2003, the provider must use procedure codes that were payable at that time. Please refer to Appendix P for the valid codes for Florida Medicaid services.
### Reimbursement Information, continued

#### Units of Service
A unit of service is the number of times a procedure is performed. The definition of unit varies by service. Chapter 2 of this handbook contains service-specific information on how to compute units. If one hour equals one unit of service, then the total units of service for the day must be entered on the CMS-1500 claim form. When only one procedure is performed, enter a ‘1’ on the claim form.

For services defined in 15-minute increments, the total units of service for the day must be entered on the claim form. If multiple units are provided on the same day, the actual time spent must be totaled. If the minutes total ends in 7 or less, round down to the nearest 15-minute increment. If the minutes total ends in 8 or more, round up to the nearest 15-minute increment. For example, 37 minutes is billed as two units of service; 38 minutes is billed as three units of services. The provider may not round up each service episode to the nearest 15-minute increment before summing the total.

**Note:** See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for information on entering units of service on the claim.

#### Recoupment
Payments received from Medicaid in violation of program policy or for procedure codes not found in this handbook or handbook updates are subject to recoupment.

#### Exceptions to Service Limits
Requests to exceed service limits for recipients under age 21 must be made through Medicaid’s prior authorization process.

**Requests to exceed service limits for recipients over age 21 must be made through the district or regional Substance Abuse and Mental Health program office.**

#### Time Frames
In order for Medicaid to reimburse a procedure, the time frame established for the procedure must be met and documented in the recipient’s medical record.

#### Copayment
Providers are required to collect a copayment of $2.00, per service, per day from the recipient unless the recipient of the service is exempt.

**Note:** See Chapter 1 of the Florida Medicaid Provider General Handbook for information on copayments and the categories of recipients and services exempt from the copayment.

#### Procedure Code Table
Each procedure code on the Procedure Codes and Fee Schedule, Appendix P, corresponds to a service listed in Chapter 2. The descriptor gives a brief description of the service, and the maximum fee shows the maximum amount that Medicaid will reimburse for the procedure.
**Procedure Code Modifiers**

<table>
<thead>
<tr>
<th>Definition of Modifier</th>
<th>For certain types of services, one or two two-digit modifier must be entered on the CMS-1500 claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The modifiers are entered in the field next to the procedure code field in item 24D, under Modifier.</td>
</tr>
<tr>
<td></td>
<td>Community behavioral health services providers must use the modifiers with the procedure codes listed on Appendix P, Procedure Codes and Maximum Fees, when billing for the specific services in the procedure code descriptions. The modifiers listed in Appendix P can only be used with the procedure codes listed. Use of modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering modifiers on the claim form.</td>
</tr>
</tbody>
</table>
APPENDIX A

LIMITED TEMPORARY SERVICE AUTHORIZATION

Recipient name

Recipient Medicaid number

Date of service(s)

Service(s) provided

Medicaid procedure code(s)

I have reviewed the relevant clinical information and confirm that the service(s) provided was (were) medically necessary.

Treating Practitioner’s Signature Printed Name Date

Treating Practitioner’s Name Signature Date

To be placed in the recipient’s medical-clinical record.
APPENDIX B
AUTHORIZATION FOR
COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT

This is to certify that

Child's Name __________________________________________

Date __________________

Medicaid Number ____________________

has been screened and determined to be in need of a Comprehensive Behavioral Health Assessment as outlined in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations handbook. The behavioral health comprehensive behavioral health assessment will be provided by:

________________________________________________________(provider).

____________________________

AND

Community-Based Care

Circuit Substance Abuse and Mental Health Representative

District Family Safety or Community-Based Care Representative

OR

-Child Welfare Prepaid Mental Health Plan Vendor or designee - ________________ Date

AND OR

Circuit Department of Department Juvenile Justice Representative or designee

Date

AUTHORIZATION FOR COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT
FOR CHILD IN SHELTER

This is to certify that

Child's Name ______________________________ Date of Referral ______________

Medicaid Number ____________________

October 2004 DRAFT – Rule Development October 2011
Community Mental Health Services Coverage and Limitations Handbook

Shelter Name_____________________________________

Shelter Address___________________________________

has been screened and determined to be in need of a Comprehensive Behavioral Health Assessment as outlined in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations handbook. The comprehensive behavioral health comprehensive assessment will be provided by:

_________________________________________________________(provider).

________________________________________________________

Circuit Family Safety or District Family Safety or Community Based Care Lead Agency Representative

Date

To be placed in recipient's (child's) medical-clinical record.
APPENDIX C

COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT PROVIDER—AGENCY AND PRACTITIONER CERTIFICATION

(Note: an Occupational License is NOT Required for Specialty Type 66)

INITIAL ____________________________________________________________________________ ANNUAL __________________________________________________________________

This is to certify that

Name ________________________________________________________________________________

Address ______________________________________________________________________________
____________________________________________________________________________________

Phone Number (___) ____________

Agency Medicaid Number _________________ (if enrolled)

Practitioner Medicaid Number ____________________________ (if enrolled)

has met the qualifications to be a provider of Comprehensive Behavioral Health Assessments, based upon submission and review of documentation (see Chapter 2, Section 2) documentation to Substance Abuse and Mental Health staff who will provide this service to meet the qualifications as outlined in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations handbook.

Begin date: _________________ End date: _________________

District Substance Abuse and Mental Health Representative
Child Welfare Prepaid Mental Health Plan Vendor Representative

AND

District Family Safety or Medicaid Representative
designee Community Based Care Representative

AND

Date

Date

October 2004 DRAFT – Rule Development October 2011
To complete the initial Medicaid provider enrollment process, submit this form with your Florida Medicaid Provider Enrollment Application to the address listed below.

ACS State Healthcare
Florida Medicaid Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070
APPENDIX D
SPECIALIZED THERAPEUTIC FOSTER CARE
PROVIDER AGENCY CERTIFICATION

INITIAL ____________________________________________ ANNUAL __________

This is to certify that:

Agency Name:
______________________________________________________________

Address:
______________________________________________________________

Phone Number (__) ___________ Agency Medicaid No. _________________________ (if enrolled)

has met the qualifications for certification as a provider of Specialized Therapeutic Foster Care based
upon a review of the following:

1) Qualifications as outlined in the Florida Medicaid Community Behavioral Health Coverage and
   Limitations Services handbook for all clinical staff who will provide this service;

2) An approved pre-service and in-service training plan;

3) Their list of foster parents, who are licensed by the Department of Children and Families;

4) The financial and therapeutic agreement between the agency and foster parents;

5) Sufficient administrative capacity to operate the program;

6) Policies and procedures that address good therapeutic practice, ensure therapeutic foster parents are
   the primary therapeutic agent, provide appropriate treatment plans and documentation, and protects the
   rights of children and families; and

7) A system for program evaluation system;

8) Cooperation with an on-site survey by the Agency for Health Care Administration, or designee for
   Specialized Therapeutic Foster Care Provider Agency Certification; and

9) Adherence to the provisions for provider qualifications and certification criteria.

_________ Begin date:_____________ End date:_____________________

October 2004  DRAFT – Rule Development October 2011
For initial certification, submit this form with your Florida Medicaid Provider Enrollment Application to the address listed below.

ACS State Healthcare
Florida Medicaid Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070
APPENDIX E
AUTHORIZATION FOR
SPECIALIZED THERAPEUTIC FOSTER CARE

This is to certify that
Child's Name __________________________________________Date__________________

Medicaid Number __________________________

has been screened and recommended by a multidisciplinary team for Specialized Therapeutic Foster Care and has been determined to require the following level of service:

_____ Level I Specialized Therapeutic Foster Care
_____ Level II Specialized Therapeutic Foster Care

These services are to be provided by
______________________________________________________________ (provider agency), as authorized by:

______________________________________________________________   ___________________________
Circuit Substance Abuse and Mental Health Representative
District Juvenile Justice Representative

______________________________________________________________   ___________________________
Medicaid Representative

______________________________________________________________   ___________________________
Community-Based Care Lead Agency Representative

OR

(C)

______________________________________________________________   ___________________________
Department of Juvenile Justice Representative or designee

AND

______________________________________________________________   _________________
Community-Based Care Representative


October 2004 DRAFT – Rule Development October 2011
OR

(D) ___________________________________________ Date

Child Welfare Prepaid Mental Health Plan Vendor-Representative Date

AND

_________________________________________ Date

Area Medicaid Representative

Services will be reviewed and reauthorized by the multidisciplinary team prior to __________.

Date

Refer to policy in the Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook for instructions on what must be completed for the specific service.

***To be placed in recipient's (child's) clinical record. Medicaid reimbursement covers only dates of service authorized on this form.
APPENDIX F
AUTHORIZATION FOR
CRISIS INTERVENTION

This is to certify that

Child's Name ___________________________________________ ___-Date ______________

Medicaid Number ____________________________

has been screened and recommended for Crisis Intervention.

This service will be provided by:

_________________________________________ (provider agency) as authorized by:

at least one of the following:

_________________________________________ Date

District Substance Abuse and Mental Health Representative

AND

_________________________________________ Date

Community-Based Care Lead Agency Representative
District Children and Families or Community Based Care Representative

_________________________________________ Date

Circuit Substance Abuse and Mental Health Representative

_________________________________________ Date

Department of Juvenile Justice Representative

_________________________________________ Date

Child Welfare Prepaid Mental Health Plan Vendor or Representative

OR

_________________________________________ Date

District Juvenile Justice Representative

AND

_________________________________________ Date

Circuit Substance Abuse and Mental Health

OR

October 2004 DRAFT – Rule Development October 2011
Circuit Substance Abuse and Mental Health Representative __________________________ Date ____________

_________________________ AND

Circuit Department of Juvenile Justice _________________________________ Date ____________

OR

Child Welfare Prepaid Mental Health Plan _________________________________ Date ____________

Services will be reviewed by the multidisciplinary team prior to _________________.

Refer to policy in the Florida Medicaid Community Behavioral Health Coverage and Limitations Handbook for instructions on what must be completed for the specific service.

To be placed in recipient's clinical record. Medicaid reimbursement will cover certified dates, only.
APPENDIX G
PROVIDER AGENCY SELF-CERTIFICATION FOR
BEHAVIORAL HEALTH OVERLAY SERVICES
IN JUVENILE JUSTICE SETTINGS

DEPARTMENT OF JUVENILE JUSTICE

Provider Agency Name: _______________________________ Medicaid No. __________________

Provider Agency Address: ___________________________________________________________

City: ___________________________ Zip Code: ___________________________ Phone No.: __________

County: ___________________________ Circuit: ___________________________ Area: __________

Name and Address of Site: ___________________________________________________________

This is to certify that the above named provider agency has conducted a self-survey of the above named site
and determined that the provider and site are in compliance with the certification criteria, presented in the
Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, Chapter 2,
Section 46, as required to be a Behavioral Health Overlay Services Provider, including the following:

1. Is an enrolled Medicaid Community Behavioral Health Services provider;
2. Is under contract with the Department of Juvenile Justice as a residential group care provider;
3. Has the primary mission in this program to provide an alternative living situation to children who have been
   adjudicated delinquent;
4. Is designated by the Department of Juvenile Justice as an essential behavioral health care provider; and
5. Will cooperate with an on-site survey by the district Substance Abuse and Mental Health program office or
   Agency for Health Care Administration, or designee Utilization Management organization, local Mental
   Health authority for Behavioral Health Overlay Services Provider Agency Certification within six months of
   this self-certification and agrees to adhere to the provisions for provider qualifications and certification
   criteria. These certification criteria include:
   • Services to be provided
   • Provider capacity
   • Intensity of services
   • Quality assurance program
   • Required policies and procedures
   • Organizational chart and staff credentials
   • Clinical staffing requirements
   • Staffing ratios
   • Qualifications and responsibilities
   • Clinical supervision
   • Behavioral health overlay services design
   • Recipient eligibility
   • Recipient certification and re-certification
   • Medical record and documentation requirements

I certify that the above named site is in compliance with Medicaid policies and procedures as put forth in the
Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook and with the
specific standards for Behavioral Health Overlay Services in Chapter 2, Section 46. I further certify that
statements made in this document are accurate and correct to the best of my knowledge.

Executive Director’s Name (please print) ________________________________

Executive Director’s Signature _______________ Date ________________________

Send original form to:
AHCA, Medicaid Services
Behavioral Health Unit-DJJ/Overlay
2727 Mahan Drive, MS 20

October 2004 DRAFT – Rule Development October 2011
Tallahassee, FL 32308

Provider should maintain a copy.
APPENDIX H
PROVIDER AGENCY CERTIFICATION FOR
BEHAVIORAL HEALTH OVERLAY SERVICES
FOR YOUTH IN JUVENILE JUSTICE SETTINGS

Provider Agency Name: _______________________________ Medicaid No. ________________
Provider Agency Address: _______________________________
City: __________________ Zip Code: __________ Phone No.: ______________
County: __________________ Circuit: __________ Area: ______________
Name and Address of Site: ____________________________ Zip Code: ______________

Surveyed By: ____________________________ Date of Survey ______________

This is to certify that the above named provider agency and site meet the following qualifications and
certification criteria as presented in the Florida Medicaid Community Behavioral Health Services Coverage
and Limitations Handbook, Chapter 2, Section 6.

1. Is an enrolled Medicaid Community Behavioral Health Services provider.
2. Is under contract with the Department of Juvenile Justice as a residential group care provider.
3. Has the primary mission in this program to provide an alternative living situation to children who
   have been adjudicated delinquent.
4. Is designated by the Department of Juvenile Justice as an essential behavioral health care provider.
5. Received an on-site survey by the district Substance Abuse and Mental Health (SAMH) program
   office Agency for Health Care Administration, or representative, local Mental Health authority for
   Behavioral Health Overlay Services Provider Agency Certification and was found to be in
   compliance with the provisions for provider qualifications and certification criteria.

These certification criteria include:

- Services to be provided
- Provider capacity
- Intensity of services
- Quality assurance program
- Required policies and procedures
- Organizational chart and staff credentials
- Clinical staffing requirements
- Qualifications and responsibilities
- Clinical supervision
- Behavioral health overlay services design
- Recipient eligibility
- Recipient certification and re-certification
- Medical record and documentation requirements

I certify that statements made in this document are accurate and correct to the best of my knowledge,
information, and belief.

______________________________ Date
Executive Director’s Signature

This certification has been reviewed by:

______________________________ Date
Medicaid Representative

Original to provider, copies to District Circuit SAMH, and Medicaid Area office

October 2004 DRAFT – Rule Development October 2010
APPENDIX I
CERTIFICATION OF ELIGIBILITY FOR
BEHAVIORAL HEALTH OVERLAY SERVICES
IN JUVENILE JUSTICE SETTINGS

DEPARTMENT OF JUVENILE JUSTICE

This is to certify that: Date: ____________________

Child’s Name: __________________________________ Medicaid No: ____________________

has been screened and meets the following clinical eligibility criteria to receive Behavioral Health Overlay Services.

The child or adolescent is placed in: ____________________________________________

(Name of provider/site),
a Medicaid enrolled residential program that has been certified (or self-certified) to provide Behavioral Health Overlay Services and meets the clinical criteria as listed below.

The child or adolescent meets the diagnostic eligibility criteria described in Section A, 1 or 2, and one of the four risk factors in Section B.

Section A: Diagnostic Criteria. The child or adolescent:

1. Has an ICD-9-CM diagnosis of 295.0 through 298.9 (psychotic disorder, major depression or bipolar disorder);  

   (Specify diagnosis)  

   OR

2. Has an ICD-9-CM diagnosis in the following range: 294.8, 294.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; and 303.0 through 305.9;  

   (Specify diagnosis)  

   AND

   Has been enrolled in a special education program for the seriously emotionally disturbed or emotionally handicapped;

   (Specify type of program)  

   OR

   Has scored a 60 or below on the Axis V Global Assessment of Functioning Scale, or Child’s Global Assessment Scale, within the last 6 months and the justification for such a score is well documented and detailed on the certification form.

   (Scale/Score)
CERTIFICATION OF ELIGIBILITY FOR BEHAVIORAL HEALTH OVERLAY SERVICES

Section B: Risk Factors. The recipient is at risk due to one of the following (check one) and such risk is documented and detailed. Please check and attach relevant documentation to this form on the back of this eligibility certification form:

☐ (1) Within the past 12 months, recipient has exhibited, has a history of suicidal gestures, attempt or self-injurious behaviors, or current ideation related to suicidal or self-injurious behavior, though not currently in need of acute care;

OR

☐ (2) Within the past 12 months, recipient has exhibited has a history of physical aggression or violent behavior toward persons, people, animals or property. This risk may also be evidenced by current threats of such aggression;

OR

☐ (3) Within the past 12 months, recipient has has a history of running away from home or placements or current verbal threatened to run away on one or more occasions;

OR

☐ (4) Within the past 12 months, recipient has exhibited problems with substance abuse.

Recipient has history, or recent occurrences of sexual aggression.

Recipient has history of victimization, trauma.

Certified by:

Counselor

Date

Licensed Practitioner

Date

Services will be reviewed and re-certified prior to: (six months from the date of original certification)

To be placed in recipient’s (child’s) medical-clinical record.
APPENDIX J

PROVIDER AGENCY ACKNOWLEDGEMENT SELF-STUDY FORM FOR

THERAPEUTIC GROUP HOME CARE SERVICES

Provider Agency Name: _______________________________ Medicaid No. ______________

Provider Agency Address: __________________________________________________________

City: _____________________ Zip Code ___________ Phone No.: (______) __________

County: _____________________ District Circuit: ___________ Area: ___________ 

Name and Address of Site: _________________________________________________________

This is to certify that the above named provider agency has conducted a self-study of the above named site and determined that the provider and site are in compliance with the certification criteria for the provision of Therapeutic Group Care Services included in Section 6 of the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, including the following:

• Be designated by the Department of Children and Families, District Substance Abuse and Mental Health (SAMH) Program Office as a Therapeutic Group Care Services provider;

• Is properly licensed in accordance with Chapter 394, 409, 175, F.S., and Chapter 65E-9, F.A.C 64C-13, F.A.C., or 65C-14, F.A.C., by the Agency for Health Care Administration.
• Has submitted the Provider Agency Acknowledgement form for Therapeutic Group Care Services and attached a copy of licensure.

• Will cooperate with an on-site surveys by the Agency for Health Care Administration or designee or the Child Welfare Prepaid Mental Health Plan vendor or designee, and agrees to adhere to the provisions for provider qualifications and certification criteria as set forth in the Community Behavioral Health Services Handbook and the Florida Medicaid Provider General Handbook, district Family Safety Program office. The program must become licensed by AHCA as required under Chapter 65E-9, F.A.C., when it is promulgated.

• Will cooperate with an on-site survey by the district Substance Abuse and Mental Health and the Family Safety Program Offices for the purpose of Provider Agency Certification prior to initiation of billing, within six months of initial certification and annually thereafter, and agrees to adhere to the provisions for provider qualifications and certification criteria.

These certification criteria include:

• Required Capabilities for Therapeutic Group Care Providers
• Quality Assurance Program Requirements
• Services to be Provided
• Staff Qualifications and Training
• Required Policies And Procedures

I certify that the above named site is in compliance with Medicaid policies and procedures as put forth in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook and with the specific standards for Therapeutic Group Home Services and further certify that statements made in this document are accurate and correct to the best of my knowledge.

Executive Director’s Name (please print) __________________________________________________ Date

Executive Director’s Signature __________________________________________________________________________

Executive Director’s Name (please print)

Send original form to:

AHCA,
Medicaid Services,
Long Term Care and Behavioral Health Unit,
2727 Mahan Drive, MS 20,
Tallahassee FL 32308.
Provider should maintain a copy.
APPENDIX K
THERAPEUTIC GROUP CARE SERVICES
PROVIDER AGENCY CERTIFICATION

Provider Agency Name: ___________________________ Medicaid No. ____________
Provider Agency Address: ___________________________
City: __________________________ Zip Code __________ Phone No.: (____ ) _______
County: __________________________ District: _________ Area: _______
Name and Address of Site: __________________________
________________________________________ Zip Code __________

This is to certify that the above named provider agency and site has been surveyed and determined to be in compliance with the certification criteria for the provision of Therapeutic Group Care Services included in Chapter 2, Section 64 of the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, including the following:

- Is designated by the Department of Children and Families, District Substance Abuse and Mental Health (SAMH) Program Office Agency for Health Care Administration (AHCA) as a Therapeutic Group Care Services provider;
- Is properly licensed in accordance with Chapter 409.175, F. S., and Chapter 65C -14, F. A. C., by the district Family Safety Program office. The program must become licensed by AHCA as required under Chapter 65E-9, F.A.C., when it is promulgated.
- Has met the qualifications for certification to be a provider of Therapeutic Group Care Services for children and adolescents, based upon a review by the Department of Children and Families District Substance Abuse and Mental Health Program Offices and the Agency for Health Care Administration Area office, or representative, of the following certification criteria as outlined in Chapter 2, Section 64 of the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Services Handbook.

These certification criteria include:

• Required Capabilities for Therapeutic Group Care Providers
• Quality Assurance Program Requirements
• Services to be Provided
• Staff Qualifications and Training
• Required Policies and Procedures

Begin Date: ___________________________ End Date: ___________________________

Child Welfare Prepaid Mental Health Plan Vendor District Substance Abuse and Mental Health Representative Date

Medicaid Field Medicaid Office Representative: ___________________________ Date

This form must be kept in the provider’s records with a copy to area Medicaid Office

October 2004 DRAFT – Rule Development October 2011
APPENDIX L

AUTHORIZATION FOR THERAPEUTIC GROUP CARE SERVICES

This is to certify that:

Child's Name ___________________________________________ Date _______________________

Medicaid Number ________________________________________ Date of Birth _______________

Has been screened by a multidisciplinary team or by a Qualified Evaluator, under Chapter 39.407, and
determined to require and be suitable for Therapeutic Group Care Services:

These services are to be provided by ______________________________________________________

__________________________________________ (TGC provider) / agency

as authorized by:

1) Recipients in Areas Not Covered by the Child Welfare Prepaid Mental Health Plan:

__________________________ Date

__________________________________________

Circuit Substance Abuse and Mental Health Community Based Care Representative

__________________________________________

Medicaid Representative

AND

Area Medicaid Office Representative ____________________________ Date

AND

2) Recipients in the Child Welfare Prepaid Mental Health Plan:

__________________________ Date

__________________________________________

District Child Welfare or Community-Based Care Representative Child Welfare Prepaid Mental Health Plan Vendor

AND

AND

__________________________ Date

__________________________

Medicaid Field Office Representative 3) Recipients in Area In-Covered by the Child Welfare Prepaid Mental Health Plan, But Not Enrolled in Plan

Community-Based Care Representative

Date
Community Behavioral Health Services Coverage and Limitations Handbook

Medicaid Representative

________________________  __________________________

Area Medicaid Office Representative

Date

And

________________________  __________________________

Community-Based Care Representative

Date

Services will be reviewed and reauthorized by the multidisciplinary team prior

to this date: ___________________

This form must be placed in child's clinical record. Medicaid will reimburse services only for the
dates of service authorized on this form.
APPENDIX M
CERTIFICATION OF ELIGIBILITY
FOR BEHAVIORAL HEALTH OVERLAY SERVICES –
IN CHILD WELFARE SETTINGS

Date: ___________________________

This is to certify that:

Child's Name ___________________________ Date _______________________

Medicaid Number ___________________________ Date _______________________

has been screened and meets the following clinical eligibility criteria to receive Behavioral Health Overlay Services – Child Welfare.

The child or adolescent is placed in: ___________________________ (Name of provider and site),

a Medicaid enrolled residential program that has been certified (or self-certified) to provide behavioral health overlay services and meets the clinical criteria as listed below.

The child or adolescent meets the diagnostic eligibility criteria described in Section A and one of the five risk factors in Section B.

Section A:

• The child has an ICD-9-CM diagnosis in the following range: 294.8, 295.0 through 298.9, 300 through 301.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; And 303.0 through 305.9;

(Specify diagnosis)

AND

• The child demonstrates significant impairment of age-appropriate, developmental progression or psychosocial functioning due to the ICD-9-CM psychiatric disorder, in one or more of the following areas: family, social and peer relationships, educational or vocational.

AND

Section B: Risk Factors. The recipient is at risk due to at least one of the eligible factors listed on. Note: See Chapter 2, Section 7 of the Medicaid Community Behavioral Health Services Coverage and Limitations Handbook for eligible risk factors. Please specify at least one risk factor below, and attach relevant documentation to this form in the recipient's clinical record.

(1) A history of suicidal gesture, attempt or self-injurious behavior or current ideation related to suicidal or self-injurious behavior, though not currently in need of acute care;

(2) A history of physical aggression or violent behavior toward persons, animals or property. This risk may also be evidenced by current threats of such aggression;

(3) A history of running away from home or placements or current verbal threats to run away on one or more occasions;

(4) A history or recent occurrences of sexual aggression or victimization;

(5) A history of criminal or delinquent behavior;

(6) A history of or current psychoactive chemical use
(7) A history of disrupted out-of-home placements; or
(8) Has recently been removed from home because of abuse or neglect and placed in a group shelter setting.

Certified by:


Certified by:

Counselor ________________________________ Date ________________
Licensed Practitioner ________________________________ Date ________________
Services will be reviewed and re-certified prior to: ____________________________
(six months from the date of original certification)

This form is to be placed in recipient’s (child’s) medical-clinical record.
APPENDIX N

PROVIDER AGENCY SELF-CERTIFICATION FOR FORM BEHAVIORAL HEALTH OVERLAY SERVICES IN CHILD WELFARE SETTINGS

Provider Agency Name: ____________________________ Medicaid No. __________________

Provider Agency Address: ____________________________

City: __________________ Zip Code __________ Phone: ( )

County: ____________________________ Circuit: __________ Area: __________

Name and Address of Site: ____________________________

______________________________________________ Zip Code __________

This is to certify that the above named provider agency has conducted a self-survey of the above named site and determined that the provider and site are in compliance with the certification criteria, presented in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, including the following:

1. Is an enrolled Medicaid Community Behavioral Health Services provider;
2. Is licensed by the Department of Children and Families under Chapter 64C-14, F.A.C. as a child caring agency and is under contract with Child Welfare and Community Based Care office or provider to provide group shelter or residential group care.
3. Has as the primary mission in this program to provide an alternative living situation to children who have been removed from the home due to abuse or neglect or adjudicated dependent;
4. Is designated by the Department Children and Families as an essential behavioral health care provider; and
5. Will cooperate with an on-site survey by the district SAMH and Child Welfare offices, or representative, for the purpose of provider agency certification within six months of this self-certification and agrees to adhere to the provisions for provider qualifications and certification criteria. These certification criteria include:

   • Services to be provided
   • Provider capacity
   • Intensity of services
   • Quality assurance program
   • Required policies and procedures
   • Organizational chart and staff credentials
   • Clinical staffing requirements
   • Staffing ratios
   • Qualifications and responsibilities
   • Clinical supervision
   • Behavioral health overlay services design
   • Recipient eligibility
   • Recipient certification and re-certification
   • Medical record and documentation requirements

I certify that statements made in this document are accurate and correct to the best of my knowledge.

Executive Director’s Name (please print) __________________________

Executive Director’s Signature __________________________ Date __________

Send original form to AHCA, Medicaid Services, Long Term and Behavioral Health Unit, 2727 Mahan Drive, Mail Stop #20, Tallahassee FL 32308. Provider should maintain a copy.
APPENDIX O
PROVIDER AGENCY CERTIFICATION FOR FORM
BEHAVIORAL HEALTH OVERLAY SERVICES
IN CHILD WELFARE SETTINGS

Provider Agency Name: ___________________________ Medicaid No. __________________
Provider Agency Address: ___________________________
City: ___________________________ Zip Code __________ Phone: ( ___ ) __________
County: ___________________________ Circuit: _________ Area: __________
Name and Address of Site: ___________________________ Zip Code __________
Surveyed By: ___________________________ Date of Survey: __________

This is to certify that the above named provider agency and site meet the following qualifications
and certification criteria as specified Chapter 2, Section 7 of this handbook:

1. Is an enrolled Medicaid Community Mental Health Services provider.
2. Is licensed by the Department of Children and Families under Chapter 65C-14, F.A.C. as a child
caring agency and is under contract with the Child Welfare and Community Based Care office or
provider to provide group shelter care or residential group care.
3. Has the primary mission in this program to provide an alternative living situation to children who have
been removed from the home due to abuse or neglect or adjudicated dependent;
4. Is designated by the Department of Children and Families as an essential behavioral health care
provider.
5. Received an on-site survey by the district Substance Abuse and Mental Health and Child Welfare
offices for Behavioral Health Overlay Services provider agency certificationAgency for Health Care
Administration, or its representative, and was found to be in compliance with the provisions for
provider qualifications and certification criteria.

These certification criteria include:

- Services to be provided
- Provider capacity
- Intensity of services
- Quality assurance program
- Required policies and procedures
- Organizational chart and staff credentials
- Clinical staffing requirements, including staff ratios
- Qualifications and responsibilities
- Clinical supervision
- Behavioral health overlay services design
- Recipient eligibility
- Recipient certification and re-certification
- Medical record and documentation requirements

I certify that statements made in this document are accurate and correct to the best of my knowledge,
information, and belief.

___________________________________________  ___________________________
Executive Director’s Signature  Date

This certification has been reviewed by:

___________________________________________  ___________________________
AHCA Medicaid Representative  Date

Original to provider, copies to district Circuit or Regional SAMH, and Medicaid Area offices.

DRAFT – Rule Development October 2011
# APPENDIX P
## PROCEDURE CODES AND FEE SCHEDULE

These procedure codes are to be used for dates of service **October 1, 2004, January 2, 2004, and after.**

### Assessment Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
</tr>
</thead>
</table>
| H2000 | HP       | HIPAA description: Comprehensive multidisciplinary evaluation, doctoral level  
Psychiatric Evaluation by physician  
(Medicaid Service: Psychiatric Evaluation by physician) | $210.00 per evaluation |
|      | HO       | HIPAA description: Comprehensive multidisciplinary evaluation, masters degree level  
Psychiatric Evaluation by non-physician  
(Medicaid Service: Psychiatric Evaluation by non-physician) | $150.00 per evaluation |
| H2010 | HO       | HIPAA description: Comprehensive Medication Services, per 15 minutes, masters degree level  
Brief Behavioral Health Status Exam  
(Medicaid Service: Brief Behavioral Health Status Exam) | $14.66 per quarter hour |
| H2000 | (none)   | HIPAA description: Comprehensive multidisciplinary evaluation  
Psychiatric Review of Records  
(Medicaid Service: Psychiatric Review of Records) | $26.00 per review |
| H0031 | HO       | HIPAA description: Mental health assessment, by non-physician, masters degree level  
In-depth assessment, new patient, mental health  
(Medicaid Service: In-depth assessment, new patient, mental health) | $125.00 per assessment |
| H0031 | TS       | HIPAA description: Mental health assessment by non-physician, follow-up service  
In-depth assessment, established patient, mental health  
(Medicaid Service: In-depth assessment, established patient, mental health) | $100.00 per assessment |
| H0001 | HO       | HIPAA description: Alcohol and/or drug assessment, masters degree level  
In-depth assessment, new patient, substance abuse  
(Medicaid Service: In-depth assessment, new patient, substance abuse) | $125.00 per assessment |
| H0001 | TS       | HIPAA description: Alcohol and/or drug assessment, follow-up service  
In-depth assessment, established patient, substance abuse  
(Medicaid Service: In-depth assessment, established patient, substance abuse) | $100.00 per assessment |
| H0031 | HN | **HIPAA description**: Mental health assessment, bachelors degree level  
Bio-psychosocial Evaluation, mental health  
*(Medicaid Service: Bio-psychosocial Evaluation, mental health)* | $48.00 per assessment |
## Assessment Services, continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0001</td>
<td>HN</td>
<td><strong>HIPAA description:</strong> Alcohol and/or drug assessment, bachelors degree level</td>
<td>$48.00 per assessment</td>
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<tr>
<td></td>
<td></td>
<td>Bio-psychosocial Evaluation, substance abuse</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><em>(Medicaid Service: Bio-psychosocial Evaluation, substance abuse)</em></td>
<td></td>
</tr>
<tr>
<td>H2019</td>
<td>(none)</td>
<td><strong>HIPAA description:</strong> Therapeutic behavioral services, per 15 minutes</td>
<td>$15.00 per quarter hour</td>
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<tr>
<td></td>
<td></td>
<td>Psychological testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Medicaid Service: Psychological testing)</em></td>
<td></td>
</tr>
<tr>
<td>H0031</td>
<td>(none)</td>
<td><strong>HIPAA description:</strong> Mental health assessment, by non-physician</td>
<td>$15.00 per assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited functional assessment, mental health</td>
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<td><em>(Medicaid Service: Limited functional assessment, mental health)</em></td>
<td></td>
</tr>
<tr>
<td>H0001</td>
<td>(none)</td>
<td><strong>HIPAA description:</strong> Alcohol and/or drug assessment</td>
<td>$15.00 per assessment</td>
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<tr>
<td></td>
<td></td>
<td>Limited functional assessment, substance abuse</td>
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<td><em>(Medicaid Service: Limited functional assessment, substance abuse)</em></td>
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</table>

## Treatment Plan Development and Modification

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
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<tbody>
<tr>
<td>H0032</td>
<td>(none)</td>
<td><strong>HIPAA description:</strong> Mental health service plan development by non-physician</td>
<td>$97.00 per event</td>
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<tr>
<td></td>
<td></td>
<td>Treatment plan development, new and established patient, mental health</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><em>(Medicaid Service: Treatment plan development, new and established patient, mental health)</em></td>
<td></td>
</tr>
<tr>
<td>T1007</td>
<td>(none)</td>
<td><strong>HIPAA description:</strong> Alcohol and/or substance abuse services, treatment plan development and/or modification</td>
<td>$97.00 per event</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treatment plan development, new and established patient, substance abuse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Medicaid Service: Treatment plan development, new and established patient, substance abuse)</em></td>
<td></td>
</tr>
<tr>
<td>H0032</td>
<td>TS</td>
<td><strong>HIPAA description:</strong> Mental health service plan development by non-physician, follow-up service</td>
<td>$48.50 per event</td>
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<tr>
<td></td>
<td></td>
<td>Treatment plan review, mental health</td>
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</tr>
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<td></td>
<td></td>
<td><em>(Medicaid Service: Treatment plan review, mental health)</em></td>
<td></td>
</tr>
<tr>
<td>T1007</td>
<td>TS</td>
<td><strong>HIPAA description:</strong> Alcohol and/or substance abuse services, treatment plan development and/or modification, follow-up service</td>
<td>$48.50 per event</td>
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<tr>
<td></td>
<td></td>
<td>Treatment plan review, substance abuse</td>
<td></td>
</tr>
</tbody>
</table>

*October 2004 DRAFT – Rule Development October 2010*
(Medicaid Service: Treatment plan review, substance abuse)
<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
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</thead>
<tbody>
<tr>
<td>T1015</td>
<td>(none)</td>
<td><strong>HIPAA description:</strong> Clinic visit/encounter, all inclusive Medication management</td>
<td>$60.00 per event</td>
</tr>
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<td></td>
<td></td>
<td><em>(Medicaid Service: Medication management)</em></td>
<td></td>
</tr>
<tr>
<td>H2010</td>
<td>HE</td>
<td><strong>HIPAA description:</strong> Comprehensive medication services, per 15 minutes, mental health program Brief individual medical psychotherapy, mental health</td>
<td>$15.00 per quarter hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Medicaid Service: Brief individual medical psychotherapy, mental health)</em></td>
<td></td>
</tr>
<tr>
<td>H2010</td>
<td>HF</td>
<td><strong>HIPAA description:</strong> Comprehensive medication services, per 15 minutes, substance abuse program Brief individual medical psychotherapy, substance abuse</td>
<td>$15.00 per quarter hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Medicaid Service: Brief individual medical psychotherapy, substance abuse)</em></td>
<td></td>
</tr>
<tr>
<td>H2010</td>
<td>HQ</td>
<td><strong>HIPAA description:</strong> Comprehensive medication services, per 15 minutes, group setting Group medical therapy</td>
<td>$8.65 per quarter hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Medicaid Service: Group medical therapy)</em></td>
<td></td>
</tr>
<tr>
<td>T1015</td>
<td>GT</td>
<td>Telepsychiatry</td>
<td>$60.00 per event</td>
</tr>
<tr>
<td>T1023</td>
<td>HE</td>
<td><strong>HIPAA description:</strong> Screening to determine appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter, mental health program Behavioral health screening, mental health</td>
<td>$43.62 per event</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Medicaid Service: Behavioral health screening, mental health)</em></td>
<td></td>
</tr>
<tr>
<td>T1023</td>
<td>HF</td>
<td><strong>HIPAA description:</strong> Screening to determine appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter, substance abuse program Behavioral health screening, substance abuse</td>
<td>$43.62 per event</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Medicaid Service: Behavioral health screening, substance abuse)</em></td>
<td></td>
</tr>
</tbody>
</table>
### Community Behavioral Health Services Coverage and Limitations Handbook

**H0046 (none)**

**HIPAA description:** Mental health services, not otherwise specified  
Behavioral health services: verbal interaction, mental health  
(\textit{Medicaid Service: Behavioral health services: verbal interaction, mental health})  
$15.00 per event

**H0047 (none)**

**HIPAA description:** Alcohol and/or drug abuse services, not otherwise specified  
Behavioral health services: verbal interaction, substance abuse  
(\textit{Medicaid Service: Behavioral health services: verbal interaction, substance abuse})  
$15.00 per event

### Medical and Psychiatric Services, continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
</tr>
</thead>
</table>
| T1015 | HE | Clinic visit/encounter, all inclusive, mental health program  
Behavioral health services: specimen collection, mental health  
(\textit{Medicaid Service: Behavioral health services: specimen collection, mental health}) | $10.00 per event |
| T1015 | HF | Clinic visit/encounter, all inclusive, substance abuse program  
Behavioral health services: specimen collection, substance abuse  
(\textit{Medicaid Service: Behavioral health services: specimen collection, substance abuse}) | $10.00 per event |
| H0020 (none) | | Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)  
Methadone or Buprenorphine administration  
(\textit{Medicaid Service: Methadone or Buprenorphine administration}) | $67.48, weekly rate |

### Behavioral Health Therapy Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
</tr>
</thead>
</table>
| H2019 | HR | Therapeutic behavioral services, per 15 minutes, family/couple with client present  
Individual and family therapy  
(\textit{Medicaid Service: Individual and family therapy}) | $18.33 per quarter hour |
| H2019 | GT | Telebehavioral health individual therapy | $18.33 per quarter hour |
| H2019 | HQ | Therapeutic behavioral services, per 15 minutes, group setting  
Group therapy  
(\textit{Medicaid Service: Group therapy}) | $6.67 per quarter hour |
| H2012 (none) | | Behavioral health day treatment, per hour  
Behavioral health day services, mental health  
(\textit{Medicaid Service: Behavioral health day services, mental health}) | $12.50 per hour |
### Community Behavioral Health Services Coverage and Limitations Handbook

- **H2012 HF**
  - **HIPAA description:** Behavioral health day treatment, per hour, substance abuse program
  - **Behavioral health day services, substance abuse**
  - **(Medicaid Service: Behavioral health day services, substance abuse)**
  - Maximum Fee: $12.50 per hour

### Community Support and Rehabilitative Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2017</td>
<td>(none)</td>
<td><strong>HIPAA description:</strong> Psychosocial rehabilitation services, per 15 minutes</td>
<td>$9.00 per quarter hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Psychosocial rehabilitation services</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>(Medicaid Service: Psychosocial rehabilitation services)</strong></td>
<td></td>
</tr>
<tr>
<td>H2030</td>
<td>(none)</td>
<td><strong>HIPAA description:</strong> Mental health clubhouse services, per 15 minutes</td>
<td>$5.00 per quarter hour</td>
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<tr>
<td></td>
<td></td>
<td>Clubhouse services</td>
<td></td>
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<td></td>
<td></td>
<td><strong>(Medicaid Service: Clubhouse services)</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Therapeutic Behavioral On-Site Services for Children and Adolescents

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2019</td>
<td>HO</td>
<td><strong>HIPAA description:</strong> Therapeutic behavioral services, per 15 minutes, masters degree level</td>
<td>$16.00 per quarter hour</td>
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<td></td>
<td>Therapeutic behavioral on-site services, therapy</td>
<td></td>
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<td></td>
<td></td>
<td><strong>(Medicaid Service: Therapeutic behavioral on-site services, therapy)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HNM</td>
<td><strong>HIPAA description:</strong> Therapeutic behavioral services, per 15 minutes, less than bachelor degree level</td>
<td>$10.00 per quarter hour</td>
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<tr>
<td></td>
<td></td>
<td>Therapeutic behavioral on-site services, behavior management</td>
<td></td>
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<td></td>
<td></td>
<td><strong>(Medicaid Service: Therapeutic behavioral on-site services, behavior management)</strong></td>
<td></td>
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<tr>
<td></td>
<td>HMN</td>
<td><strong>HIPAA description:</strong> Therapeutic behavioral services, per 15 minutes, less than bachelors degree level</td>
<td>$4.00 per quarter hour</td>
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<td></td>
<td></td>
<td>Therapeutic behavioral on-site services, therapeutic support</td>
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<td></td>
<td></td>
<td><strong>(Medicaid Service: Therapeutic behavioral on-site services, therapeutic support)</strong></td>
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</table>

### Comprehensive Behavioral Health Assessment

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
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</thead>
<tbody>
<tr>
<td>H0031</td>
<td>HA</td>
<td><strong>HIPAA description:</strong> Mental health assessment, by non-physician, child/adolescent program</td>
<td>$48.50 12.12 per quarter hour</td>
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<td></td>
<td></td>
<td>Comprehensive behavioral health assessment</td>
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<td></td>
<td></td>
<td><strong>(Medicaid Service: Comprehensive behavioral health assessment)</strong></td>
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*October 2004 DRAFT – Rule Development October 2010*
## Specialized Therapeutic Foster Care Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>HIPAA Description</th>
<th>Medicaid Service</th>
<th>Maximum Fee</th>
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<tbody>
<tr>
<td>S5145</td>
<td>(none)</td>
<td>Foster care, therapeutic, child; per diem</td>
<td>Specialized therapeutic foster care, Level 1</td>
<td>$87.30 per day</td>
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<td><a href="#">Specialized therapeutic foster care, Level 1</a></td>
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<tr>
<td>S5145</td>
<td>HE</td>
<td>Foster care, therapeutic, child; per diem, mental health program</td>
<td>Specialized therapeutic foster care, Level 2</td>
<td>$135.80 per day</td>
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<td></td>
<td><a href="#">Specialized therapeutic foster care, Level 2</a></td>
<td><a href="#">Specialized therapeutic foster care, Level 2</a></td>
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<tr>
<td>S5145</td>
<td>HK</td>
<td>Foster care, therapeutic, child; per diem, specialized mental health programs for high-risk populations</td>
<td>Specialized therapeutic foster care, Crisis intervention</td>
<td>$135.80 per day</td>
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<tr>
<td></td>
<td></td>
<td><a href="#">Specialized therapeutic foster care, Crisis intervention</a></td>
<td><a href="#">Specialized therapeutic foster care, Crisis intervention</a></td>
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</tr>
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</table>
### Behavioral Health Overlay Services

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<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
</tr>
</thead>
</table>
| H2020 HK |          | **HIPAA description:** Therapeutic behavioral services, per diem, specialized mental health programs for high-risk populations  
             Behavioral health overlay services, juvenile justice setting  
             *(Medicaid Service: Behavioral health overlay services, juvenile justice setting)* | $35.00 per day |
| H2020 HA |          | **HIPAA description:** Therapeutic behavioral services, per diem, child/adolescent program  
             Behavioral health overlay services, child welfare setting  
             *(Medicaid Service: Behavioral health overlay services, child welfare setting)* | $32.75 per day |

### Therapeutic Group Care Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
</tr>
</thead>
</table>
| H0019 (none) |          | **HIPAA description:** Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem.  
             Therapeutic group care services  
             *(Medicaid Service: Therapeutic group care services)* | $180.00 per day |

### Medicaid Certified County Match Program for Substance Abuse

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description of Service</th>
<th>Maximum Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0022 (none)</td>
<td></td>
<td>Alcohol and drug intervention services, licensed practitioner or master's degree level CAP</td>
<td>$15.00 per quarter hour</td>
</tr>
<tr>
<td>H2015 (none)</td>
<td></td>
<td>Peer recovery support services for individuals, bachelor's degree level or less.</td>
<td>$9.75 per quarter hour</td>
</tr>
<tr>
<td>H2015 HQ</td>
<td></td>
<td>Peer recovery support services for groups, bachelor's degree level or less</td>
<td>$2.44 per quarter hour</td>
</tr>
<tr>
<td>H2015 HN</td>
<td></td>
<td>Comprehensive community support services for substance abuse, bachelors degree level</td>
<td>$15.00 per quarter hour</td>
</tr>
</tbody>
</table>