



Florida Medicaid

SPECIALIZED THERAPEUTIC SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration
March 2014



SPECIALIZED THERAPEUTIC SERVICES COVERAGE AND LIMITATIONS HANDBOOK UPDATE LOG

How to Use the Update Log

Introduction

The update log provides a history of the handbook updates. Each Florida Medicaid handbook contains an update log.

Obtaining the Handbook Update

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

Medicaid 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 Services Contact Center at 1-800-289-7799.

Explanation of the Update Log

Providers can use the update log below to determine if updates to the handbook have been received.

Update describes the change that was made.

Effective Date is the date that the update is effective.

UPDATE	EFFECTIVE DATE
New Handbook	March 2014

**SPECIALIZED THERAPEUTIC SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter outlines the three types of Florida Medicaid policy handbooks that all enrolled providers must comply with in order to obtain reimbursement. This chapter also describes the format used for the handbooks and instructs 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 any corresponding fee schedules. Fee schedules can be incorporated within the handbook or separately.
- Reimbursement handbooks describe how to complete and file claims for reimbursement from Medicaid.

The current Florida 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.

Federal and State 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
 - Rule Division 59G, Florida Administrative Code
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In This Chapter

This chapter contains:

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Handbook Use

Purpose

The purpose of the Medicaid handbooks is to educate the Medicaid provider about 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

Term 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

Term used to describe an individual enrolled in Florida Medicaid.

**Provider
General
Handbook**

Information that applies to all 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.

**Coverage and
Limitations
Handbook**

Each coverage and limitations handbook is named for the service it describes. A provider who renders more than one type of Medicaid service will have more than one coverage and limitations handbook with which they must comply.

**Reimbursement
Handbook**

Most reimbursement handbooks are named for the type of claim form submitted.

Characteristics of the Handbook

Format	The format of the handbook represents a reader-friendly way of displaying material.
Label	Labels 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.
Information Block	<p>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.</p> <p>Each block is identified or named with a label.</p>
Chapter Topics	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.
Note	Note is used to refer the reader to other important documents or policies contained outside of this handbook.
Page Numbers	Pages are numbered consecutively within each chapter throughout the handbook. The chapter number appears as the first digit before the page number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

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 “Effective Date.”

How Changes are Updated

The Medicaid handbooks will be updated as needed. Updates are classified as either a:

- Replacement handbook – Major revisions resulting in a rewrite of the existing handbook, without any underlines and strikethroughs throughout the rulemaking process.
 - Revised handbook – Minor revisions resulting in modification of the existing handbook identified during the rulemaking process by underlines and strikethroughs.
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Handbook Effective Date

The effective date of a handbook is the month and year that will appear on the final published handbook. The provider can check this date to ensure that the material being used is the most current and up to date.

Identifying New Information

New information or information moved from one place to another within the handbook will be identified by an underline on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., new information).

Identifying Deleted Information

Deleted information will be identified by a line through the middle of the selected text on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., ~~deleted information~~).

Final Published Handbook

The adopted and published version of the handbook will not have underlines (indicating insertions) and text with strikethroughs (indicating deletions).

CHAPTER 1
QUALIFICATIONS, ENROLLMENT, AND REQUIREMENTS

Overview

Introduction

This chapter describes Florida Medicaid’s specialized therapeutic services, the specific authority regulating these services, staff qualifications, and provider enrollment and requirements.

Legal Authority

Specialized therapeutic services are authorized by section 409.906, Florida Statutes (F.S.), and in Rule 59G-4.295, Florida Administrative Code (F.A.C.).

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Purpose and Definitions

**Medicaid
Provider
Handbooks**

This handbook is intended for use by specialized therapeutic services providers that render services to eligible Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains information about specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid program.

Note: The Florida Medicaid provider handbooks are available 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. All of the Florida Medicaid provider handbooks are incorporated by reference in Rule Division 59G, F.A.C.

**Aftercare
Planning**

The process of planning for a recipient’s transition from the current level of care. This process begins during the assessment process when the recipient’s needs and possible barriers to care are identified.

Specialized therapeutic foster care and therapeutic group care services require the development of a formal aftercare plan.

Purpose and Definitions, continued

Bachelor’s Level Infant Mental Health Practitioner	A bachelor’s level practitioner who provides services to recipients under the age of six years.
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Emotional Disturbance	A person under the age of 21 years who is diagnosed with a mental, emotional, or behavioral disorder of sufficient duration to meet one of the diagnostic categories specified in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, but who does not exhibit behaviors that substantially interfere with or limit the role or ability to function in the family, school, or community. The emotional disturbance must not be considered to be a temporary response to a stressful situation.
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Discharge Criteria	Measurable criteria established at the onset of treatment that identify a recipient’s readiness to transition to a new level of care or out of care. Discharge criteria must be included on the recipient’s individualized treatment plan and are separate and apart from the recipient’s treatment plan goals and objectives.
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Group Therapy Services	<p>Group therapy services include the provision of cognitive behavioral, supportive therapy interventions to individuals or families, and consultation with family or other responsible persons for sharing of clinical information. Also included is educating, counseling, or advising family or other responsible persons on how to assist the recipient. Group therapy services include the provision of cognitive behavioral, supportive therapy, or counseling interventions to recipients or their families.</p> <p>In addition to counseling, group therapy services to recipient families or other responsible persons include education, the sharing of clinical information, and guidance on how to assist recipients.</p>
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Hub Site	The telecommunication distance site in Florida at which the consulting physician, dentist or therapist is delivering telemedicine services.
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Individual and Family Therapy Services	<p>Individual and family therapy services include the provision of insight-oriented, cognitive behavioral or supportive therapy interventions to an individual recipient or family.</p> <p>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.</p>
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Purpose and Definitions, continued

Institution for Mental Disease

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 in accordance with 42 CFR 435.1010.

Multidisciplinary Team (MDT)

The role of the MDT is to assess whether the recipient is appropriate for specialized therapeutic foster care (STFC).

A MDT consists of a representative from the Department of Children and Families (DCF), or its designee, the local Medicaid area office, or the Department of Juvenile Justice (when applicable). Other MDT members should include the recipient, the recipient's case manager, a representative from the recipient's school, the recipient's biological or adoptive parents or relatives, the foster care parents or emergency shelter staff, assigned counselors or case managers, and the recipient's medical health care provider.

Other Responsible Persons

A relative, legal guardian, caretaker, or other individuals and natural supports who are known to the recipient and family and are active in providing care to the recipient.

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.

Primary Clinician

The Medicaid-enrolled, clinical staff who provide services under a specialized therapeutic foster care or therapeutic group care provider group.

Psychiatric Advanced Registered Nurse Practitioner (ARNP)

A licensed ARNP who works in collaboration with a physician according to protocol to provide diagnostic and interventional patient care.

Rehabilitative Services

Rehabilitative services utilize direct care interventions to assist the recipient in the development of the skills necessary for independent living and for symptom management.

Purpose and Definitions, continued

Serious Emotional Disturbance

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

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

Shelter Status

The legal status that begins when a recipient under the age of 18 years is taken into the protective custody of DCF and ceases when one of the following occurs:

- Court grants custody to a parent
- After disposition of the petition for dependency
- Court orders the child to be released to a parent or placed in the temporary custody of a relative, a nonrelative, or DCF

Specialized Therapeutic Foster Parent Pre-Service Training

Specialized therapeutic foster parent pre-service training must be approved by the DCF or their designee, or by a managed care plan for their network providers. The specialized therapeutic foster parent pre-service 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
- Behaviors and emotional issues of children who have been sexually abused

Purpose and Definitions, continued

Spoke Site The provider office location in Florida where an approved service is being furnished through telemedicine.

Telemedicine The practice of health care delivery using telecommunication equipment by the treating provider (at the spoke site) for the provision of approved covered services by the consulting provider (at the hub site) for the purpose of evaluation, diagnosis, or treatment.

Therapeutic Home Assignments Therapeutic home assignments are overnight stays the recipient spends with the biological, adoptive, or extended family, or in a potential placement in order to practice the generalized skills learned in treatment at the recipient's home or other natural settings.

Therapeutic home assignments must be prior authorized by the primary clinician and they must be recorded in the recipient's clinical record.

Therapeutic home assignments may include time spent away overnight with friends, school, or club activities. Therapeutic home assignments are planned in conjunction with the recipient's treatment goals and objectives. A primary clinician or a specialized therapeutic foster parent must be accessible and must maintain a level of communication during therapeutic home assignments.

Treating Practitioner A Medicaid-enrolled professional who authorizes services within the purview of the treating practitioner's credentials and state law on behalf of the Medicaid group provider (provider type 05).

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

Individualized recipient treatment plans must directly address the primary diagnosis(es) that is(are) consistent with the assessment. The provider must document efforts to coordinate services for behavioral health diagnoses outside their expertise that, if treated, would assist meeting the recipient's goals.

Purpose and Definitions, continued

Treatment Plan,
continued

Specialized therapeutic foster care and therapeutic group care services must be prescribed on a treatment plan authorized by one of the group provider's treating practitioners.

The treatment plan must be jointly developed by the recipient and the treatment team. The treatment plan must be recipient-centered and consistent with the recipient's identified strengths, abilities, needs, and preferences.

The recipient's parent or guardian should be included in the development of the recipient's individualized treatment plan, if the recipient is under the age of 18 years. Treatment planning for a recipient under the age of 18 years that does not include the recipient's parent, guardian, or legal custodian in a situation of exception requires a documented explanation.

The treatment plan must contain all of the following:

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

The treatment plan review must contain all of the following components:

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

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

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

Treatment Team

Key staff involved in planning and providing specialized therapeutic services to the recipient.

Staff Qualifications

General

Specialized therapeutic services staff must provide services within the scope of their professional licensure or certification, training, protocols, and competence.

Providers must maintain staff records with background screening results, state mandated I-9 results, staff qualifications, verification of work experience, reference checks, and evidence of ongoing training. These records must additionally reflect adherence to human resources policies and procedures established by the provider.

Advanced Registered Nurse Practitioner (ARNP)

A licensed ARNP 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 in accordance with Chapter 464, F.S., and protocols filed with the Florida Board of Nursing.

Bachelor's Level Infant Mental Health Practitioner

A bachelor's level infant mental health practitioner must complete 20 hours of documented training in the following areas, prior to work with this age population:

- 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 young children
- Crisis intervention training

Bachelor's level practitioners who have had the above training through conferences, workshops, continuing education credits, or academic training are not required to repeat the training.

Bachelor's level infant mental health practitioners must be supervised by a master's level practitioner with two years of full-time experience with recipients, under the age of six years, or by a licensed practitioner of the healing arts.

Staff Qualifications, continued

Bachelor’s Level Practitioner

A bachelor’s level practitioner must meet all of the following criteria:

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

Certified Addictions Professional (CAP)

A CAP must be certified by the Florida Certification Board (FCB) in accordance with Chapter 397, F.S.

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

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

Comprehensive Behavioral Health Assessor

Comprehensive behavioral health assessors include the following licensed providers:

- Psychiatric advanced registered nurse practitioner
- Clinical social worker
- Mental health counselor
- Marriage and family therapist
- Psychiatric clinical nurse specialist
- Psychologist
- Psychiatric physician’s assistant
- Psychiatrist

These licensed practitioners must have a minimum of two years of direct, full-time experience working with children and families who are victims of physical abuse, sexual abuse, or neglect; emotionally disturbed; or delinquent.

Comprehensive behavioral health assessors can be master’s level practitioners working under a licensed practitioner of the healing arts, who have all of the following:

- Master’s degree in the field of counseling, social work, psychology, rehabilitation, special education, or a human services field.
- Minimum of five years of full-time experience working directly with children and families who are victims of physical abuse, sexual abuse, neglect; or youth who are emotionally disturbed and who have been determined to be delinquent by the Department of Juvenile Justice.

Staff Qualifications, continued

Comprehensive Behavioral Health Assessor, continued

- Minimum of two years of experience working with foster parents.
- Minimum of 30 hours of documented training, dedicated to relevant child and family treatment issues, within the last two years.

Master's level practitioners must complete child and adolescent needs and strengths (CANS) recertification and a minimum of 30 hours of training, relevant to child and family issues, every two years.

To be in compliance with the policy of DCF related to assessment of children in the legal custody of DCF, comprehensive behavioral health assessments completed by a nonlicensed person must be reviewed and co-signed by a licensed professional to verify the assessment is accurate and complete.

Licensed Practitioner of the Healing Arts (LPHA)

LPHAs include:

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

Master's Level Practitioner

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

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

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

Staff Qualifications, continued

Primary Clinician

Primary clinicians include the following LPHAs:

- Clinical social worker
- Mental health counselor
- Marriage and family therapist
- Psychiatric nurse
- Psychiatric CNS
- Psychiatric physician assistant
- Psychiatrist
- Psychologist

These licensed primary clinicians must have a minimum of two years of direct experience working with children and families who are victims of physical abuse, sexual abuse, or neglect; emotionally disturbed; or delinquent.

Master's level practitioners working under the supervision of an LPHA can also be primary clinicians. Master's level, primary clinicians must be Medicaid-enrolled clinical staff who provide services under a specialized therapeutic foster care or therapeutic group care provider group. Master's level primary clinicians must have all of the following:

- A master's degree in the field of counseling, social work, psychology, rehabilitation, special education, or a human services field.
- A minimum of two years of full-time experience working directly with children and families who are victims of physical abuse, neglect; or, youth who are emotionally disturbed who have been adjudicated.
- A minimum of 30 hours of documented training, 15 of which must be dedicated to relevant child and family treatment issues, within the last two years.

**Psychiatric
Advanced
Registered Nurse
Practitioner
(ARNP)**

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

Staff Qualifications, continued

**Psychiatric
Clinical Nurse
Specialist (CNS)**

A CNS must have a subspecialty in child/adolescent psychiatric and mental health or psychiatric and mental health and is licensed in accordance with Chapter 464, F.S., and must meet all of the following criteria:

- Hold a current and active license as a registered nurse in Florida
- Hold a master's degree or higher in nursing as a CNS
- Provide proof of current certification in a specialty area as a CNS from one of the four certifying bodies: American Nursing Credentialing Center, American Association of Critical-Care Nurses, Oncology Nursing Certification Corporation, and National Board of Certification of Hospice and Palliative Nurses; or meet the requirements of Chapter 464, F.S. and has provided the required affidavit
- Hold a certificate issued by the Florida Board of Nursing as a CNS

A registered nurse currently enrolled as an LPHA must be licensed as a CNS with a subspecialty of child/adolescent psychiatric and mental health or psychiatric and mental health by January 1, 2016.

**Psychiatric
Physician
Assistant (PPA)**

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

**Specialized
Therapeutic
Foster Parents**

Specialized therapeutic foster parents must be licensed in accordance with Chapter 65C-14, F.A.C. and must have completed an additional 30 hours of pre-service training specific to specialized therapeutic foster care. The specialized therapeutic foster parent(s) serves as the primary agent in the delivery of therapeutic services to the recipient. Specialized therapeutic foster parents are trained in interventions designed to meet the individual needs of the recipient.

Specialized therapeutic foster parents must be available 24 hours per day to respond to crises or to the need for special therapeutic interventions.

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: 8 clock hours every six months
- Level II: 12 clock hours every six months

Staff Qualifications, continued

Treating Practitioner

Treating practitioners include:

- Physician
 - Psychiatrist
 - Psychiatric ARNP
 - PPA
 - LPHA
 - Master's level CAP (for the authorization of substance use treatment only)
-

Enrollment

Introduction

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

- Comprehensive behavioral health assessment (provider type 07, specialty code 66)
- Specialized therapeutic foster care services (provider type 07, specialty code 67)
- Therapeutic group care services (provider type 05)
- Treating physicians (provider types 25 and 26)
- Treating practitioners (provider type 07)

Note: Enrollment forms may be obtained from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com, select Public Information for Providers, then Provider Support, and then Enrollment, or by calling Provider Enrollment at 1-800-289-7799 and selecting Option 4.

Comprehensive Behavioral Health Assessment Provider

Comprehensive behavioral health assessment group provider agencies and individual practitioners must complete a Comprehensive Behavioral Health Assessment Agency and Practitioner Self-Certification, found in the appendices. Group provider agencies and the individual practitioners must submit this self-certification to the Medicaid fiscal agent with the enrollment application.

Comprehensive behavioral health assessment group provider agencies are not required to be linked to a treating physician.

Prior to enrollment, an individual practitioner not currently enrolled in Florida Medicaid, must complete child and adolescent needs and strengths (CANS) assessment training, provided by a certified trainer or an approved online training course, and must obtain CANS certification.

Individual practitioners who meet the eligibility criteria to provide comprehensive behavioral health assessments must be linked to a certified comprehensive behavioral health assessment group provider agency before rendering this service.

Enrollment, continued

Comprehensive Behavioral Health Assessment Provider Self-Certification

An agency enrolling in Medicaid as a comprehensive behavioral health assessment group provider must have policies and procedures that address the following:

- Maintaining written records for every recipient
- Maintaining confidentiality and security of clinical records
- Credentialing, recredentialing, and reappointing practitioners
- Establishing a program evaluation system to review the processes and outcomes on at least an annual basis

An individual must be certified as meeting the requirements of a comprehensive behavioral health assessor, as defined in this handbook, before enrolling in Medicaid as an individual comprehensive behavioral health assessment provider.

Specialized Therapeutic Foster Care Provider

Providers must be linked to a treating psychiatrist (provider type 25 or 26). Specialized therapeutic foster care providers must complete the Specialized Therapeutic Foster Care Provider Agency Self-Certification, found in the appendices. This self-certification also requires the signature of DCF or its designee. Providers must submit the completed self-certification to the Medicaid fiscal agent with their enrollment application.

Specialized Therapeutic Foster Care Provider Self-Certification

The following conditions must be met before the provider can enroll in Medicaid as a specialized therapeutic foster care services provider:

- The provider's primary clinicians, 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 primary clinicians and foster care parents who provide the services. (The primary clinicians 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 65C-13 or 65C-14, F.A.C, by the 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 has a financial agreement with the foster parents that reimburses the foster parents for their therapeutic intervention services.
- The provider has policies and procedures that promote good therapeutic practice, ensure that therapeutic foster parents are the primary therapeutic agent, provide for appropriate treatment plans and documentation, and protect the rights of recipients and their families.

Enrollment, continued

Specialized Therapeutic Foster Care Provider Self-Certification, continued

- The provider has a program evaluation system to review the process and outcomes on at least an annual basis.
- The provider has policies and procedures that are consistent with section 1003.57(3)(b), F.S. to address the school notification requirements.

Therapeutic Group Care Provider

To be eligible to enroll as a Medicaid therapeutic group care provider agency, providers must meet all of the following:

- Be enrolled as a community behavioral health services group provider (provider type 05).
- Be properly licensed in accordance with Chapter 394, F.S., and Chapter 65E-9, F.A.C., by the Agency for Health Care Administration (AHCA).
- Achieve compliance on the Community Behavioral Health Services Provider Pre-Enrollment Certification Review.

Eligible group providers must submit an enrollment application to the Medicaid fiscal agent and must submit the Provider Agency Acknowledgement for Therapeutic Group Care Services form, found in the appendices, which has been completed by the provider's executive director, to the Agency as directed on the form. AHCA will then send the provider and the local Medicaid area office a letter that acknowledges receipt of the form and confirms initial certification. Based on licensure and the provider's assurance, Medicaid will grant temporary certification for billing therapeutic group care services.

Therapeutic Group Care Provider Self-Certification

A provider must demonstrate the administrative and clinical capacity to operate as a therapeutic group care provider by meeting the service requirements listed in this section.

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

- Required provider capabilities of therapeutic group care services
 - Services to be provided
 - Quality assurance program requirements
 - Required policies and procedures
-

Enrollment, continued

Therapeutic Group Care Provider Certification Process

An AHCA representative and DCF, or its designee, will initially certify the therapeutic group care providers within approximately six 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 noncompliant, the provider must complete a corrective action plan within 30 days to continue billing for services. If the program remains noncompliant with the certification criteria during a follow-up review, the temporary certification will be withdrawn within six months from the date that the corrective action plan was approved.

Therapeutic Group Care Services Required Provider Capabilities

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

- A home-like, therapeutic group care setting serving no more than 12 recipients.
 - A therapeutic environment with an identified treatment orientation described and supported in the literature and that is understood by all staff and by the recipients.
 - Psychiatric services and clinical assessment, treatment planning, and therapy services by qualified staff, per the requirements in this handbook.
 - Consistent implementation of programmatic policy by administrative, clinical, and direct care staff within the therapeutic group care program.
 - 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.
 - Access to, and coordination with, an accredited educational program for each recipient that complies with the State Board of Education, Rule 6A-6.0361, F.A.C.
 - Access to and coordination with primary care providers.
 - Behavioral programming that is individually designed and implemented and includes structured interventions and contingencies to support the development of adaptive, pro-social, interpersonal behavior.
 - Psychiatric crisis management with demonstrated 24-hour response capability and access to acute care setting and behavioral health emergency management services.
 - The provider must meet the staffing requirements specified in Rule 65E-9.006, F.A.C.
-

Enrollment, continued**Therapeutic Group Care Providers Quality Assurance Program Requirements**

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

- Monitoring of behavioral health treatment planning and implementation.
 - Treatment plan review and assessment of progress at least monthly.
 - Ongoing review of treatment staff performance.
 - Review of medication administration and monitoring.
 - The coordination of care with primary care providers.
 - Implementing and documenting pre-service and ongoing staff training that improves and supports the delivery of high level therapeutic service.
 - 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.
 - Quality and effectiveness of treatment services with recipients and their families.
 - Quality and effectiveness of aftercare planning.
 - Quality and degree of involvement of recipients in extracurricular activities in the community.
-

Therapeutic Group Care Required Policies and Procedures

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:

- Thorough screening, evaluation, and diagnosis of symptoms, risks, functional status, and co-morbidity.
 - 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.
 - Treatment teams that are responsible for organizing the delivery of therapeutic services.
 - Individualized treatment plans that are integrated into the activities of daily living associated with therapeutic group care treatment.
 - Inclusion of the recipient's family or guardian in the clinical treatment process.
 - A monthly summary note, required to document the overall progress of the recipient in therapy and in the therapeutic milieu, report on contacts with the recipient's family, community, school, and activity program, and include input from the recipient's case manager relating to medical management of recipients who require psychotropic medical intervention.
 - Medication administration, training, monitoring and storage.
 - Prohibition of the use of mechanical restraints and seclusion.
 - The use of time out.
-

Enrollment, continued

Therapeutic Group Care Required Policies and Procedures, continued

- Clinical aftercare planning that is coordinated with the permanency plan and supports development of independent living skills, when developmentally appropriate.
- An internal review process for determining the recipient's continued eligibility and need for therapeutic group care services, on at least a monthly basis.
- The clinical management of specific types of emotional and behavioral problems encountered by recipients served in the facility.
- 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.
- Staff orientation and training requirements that comply with Chapter 65E-9, F.A.C.
- School notification requirements as outlined in 1003.57(3)(b), F.S.

Treating Practitioner

A treating practitioner must be independently enrolled in the Florida Medicaid program per provider type.

Treating Physician

A treating physician must enroll as a provider type 25 or 26 and must also be linked to the community behavioral health group (provider type 05).

Psychiatric Advanced Registered Nurse Practitioner (ARNP)

A psychiatric ARNP must enroll as a provider type 07 and must also be linked to a group provider type 05. To enroll as a provider type 07, psychiatric ARNPs must submit a signed Practitioner Collaborative Agreement form with a physician (provider type 25 or 26) that is linked to the community behavioral health group (provider type 05).

Psychiatric Physician Assistant (PPA)

A PPA must enroll as a provider type 07 and must also be linked to a community behavioral health group (provider type 05). To enroll as provider type 07, a PPA must submit a signed Practitioner Collaborative Agreement form with a physician (provider type 25 or 26) that is linked to the community behavioral health group (provider type 05).

Licensed Practitioner of the Healing Arts (LPHA)

A treating LPHA must enroll as a provider type 07 and must be linked to a group provider type 05 for services rendered in the capacity of a treating practitioner in order to be qualified.

Certified Addictions Professional (CAP)

A CAP with a master's degree must enroll as provider type 07 and must also be linked to a community behavioral health group (provider type 05) in order to authorize services for treatment for substance use disorders.

Enrollment, continued

Multiple Service Locations within the Same Medicaid-Designated Area

Specialized therapeutic services agency providers who render services at more than one service address within the same Medicaid-designated area are required to submit an Application for New Location Code to identify each separate physical address where services are provided. The Application for New Location Code is an attachment to the Florida Medicaid Provider Enrollment Application.

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 office or its designee.

Multiple Service Locations in Different Medicaid-Designated Areas

Specialized therapeutic services agency providers who render services at more than one service address in different Medicaid-designated areas are required to submit a separate Florida Medicaid Provider Enrollment Application for each Medicaid-designated area.

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 office or its designee.

Subcontracting

Florida Medicaid allows a provider to contract with an individual practitioner, but not with another agency for service delivery.

As of July 1, 2014, providers are required to retain all contracts with subcontracted staff for no less than five years from the termination date of the contract. Providers must maintain subcontractor records with background screening results, staff qualifications, and verification of work experience. These records must additionally reflect adherence to human resources policies and procedures established by the provider related to subcontracting.

Requirements

Providers Contracted with Medicaid Health Plans

The service-specific Medicaid coverage and limitations handbooks provide the minimum requirements for all providers. This includes providers who contract with Florida Medicaid health plans (e.g., provider service networks and health maintenance organizations). Providers shall comply with all of the requirements outlined in this handbook, unless otherwise specified in their contract with the health plan. The provision of services to recipients enrolled in a Medicaid health plan shall not be subject to more stringent criteria or limits than specified in this handbook.

CHAPTER 2 COVERED, LIMITED, AND EXCLUDED SERVICES

Overview

Introduction

This chapter provides service coverage, limitations, and exclusions information. It also describes who can provide and receive services, as well as any applicable service requirements.

In This Chapter

This chapter contains:

TOPIC	PAGE
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General Coverage Information	2-1
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Specialized Therapeutic Foster Care Services	2-11
Therapeutic Group Care Services	2-16
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General Coverage Information

Medical Necessity

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

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

"[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

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

"(c) 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."

General Coverage Information, continued

Exceptions to the Limits (Special Services) Process

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a).

Services for recipients under the age of 21 years in excess of limitations described within this handbook or the associated fee schedule may be approved, if medically necessary, through the process described in the Florida Medicaid Provider General Handbook.

Description

Specialized therapeutic services include comprehensive behavioral health assessments, specialized therapeutic foster care, and therapeutic group home services provided to recipients under the age of 21 years with mental health, substance use, and co-occurring mental health and substance use disorders.

The intent of specialized therapeutic services is the maximum reduction of the recipient's disability and restoration to the best possible functional level. Services must be diagnostically relevant and medically necessary.

Specialized therapeutic foster care and therapeutic group home services must be included in an individualized treatment plan that has been approved by a treating practitioner.

Services are treatment events that correspond with Medicaid procedure codes.

Services are not the same as interventions. Unless otherwise specified, the date(s) of service on each claim must correspond to the date(s) the service was rendered.

General Requirement

Providers must request reimbursement only for services that are provided by individuals employed by, under contract with, or who are compensated monetarily by the provider.

General Coverage Information, continued

Assessment Requirement

Prior to the development of a treatment plan the provider must complete and present the recipient with an assessment of the recipient's mental health status, substance use concerns, functional capacity, strengths, and service needs or must have an assessment on file that has been conducted in the last six months. The purpose of the assessment is to gather information to be used in the formulation of a diagnosis and development of a plan of care for the recipient that includes the discharge criteria.

A comprehensive behavioral health assessment completed within the past year in accordance with this handbook can satisfy the current assessment requirement.

Recipient Clinical Record

Providers must maintain a clinical record for each recipient treated that contains all of the following:

- Consent for treatment that is signed by the recipient or the recipient's legal guardian. An explanation must be provided for signatures omitted in situations of exception.
- An evaluation or assessment that, at a minimum, contains the components of a brief behavioral health status examination conducted by a physician, psychiatrist, a licensed practitioner of the healing arts (LPHA), or master's level certified addictions professional for diagnostic and treatment planning purposes. For new admissions, the evaluation or assessment by an LPHA 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 treatment plans (within the last six months), reviews, and addenda.
- Copies of all certification forms (e.g., comprehensive behavioral health assessment).
- The practitioner's orders and results of diagnostic and laboratory tests.
- Documentation of medication assessment, prescription, and management.

For therapeutic group care services, the recipient's clinical record must comply with Chapter 65E-9, F.A.C.

Note: For information about electronic records, see the Florida Medicaid Provider General Handbook.

General Coverage Information, continued

General Service Documentation Requirements

Providers must maintain documentation to support each service for which Medicaid reimbursement is requested; clearly distinguish and reference each separate service billed; and be authenticated with the dated signature of the individual who rendered the service. The date of a claim should be the same as the date the service was rendered.

Service documentation must contain all of the following:

- Recipient's name
- Date the service was rendered
- Start and end times
- 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.
- Updates regarding the recipient's progress toward meeting treatment related goals and objectives addressed during the provision of a service
- Dated signature of the individual who rendered the service
- Printed or stamped name identifying the signature of the individual who rendered the service and the credentials (e.g., licensed clinical social worker) or functional title (e.g., treating practitioner)

For therapeutic group care services, the recipient's documentation must comply with Chapter 65E-9, F.A.C.

Note: For information about electronic signatures, see the Florida Medicaid Provider General Handbook.

Compliance and Quality of Care Reviews

Provider's compliance with service eligibility determination procedures, service authorization policy, staffing requirements, and service documentation requirements can be reviewed periodically by AHCA or its designee. Providers that violate these requirements are subject to recoupments, fines, or termination in accordance with Chapter 409.913, F.S.

Aftercare Planning

The recipient and the treating staff should collaborate to develop the recipient's individualized formal aftercare plan. A formal aftercare plan should include community resources, activities, services, and supports that will be utilized to help the recipient sustain gains achieved during treatment.

Discharge Criteria

The recipient and the treating staff should collaborate to develop the individualized, measurable discharge criteria. The recipient's progress toward meeting the discharge criteria should be addressed throughout the course of treatment as part of the treatment plan review.

Comprehensive Behavioral Health Assessments

Introduction

A comprehensive behavioral health assessment is an in-depth and detailed assessment of the recipient's emotional, social, behavioral, and developmental functioning. For those settings in which the recipient routinely participates, a comprehensive behavioral health assessment must include direct observation of the recipient in the following settings:

- Home
- School or child care
- Work site
- Community

Comprehensive behavioral health assessment components requiring face-to-face contact cannot be provided using telemedicine.

Who Can Receive

To receive a comprehensive behavioral health assessment, a recipient must be under the age of 21 years and meet all of the following criteria:

- Be a victim of abuse or neglect
- Have been determined by the Department of Children and Families (DCF) or their designee to require out-of-home care or be placed in shelter status

Or the recipient must meet all of the following criteria:

- Have committed acts of juvenile delinquency
 - Be suffering from an emotional disturbance or a serious emotional disturbance
 - Be at risk for placement in a residential setting
-

Comprehensive Behavioral Health Assessments, continued**Components for Recipients Under the Age of Six Years**

A comprehensive behavioral health assessment for recipients under the age of six years, must be written in narrative form and provide detailed information on the components below. 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 recipient and the recipient's family:

- General identifying information (name, birth date, Medicaid identification number, 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 (e.g., 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 psychotropic.
- Last physical examination, including pre-natal, pregnancy and delivery history, and any known medical problems (e.g., prenatal exposure, accidents, injuries, hospitalizations) which may affect the recipient's mental health status.
- History of mental health treatment of the recipient's parents and siblings. The mother's history, including a depression screen, is important in developing this section.
- History of substance use and alcohol or chemical dependency of the recipient's family.
- Legal involvement and status of the recipient and the recipient's family.
- Resources including income, entitlements, health care benefits, subsidized housing, social services, etc.
- Emotional status, including a hands-on, interactive assessment of the recipient regarding sensory and regulatory functioning, attention, engagement, constitutional characteristics, and organization and integration of behavior.
- Educational analysis, including daycare issues concerning behavioral and developmental concerns.
- Functional analysis, including presenting strengths and problems of both the recipient and the recipient's family.
- Cultural analysis, including discovery of the family's unique values, ideas, customs and skills that have been passed on to family members and that require consideration in planning and working with the recipient's family. This component includes assessment of the family's own operational style, including habits, characteristics, preferences, roles, and methods of communicating with each other.

Comprehensive Behavioral Health Assessments, continued

Components for Recipients Under the Age of Six Years, continued

- Situational analysis including direct observation of the parent or caregiver's interaction with the recipient in the home, school or child care setting, work site, and community, whenever the recipient routinely participates in these settings.
- Present level of functioning, including social adjustment and daily living skills.
- Activities catalog, including assessment of activities in which the recipient has interest or enjoys.
- Ecological analysis, including 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 the recipient exhibits.
- Assessment of the desired services and goals from the recipient and the recipient's parent or guardian's viewpoint.
- An ICD diagnosis. If the recipient does not have a presenting ICD diagnosis, the provider must use the examination and observation diagnosis code.
- For recipients under the age of 4 years, 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 diagnosis.
- Completion of a standardized assessment, such as the Child & Adolescent Needs and Strengths An Information Integration Tool for Early Development CANS-0 to 3 Manual (CANS 0-3) and the Florida's Child and Adolescent Needs and Strengths (CANS) Comprehensive Assessment 0-5 Manual (CANS 0-5).

The assessment includes the following:

- Problem presentation and symptoms
 - Risk behaviors
 - Functioning
 - Family and caregiver needs and strengths
 - Recipient's strengths
 - Summary of findings and recommendations
-

Comprehensive Behavioral Health Assessments, continued**Components for Recipients Ages 6 Years through 20 Years**

A comprehensive behavioral health assessment for recipients ages 6 years through 20 years, must include, at a minimum, the information listed below related to the recipient and the recipient's family. The use of a checklist or fill in the blank format in lieu of a narrative is prohibited.

- General identifying information (name, birth date, Medicaid identification number, 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 (e.g., counselor, hospital, law enforcement).
- Interviews and interventions.
- Cognitive functioning (attention, memory, information, and 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 psychotropic.
- Last physical examination and any known medical problems, including any early medical information which may affect the recipient's mental health status, such as prenatal exposure, accidents, injuries, hospitalizations, etc.
- History of mental health treatment of the recipient and the recipient's family.
- History of current or past substance use of the recipient and the recipient's family.
- Legal involvement and status of the recipient and the recipient's family.
- Resources including income, entitlements, health care benefits, subsidized housing, social services, etc.
- Emotional status, including psychiatric or psychological condition.
- Educational analysis, including school-based adjustment, performance history, and current status.
- Functional analysis, including presenting strengths and problems of both the recipient and the recipient's family.
- Cultural analysis, including 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, including direct observation of the recipient at home, school or child care setting, work site, and community whenever the recipient routinely participates in these settings.
- Present level of functioning, including social adjustment and daily living skills.
- Reaction or pattern of reaction to any previous out-of-home placements.
- Activities catalog, including assessment of activities in which the recipient has interest or enjoys.

Comprehensive Behavioral Health Assessments, continued

Components for Recipients Ages 6 Years through 20 Years,
continued

- Ecological analysis, including 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 ages 14 years and older.
- Assessment of the desired services and goals from the recipient and the recipient's family's viewpoint.
- An ICD diagnosis. If the recipient does not have a presenting ICD diagnosis, the provider must use the examination and observation diagnosis code.
- For recipients ages 6 years through 20 years, completion of a standardized assessment tool, such as the Child & Adolescent Needs & Strengths An Information Integration Tool for Children and Adolescents with Mental Health Challenges CANS-MH Manual (CANS-MH) or the Child and Adolescent Needs and Strengths-(CANS) Comprehensive Multisystem Assessment Manual (CANS-Comprehensive).

The assessment includes the following:

- Problem presentation and symptoms
 - Risk behavior
 - Functioning
 - Family and caregiver needs and strengths
 - Recipient's strengths
 - Summary of findings and recommendations.
-

Authorization for Services

DCF or their designee, or the recipient's managed care plan must authorize the comprehensive behavioral health assessment services utilizing the Authorization for Comprehensive Behavioral Health Assessment form, found in the appendices. The provider must keep the authorization form on file in the recipient's clinical record.

Who Must Provide

Comprehensive behavioral health assessments must be personally rendered by a comprehensive behavioral health assessor.

Comprehensive Behavioral Health Assessments, continued

Documentation

A comprehensive behavioral health assessment must be written in narrative form and provide detailed information on the aforementioned components (pp. 2-6 and 2-8 for recipients under the age of six years and recipients ages 6 years through 20 years, respectively). The use of a checklist or fill in the blank format in lieu of a narrative is prohibited.

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.

A review of evaluations and tests previously completed by the provider or others and are deemed to be appropriate and current can be used in addition to a CANS in the development of a comprehensive behavioral health assessment.

Covered Services

Comprehensive behavioral health assessment goals 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, the recipient, and their family that will aid in the development of long- and short-term, culturally sensitive intervention strategies to enable the recipient to live and receive 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.
 - Provide information for development of an effective, individualized, strength based, culturally sensitive, comprehensive services plan and an individualized treatment plan.
-

Specialized Therapeutic Foster Care Services

Introduction

Specialized therapeutic foster care services are intensive treatment services provided to recipients under the age of 21 years with emotional disturbances who reside in a state licensed foster home. Specialized therapeutic foster care services are appropriate for long-term treatment and short-term crisis intervention.

The goal of specialized therapeutic foster care is to enable a recipient to manage and to work toward resolution of emotional, behavioral, or psychiatric problems in a highly supportive, individualized, and flexible home setting.

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 primary clinician, and a psychiatrist. A specialized therapeutic foster parent must be available 24 hours per day to respond to crises or to provide special therapeutic interventions.

There are two levels of specialized therapeutic foster care, which are differentiated by the 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 recipients who present moderate to serious emotional or behavior management problems. Programming and interventions are tailored to the age and diagnosis of the recipients.

Specialized therapeutic foster care services are offered at Level I or Level II, with crisis intervention available at both levels.

Authorization for Specialized Therapeutic Foster Care Services

The multidisciplinary team must authorize specialized therapeutic foster care services. If the multidisciplinary team determines that the recipient requires specialized therapeutic foster care services, the Authorization for Therapeutic Foster Care form, found in the appendices, is completed.

The multidisciplinary team 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 for each authorization period.

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

Level I

Level I specialized therapeutic foster care is characterized by close supervision of the recipient within a specialized therapeutic foster home. Services to the recipient must include clinical interventions by the specialized therapeutic foster parent(s), a primary clinician, and a psychiatrist.

Specialized Therapeutic Foster Care Services, continued

Who Can Receive

Level I specialized therapeutic foster care is for recipients with a history of abuse or neglect, or delinquent behavior, and who have an emotional disturbance or serious emotional disturbance. The recipient must qualify for foster care and must meet at least one of the following criteria:

- Requires admission to a psychiatric hospital, a crisis stabilization unit, or a residential treatment center without specialized therapeutic foster care.
- Within the last two years, been admitted to one of these treatment settings.

Level II

Level II specialized therapeutic foster care is characterized by the need for more frequent contact between the specialized therapeutic foster parents, the recipient, primary clinician, and the psychiatrist as a result of the recipient exhibiting the maladaptive behaviors listed below.

Level II specialized therapeutic foster care is intended to provide a high degree of structure, support, supervision, and clinical intervention.

Who Can Receive

A recipient requiring Level II specialized therapeutic foster care must meet the following criteria:

- Meet the criteria of Level I specialized therapeutic foster care.
- Be exhibiting more severe maladaptive behaviors such as:
 - Destruction of property
 - Physical aggression toward people or animals
 - Self-inflicted injuries
 - Suicidal ideations or gestures
 - An inability to perform activities of daily and community living due to psychiatric symptoms

The recipient must require the availability of highly trained specialized therapeutic foster parents as evidenced by at least one of the behaviors or deficits listed above.

Crisis Intervention Services

Specialized therapeutic foster care services may be used for a maximum of 30 days for crisis intervention for a recipient for whom services must occur immediately in order to stabilize a behavioral, emotional, or psychiatric crisis. Any exception to this length of stay must be approved in writing by the multidisciplinary team.

A comprehensive behavioral health assessment must be initiated within 10 working days of crisis intervention services for any recipient who has not had a comprehensive behavioral health assessment in the past year.

Specialized Therapeutic Foster Care Services, continued

Who Can Receive

The recipient must be in foster care or delinquent and must be determined by the multidisciplinary team to meet Level I or Level II criteria. An Authorization for Crisis Intervention form, found in the appendices, must be completed and a copy placed in the recipient's clinical record by the provider.

For recipients who are enrolled in managed care, the plan must authorize approval for crisis intervention services.

Responsibilities of the Primary Clinician

Clinical staff are responsible for:

- Directly supervising and supporting the specialized therapeutic foster parents throughout the recipient's length of stay.
 - Evaluating and assessing recipients who are receiving services.
 - Providing in-service training to the therapeutic foster care parent(s), targeting skills needed to achieve treatment plan goals and objectives.
 - Supervising the performance of the specialized therapeutic foster care parent(s).
 - Working with the community-based care lead agency or the Department of Juvenile Justice counselor to coordinate other treatment initiatives, including school performance, permanency, and reunification planning.
 - Preparing and training the recipient's biological or legal parents to resume care of the recipient when reunification is the goal.
 - Working with the recipient's targeted case manager, if one has been assigned.
 - Conducting home visits at least once weekly for recipients in Level I and at least twice weekly for recipients in Level II or crisis intervention services.
 - Conducting regularly scheduled face-to-face meetings with the specialized therapeutic foster parents in order to monitor the recipient's progress and discuss treatment strategies and services.
 - Conducting monthly visits to other community settings to observe the recipient's behavioral, psychological, and psychosocial progress and to coordinate treatment intervention.
-

Specialized Therapeutic Foster Care Services, continued

Caseload of Primary Clinicians

The maximum caseload for full-time (40-hour employment week) primary clinicians can be less than, but must not exceed:

- Level I—eight recipients receiving specialized therapeutic foster care.
- Level II—six recipients receiving specialized therapeutic foster care.
- Crisis intervention—six recipients receiving specialized therapeutic foster care.
- Combined Level I, Level II, and crisis intervention—six recipients receiving specialized therapeutic foster care.

The caseload of primary clinicians employed or under contract for 20 hours a week should not exceed the following:

- Level I—four recipients receiving specialized therapeutic foster care.
 - Level II—three recipients receiving specialized therapeutic foster care.
 - Crisis intervention—three recipients receiving specialized therapeutic foster care.
 - Combined Level I and Level II—three recipients receiving specialized therapeutic foster care.
-

Treatment Plan and Treatment Plan Review Requirements

A treatment plan must be developed by the primary clinician within the following number days of admission:

- Level I—30 days
- Level II—14 days
- Crisis intervention—14 days

A psychiatrist assigned to the program must interview the recipient and conduct a formal treatment plan review when significant changes occur or as follows from the date of authorization of the recipient's initial treatment plan:

- Level I—on a quarterly basis
 - Level II—on a monthly basis
 - Crisis intervention—on a monthly basis
-

Specialized Therapeutic Foster Care Services, continued

**Treatment Plan
and Treatment
Plan Review
Signature
Exceptions**

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

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

- As allowed by section 397.601(4)(a),(b), F.S., recipients under the age of 18 years seeking substance abuse services from a licensed service provider. Recipients ages 13 years and older, experiencing an emotional crisis in accordance with section 394.4784(1),(2), F.S.
- Recipients in the custody of the Department of Juvenile Justice who have been court ordered into treatment or require emergency treatment such that delay in providing treatment would endanger the mental or physical well-being of the recipient. The signature of the parent, guardian, or legal custodian must be obtained as soon as possible after emergency treatment is administered.

For recipients in the care and custody of the DCF (foster care or shelter status), the child's DCF or Community Based Care (CBC) caseworker must sign the treatment plan if it is not possible to obtain the parent's signature. The caseworker and foster parent should be encouraged to participate in the treatment planning. In cases in which the DCF is working toward reunification, the parent should be involved and must sign the treatment plan.

**Service Specific
Documentation
Requirements**

Documentation must include a minimum of a weekly summary progress note, completed and signed by the primary clinician, which addresses each service provided.

The summary progress note shall be co-signed by the specialized therapeutic foster parent(s).

Therapeutic Group Care Services

Introduction

Therapeutic group care services are community-based, psychiatric residential treatment services designed for recipients under the age of 21 years with moderate to severe emotional disturbances. They are provided in a licensed residential group home setting serving no more than 12 recipients under the age of 21 years.

Therapeutic group care services are intended to support, promote, and enhance competency and participation in normal age-appropriate activities of recipients who present moderate to severe psychiatric, emotional, or behavior management problems related to a psychiatric diagnosis. Programming and interventions are highly individualized and tailored to the age and diagnosis of the recipient. 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 recipients under the age of 21 years. They are appropriate for recipients under the age of 21 years who are ready to 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 recipient'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.

Therapeutic Group Care Services, continued

Covered Services

The following services must be provided in accordance with Chapter 65E-9, F.A.C:

- Thorough psychiatric, psychological, substance abuse and bio-psychosocial assessments, including assessment of the recipient's strengths and needs, including the strengths and needs of involved family members and other natural supports.
- Assignment of each recipient to a primary clinician who is responsible for the overall coordination and monitoring of the recipient's treatment.
- Provision of individualized, face-to-face therapeutic contact for each recipient with the primary clinician twice weekly, with more frequent contacts per week as indicated by the recipient's needs.
- Individual and group therapy by the primary clinician, as prescribed in the treatment plan.
- Family therapy with the primary clinician, or contact with the recipient's guardian, at least weekly, based on the recipient's treatment needs and permanency plan. Documentation of the circumstances must be provided in the recipient's record whenever this contact has not occurred.
- Provision of substance abuse prevention, assessment, and treatment services whenever indicated.
- Provision of social and rehabilitative services when indicated and prescribed in the recipient's individualized treatment plan.
- Supportive and psycho-educational services that promote increased capacity for independent living for older recipients.
- Behavioral programming that is individually designed and implemented and includes structured interventions and contingencies to support the development of adaptive, pro-social interpersonal behavior.
- Coordination of care that includes linkages with the schools, primary medical care, and community services for recipients.

Caseload of Primary Clinicians

The primary clinician's maximum caseload must not exceed 12 recipients. This caseload requirement is based on a 40-hour work week.

Who Can Receive

The multidisciplinary team, using the Authorization for Therapeutic Group Care Services, found in the appendices, must confirm that the recipient is appropriate for therapeutic group care placement by a licensed clinical psychologist, per section 490, F.S., or a board certified psychiatrist in compliance with section 394.4781 or 39.407, F.S., and has an emotional disturbance or serious emotional disturbance.

Therapeutic Group Care Services, continued

Re-authorization of Therapeutic Group Care Services

The designated multidisciplinary team must re-authorize therapeutic group care services no less than every six months. A new Authorization for Therapeutic Group Care Services, found in the appendices, must be completed and signed by the appropriate representative.

Treatment Plan and Treatment Plan Review Requirements

The treatment plan must be completed within 14 days of admission and a psychiatrist must interview the recipient and conduct a formal treatment plan review monthly or when significant changes occur.

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.

If a parent or guardian, team member or school personnel are not at a treatment plan meeting, the record must reflect that a staff person contacted them for their input.

The psychiatrist must interview each recipient monthly to assess progress toward meeting treatment goals, or more often if medically necessary.

Service Specific Documentation Requirements

In addition to a daily summary, a progress note must be completed following each service contact with a recipient.

Excluded Services

General

Medicaid does not reimburse for specialized therapeutic services for treatment of a cognitive deficit severe enough to prohibit the service from being of benefit to the recipient.

Specialized Therapeutic Services Exclusions

The following are services and supports not reimbursed under specialized therapeutic services:

- Services provided to a recipient on the day of admission into the Statewide Inpatient Psychiatric Program (SIPP). However, community behavioral health services are reimbursable on the day of discharge.
 - Case management services.
 - Partial hospitalization.
 - Services rendered to individuals residing in an institution for mental diseases.
 - Services rendered to institutionalized individuals, as defined in 42 CFR 435.1009.
 - Room and board expenditures.
 - Basic childcare programs for developmental delays, preschool, or enrichment programs.
 - Education services.
 - Travel time.
 - Activities performed to maintain and review records for facility utilization, continuous quality improvement, recipient eligibility status processing, and staff training purposes.
 - Activities (other than record reviews, services with family member or other interested persons that benefit the recipient, or services performed using telemedicine) that are not performed face-to-face with the recipient, except those defined below.
 - Services rendered by a recipient's relative.
 - Services rendered by unpaid interns or volunteers.
 - Services paid for by another funding source.
 - Escorting or transporting a recipient to and from a service site.
-

CHAPTER 3
REIMBURSEMENT AND FEE SCHEDULE

Overview

Introduction

This chapter describes reimbursement and fee schedule information for specialized therapeutic services.

In This Chapter

This chapter contains:

TOPIC	PAGE
Overview	3-1
Reimbursement Information	3-1
How to Read the Fee Schedule	3-6

Reimbursement Information

Procedure Codes

The procedure codes and fee schedule listed in the appendices are Healthcare Common Procedure Coding System (HCPCS) Level II, which is a part of a nationally standardized code set. Level II of the HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes. HCPCS Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter (A-V) followed by four numeric digits. Please refer to the current HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert® code book is copyrighted by Ingenix, Inc. All rights reserved.

Provider Agency Staff Linked to a Community Behavioral Health Group

The following provider agency staff must be reimbursed through the community behavioral health group (provider type 05) Medicaid number:

- Treating physician
- Psychiatric advanced registered nurse practitioner
- Psychiatric physician assistant
- Licensed practitioner of the healing arts

Telemedicine

Services must be delivered from a facility that is enrolled in Medicaid as a community behavioral health services provider for Medicaid to reimburse for services delivered through telemedicine.

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.

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 a 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 while, 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: For more information on entering units of service on the claim, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Community Behavioral Health Services that can be Reimbursed in Conjunction with Specialized Therapeutic Foster Care Services

Medicaid can 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 cannot be reimbursed when provided in the recipient's foster home.

Service	Procedure Code	Modifier (if required)
Therapeutic behavioral on-site services—therapy	H2019	HO
Therapeutic behavioral on-site services—behavior management	H2019	HM
Therapeutic behavioral on-site services—therapeutic support services	H2019	HN
Behavioral health day services—mental health	H2012	
Behavioral health day services—substance abuse	H2012	HF

Medicaid can reimburse medical or psychiatric services only when the treatment plan requires services by a psychiatrist more than once per month.

Reimbursement Information, continued

**Specialized
Therapeutic
Foster Care
Service
Reimbursement
for Therapeutic
Home
Assignments**

Medicaid can reimburse up to 10 therapeutic home assignments, per calendar quarter (three months).

During the last three months prior to a planned discharge to a recipient's biological family or other permanent placement, Medicaid will reimburse for a graduated number of therapeutic visits.

Three months prior to discharge, Medicaid will reimburse up to a total of five therapeutic visits in the month to the discharge placement setting.

Two months prior to discharge, Medicaid will reimburse for up to a total of eight therapeutic visits in the month to the discharge placement setting.

In the final month prior to discharge, Medicaid will reimburse for up to a total of 12 therapeutic visits to the discharge placement setting.

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 recipient's clinical record.

The specialized therapeutic foster parents will maintain contact with the recipient and the receiving placement as determined by the recipient's treatment team.

No other child may be placed in the bed of a recipient who is away on therapeutic home assignment.

**Specialized
Therapeutic
Foster Care
Service
Reimbursement
for Hospital and
Crisis
Stabilization Unit
Placements**

Medicaid can 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 not 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 recipient experiences more than one crisis placement within a six-month period, the recipient's multidisciplinary team must convene and reassess the recipient's plan to ensure that the plan is meeting the recipient's needs.

Reimbursement Information, continued

Specialized Therapeutic Foster Care Service Reimbursement for Trips

Specialized therapeutic foster care services can take place during trips when special arrangements have been pre-approved in writing by the multidisciplinary team. Arrangements must be made in advance for contact with the recipient's primary clinician during trips. Every effort must be made prior to any trips to schedule the clinician's home visits. If this is not possible, the clinician must make telephone contact during the trip. The cost of the phone calls is the responsibility of the provider agency. Documentation of any special arrangement must be maintained in the recipient's clinical record.

Specialized Therapeutic Foster Care Unauthorized Absences

Medicaid can reimburse for up to three days during times when a placement is being maintained for a recipient who has an unauthorized absence (i.e., runs away) from specialized therapeutic foster care.

Community Behavioral Health and Target Case Management Services that May Be Reimbursed in Conjunction with Therapeutic Group Care Services

Recipients 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 for recipients placed in therapeutic group care services.

Service	Procedure Code	Modifier (if required)
Comprehensive behavioral health assessment*	H0031	HA
Medication administration	T1015	
Review of records	H2000	
Brief behavioral health status examination**	H2010	HO
Brief individual psychotherapy—mental health	H2010	HE
Brief individual psychotherapy—substance abuse	H2010	HF
Psychological testing	H2019	
Psychiatric evaluation by a medical doctor or doctor of osteopathic medicine	H2000	HP
Psychiatric evaluation by a psychiatric ARNP or psychiatric PA	H2000	HO

* If not previously provided and if indicated during an admission to therapeutic group care services.

** If needed more than once a month, as documented in the clinical record.

Reimbursement Information, continued**Community Behavioral Health and Target Case Management Services that May Be Reimbursed in Conjunction with Therapeutic Group Care Services**, continued

Medicaid can reimburse the following services in addition to therapeutic group care services only when provided as part of a Medicaid approved school program or summer activities program. These services cannot be reimbursed when provided in the recipient's group home.

Service	Procedure Code	Modifier (if required)
Therapeutic behavioral on-site services—master's degree level	H2019	HO
Therapeutic behavioral on-site services—behavior management	H2019	HN
Therapeutic behavioral on-site services—therapeutic support	H2019	HM
Behavioral health day services—mental health	H2012	
Behavioral health day services—substance abuse	H2012	HF
Psychosocial rehabilitative services	H2017	

Reimbursement for Therapeutic Home Assignments

Medicaid will reimburse the therapeutic group care provider for up to 10 therapeutic home assignments per calendar quarter, increasing up to 21 days during the last quarter prior to discharge as described below.

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

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

How to Read the Fee Schedule

Introduction

Procedure codes allowed for specialized therapeutic services are listed in the Procedures Codes and Fee Schedule in the appendices.

The Procedures Codes and Fee Schedule includes the following information:

- Description of covered service
 - Covered procedure code
 - Modifiers
 - Maximum fee per code
 - Reimbursement and service limitations
-

Description of Service

Describes the service to be reimbursed.

Procedure Code

The code in the Procedure Codes and Fee Schedule, found in the appendices, that corresponds to specialized therapeutic services.

Modifier

For certain types of services, a two-digit modifier must be entered on the claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.

Maximum Fee

Maximum amount that Medicaid will reimburse for the procedure code, per unit of service.

Reimbursement and Service Limitations

Reimbursement and service limitations that pertain to the specific procedure code.

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

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

APPENDIX A

PROCEDURE CODES AND FEE SCHEDULE

PROCEDURE CODES AND FEE SCHEDULE					
These procedure codes are to be used for dates of service April 1, 2014 and after.					
Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement and Service Limitations
Comprehensive Behavioral Health Assessment	H0031	HA		\$12.12 per quarter hour	<p>The comprehensive behavioral health assessment may be reimbursed only once per state fiscal year (July 1 through June 30) per recipient.</p> <p>Reimbursement is limited to a total of 20 hours per recipient per fiscal year.</p> <p>The assessment is reimbursed on the date that the report is completed.</p> <p>The date of referral may be used as the date of service if the recipient entered the Statewide Inpatient Psychiatric Program or if the recipient loses Medicaid eligibility prior to completion of the assessment.</p>
Specialized Therapeutic Foster Care, Level I	S5145			\$87.30 per day	<p>Medicaid will not reimburse a provider for days when a recipient is in a Juvenile Justice detention center.</p> <p>The community behavioral health services psychosocial rehabilitation and clubhouse will not be reimbursed as a separate service by Medicaid for recipients receiving specialized therapeutic foster care services.</p>
Specialized Therapeutic Foster Care, Level II	S5145	HE		\$135.80 per day	
Specialized Therapeutic Foster Care, Crisis Intervention	S5145	HK		\$135.80 per day	

Specialized Therapeutic Services Coverage and Limitations Handbook

Description of Service	Procedure Code	Modifier 1	Modifier 2	Maximum Fee	Reimbursement and Service Limitations
Therapeutic Group Care Services	H0019			\$180.00 per day	<p>Medicaid will not reimburse for therapeutic group care services when a recipient is in a Department of Juvenile Justice detention center placement.</p> <p>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.</p>

APPENDIX B

**AUTHORIZATION FOR
COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT**

**AUTHORIZATION FOR
COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT**

This is to certify that:

Recipient'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 Specialized Therapeutic Services Coverage and Limitations Handbook. The comprehensive behavioral health assessment will be provided by:

_____ (provider)

Community Based Care Representative _____ Date _____

OR

Managed Care Plan Representative (or designee) _____ Date _____

OR

Department of Juvenile Justice Representative (or designee) _____ Date _____

AUTHORIZATION FOR COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT FOR CHILD IN SHELTER

This is to certify that:

Recipient's Name _____ Date of Referral _____

Medicaid Number _____ 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 Specialized Therapeutic Services Coverage and Limitations Handbook. The comprehensive behavioral health assessment will be provided by:

_____ (provider)

Department of Children and Families (or designee) _____ Date _____

To be placed in recipient's clinical record.

AHCA Form 5000-3511, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)

APPENDIX C

**COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT
AGENCY AND PRACTITIONER SELF-CERTIFICATION**

**COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT
AGENCY AND PRACTITIONER SELF-CERTIFICATION**

This is to certify that:

Name: _____

Address: _____

Phone Number: () _____

Agency Medicaid Number: _____ (if enrolled)

Practitioner Medicaid Number: _____ (if enrolled)

meets the qualifications to be a provider of comprehensive behavioral health assessment by providing documentation to the Medicaid area office staff who have verified that the agency or practitioner has met the qualifications as outlined in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook.

Begin date: _____

End date: _____

Provider Agency Representative

Date

To complete the initial Medicaid provider enrollment process, submit this form with your Florida Medicaid Provider Enrollment Application to the address listed below.

**Florida Medicaid Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070**

AHCA Form 5000-3512, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)

APPENDIX D

**SPECIALIZED THERAPEUTIC FOSTER CARE
PROVIDER AGENCY SELF-CERTIFICATION**

**SPECIALIZED THERAPEUTIC FOSTER CARE
PROVIDER AGENCY SELF-CERTIFICATION**

This is to certify that:

Agency Name: _____

Address: _____

Phone Number: () _____ Agency Medicaid No.: _____ (if enrolled)

meets the criteria for certification as a provider of specialized therapeutic foster care as outlined in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook.

Provider Agency Representative

Date

Submit this form with your Florida Medicaid Provider Enrollment Application to the address listed below.

**Florida Medicaid Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070**

APPENDIX E

**AUTHORIZATION FOR
SPECIALIZED THERAPEUTIC FOSTER CARE**

**AUTHORIZATION FOR
SPECIALIZED THERAPEUTIC FOSTER CARE**

This is to certify that:

Recipient'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:

The recipient is eligible for Specialized Therapeutic Foster Care as follows:

_____ The recipient meets eligibility criteria for service.

_____ Multidisciplinary team has determined the child is in need of the service.

Medicaid Area Office Representative (or designee) _____ Date

Services will be reviewed and reauthorized by the multidisciplinary team prior to: _____
Date

Refer to policy in the Florida Medicaid Specialized Therapeutic Services 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 covers only dates of service authorized on this form.

AHCA Form 5000-3514, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)

APPENDIX F

AUTHORIZATION FOR CRISIS INTERVENTION

AUTHORIZATION FOR CRISIS INTERVENTION

This is to certify that:

Recipient's Name _____ Date _____

Medicaid Number _____

has been screened and recommended for Crisis Intervention by the multidisciplinary team.

This service will be provided by: _____ (provider agency) as authorized by:

The recipient is eligible for Specialized Therapeutic Foster Care as follows:

____ The recipient meets eligibility criteria for service.

____ Multidisciplinary team has determined the child is in need of the service.

Medicaid Area Office Representative (or designee) _____ Date _____

Services will be authorized by the multidisciplinary team from: _____
Date _____

Services must be reviewed and reauthorized by the multidisciplinary team prior to _____
Date _____

Refer to policy in the Florida Medicaid Specialized Therapeutic Services 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.

AHCA Form 5000-3515, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)

APPENDIX G

**PROVIDER AGENCY ACKNOWLEDGEMENT FOR
THERAPEUTIC GROUP CARE SERVICES**

**PROVIDER AGENCY ACKNOWLEDGEMENT FOR
THERAPEUTIC GROUP CARE SERVICES**

Provider Agency Name: _____ Medicaid No.: _____

Provider Agency Address: _____

City: _____ Zip Code: _____ Phone No.: () _____

County: _____ Circuit: _____ Area: _____

Name and Address of Site: _____

Zip Code: _____

I certify that the above named site has met the criteria for therapeutic group care services certification and is in compliance with Medicaid policies and procedures as put forth in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook and with the specific standards for therapeutic group care services. I further certify that statements made in this document are accurate and correct to the best of my knowledge.

Executive Director's Signature: _____ Date: _____

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.

AHCA Form 5000-3519, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)

APPENDIX H

**AUTHORIZATION FOR
THERAPEUTIC GROUP CARE SERVICES**

**AUTHORIZATION FOR
THERAPEUTIC GROUP CARE SERVICES**

This is to certify that:

Recipient's Name: _____ Date: _____

Medicaid Number: _____ Date of Birth: _____

has been determined by a multidisciplinary team as appropriate for therapeutic group care placement by a licensed clinical psychologist, per section 490, F.S., or a board certified psychiatrist in compliance with section 394.4781 or 39.407, F.S., and has an emotional disturbance or serious emotional disturbance.

These services are to be provided by: _____

Medicaid Area Office Representative (or designee) Date

Services will be reviewed and reauthorized by the multidisciplinary team prior to this date: _____

This form must be placed in recipient's clinical record. Medicaid will reimburse services only for the dates of service authorized on this form.