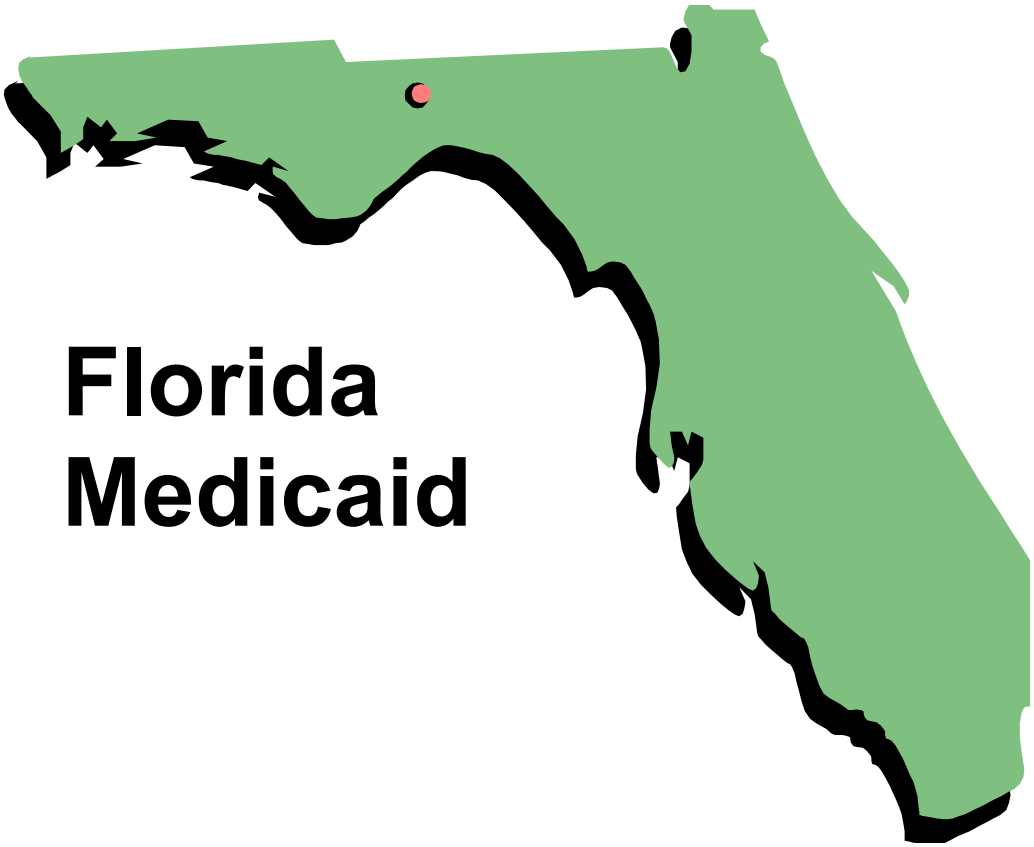

Florida Medicaid

Behavioral Health Assessment Services Coverage Policy

Agency for Health Care Administration

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1.0 Introduction

Florida Medicaid provides behavioral health assessment services to recipients for screening and identification of mental health and substance use disorders in order to develop, plan, and maintain a schedule of services to restore a recipient to the best possible functional level.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render behavioral health assessment services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Florida Medicaid behavioral health assessment services are authorized by the following:

- Title XIX of the Social Security Act, (SSA)
- Title 42, Code of Federal Regulations, (CFR), section 440.130
- Section 409.906, Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Policy.

1.4.1 Assessment

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

1.4.2 Claim Reimbursement Policy

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

1.4.3 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.4.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.5 Medically Necessary/Medical Necessity

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

1.4.6 Provider
The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

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

1.4.8 Treating Practitioner
A licensed practitioner who directs the course of treatment for recipients.

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary behavioral health assessment services.

Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments
Recipients are responsible for a $2.00 copayment in accordance with section 409.9081, F.S., unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria
Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid behavioral health assessment services.

3.2 Who Can Provide
All providers that deliver behavioral health assessment services must be either employed by, or contracted with, a Florida Medicaid-enrolled community behavioral health agency.

The following providers may deliver all services specified in section 4.0:

- Practitioners licensed in accordance with Chapters 458 or 459, F.S.
- Psychiatric advanced practice registered nurses licensed in accordance with Chapter 464, F.S.

The following providers may deliver all services specified in section 4.0 except for psychiatric evaluations and psychiatric reviews of records:

- Practitioners licensed in accordance with Chapters 490 or 491, F.S.

The following providers may deliver brief behavioral health status examinations, in-depth assessments, and bio-psychosocial evaluations and participate on treatment teams:

- Master's level certified addiction professionals

The following providers may deliver in-depth assessments and bio-psychosocial evaluations and participate on treatment teams:

- Certified addiction professionals
- Master's level practitioners

The following providers may deliver bio-psychosocial evaluations and participate on treatment teams:

- Bachelor's level practitioners

Providers delivering limited functional assessments using the Functional Assessment Rating Scale (FARS) or Children's Functional Assessment Rating Scale (C-FARS) must hold certification from the Department of Children and Families.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

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

4.2.1 Bio-psychosocial Evaluation

Bio-psychosocial evaluations describe biological, psychological, and social factors that contribute to a recipient's need for services and include brief mental health status examinations and preliminary service recommendations.

Bio-psychosocial evaluations must provide information on the following:

- Biological factors
- Diagnostic impressions
- Mental health status examinations
- Presenting problems
- Psychological factors
- Social factors
- Summary of findings
- Treatment recommendations or plans

Master's level, bachelor's level certified addiction professionals, or treating practitioners must review bio-psychosocial evaluations completed by bachelor's level practitioners and include a statement that concurs with the findings or provides alternative recommendations.

4.2.2 Brief Behavioral Health Status Examination

Brief behavioral health status examinations consist of brief clinical, psychiatric, diagnostic, or evaluative interviews to assess behavioral stability or treatment status. An examination is required prior to the development of a recipient's treatment plan.

Brief behavioral health status examinations must provide information on the following:

- Diagnostic formulation
- Mental health status
- Purpose of the exam
- Summary of findings

- Treatment recommendations or plan

Brief behavioral health status examinations are not required prior to the development of a recipient's treatment plan when a bio-psychosocial evaluation or in-depth assessment has been completed during the previous six months.

4.2.3 In-depth Assessment

In-depth assessments gather information to establish or support a diagnosis, provide the basis for developing or modifying a treatment plan, and developing discharge criteria.

In-depth assessments for recipients ages seven and older must provide information on the following:

- History of treatment that includes the following:
  - Acute care treatment
  - Desired services and goals from the recipient's viewpoint
  - Inpatient behavioral health treatment
  - Mental health status examinations
  - Psychiatric treatment and psychotropic medication information
  - Therapy and counseling
  - Treatment recommendations or plans
- Personal history that includes the following:
  - Alcohol and other drug use
  - Educational analysis
  - Identifying information
  - Legal involvement
  - Medical information
  - Resources and strengths
  - Traumatic experiences
- Recipient's perception of problems, needs, or symptoms

In-depth assessments for recipients under the age of seven years must include the following:

- Clinical interview with the primary caretaker and observation of the caretaker and recipient
- Developmental and medical history that includes the following:
  - Developmental milestones
  - History of the mother's pregnancy and delivery
  - Past and current medical conditions
- Family functioning, cultural and communication patterns, and current environmental conditions and stressors
- Family psychosocial and medical history
- Observation and assessment of the recipient's affective, language, cognitive, motor, sensory, self-care, and social functioning
- Presenting symptoms and behaviors

In-depth assessments for new patients must be administered to recipients for one of the following reasons:

- Another type of assessment is insufficient for providing a comprehensive evaluation for treatment planning.
- Recipient is high risk.

In-depth assessments for established patients must be administered to recipients for one of the following reasons:

- Recipient has received outpatient treatment with unsuccessful results and may require more intensive services.
- Recipient is identified as high utilizer of behavioral health services.

In-depth assessments require completion of an integrated summary that evaluates history and assessment information collected and provides the following:

- Diagnosis
- Discharge criteria
- Evaluation of past intervention efficacy
- Service needs

4.2.4 Limited Functional Assessment

Limited functional assessments consist of the following:

- American Society for Addiction Medicine Patient Placement Criteria (ASAM PPC-2R)
- Children's Functional Assessment Rating Scale (C-FARS)
- Functional Assessment Rating Scale (FARS)
- Other functional assessment required by the Department of Children and Families

4.2.5 Psychiatric Evaluation

Psychiatric evaluations consist of comprehensive evaluations that investigate a recipient's clinical status and include the following:

- Establishment of a therapeutic doctor-patient relationship
- Gather accurate data to formulate a diagnosis
- Initiation of an effective treatment plan

Psychiatric evaluations must include information on the following:

- Alcohol and other drug abuse history
- Diagnostic formulation
- History of presenting illnesses or problems
- Mental health status examination
- Personal strengths
- Presenting problems
- Psychiatric, physical, medication, and trauma history
- Relevant personal and family medical history
- Summary of findings
- Treatment recommendations or plans

Psychiatric evaluations must occur at the onset of illness and may be utilized following an extended hiatus, marked change in mental status, or admission to an inpatient setting due to psychiatric illness.

Psychiatric evaluations are not necessary for recipients diagnosed with an organic brain disorder unless a change in mental status requires an evaluation.

4.2.6 Psychiatric Review of Records

Psychiatric reviews of records consist of reviewing the following to evaluate and plan recipient care:

- Clinical and psychological evaluation data for diagnostic use
- Psychiatric reports
- Psychometric or projective tests

Psychiatric reviews of records must include a written report or progress note to be included in the recipient's clinical record.

4.2.7 Psychological Testing

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

Psychological testing must be administered to recipients for one of the following reasons:

- Extended hiatuses, marked changes in mental status, or assessing for admission or readmission to a psychiatric inpatient setting
- Onset of illness or suspected illness when a recipient first presents for treatment
- To obtain additional information needed to evaluate treatment or make a diagnosis

4.2.8 Treatment Plan Development

Treatment plans include individualized, structured, and goal-oriented schedules of services with measurable objectives that promote the maximum reduction of a recipient's disability and restoration to the best possible functional level. Plans must address a recipient's primary and secondary diagnoses and be consistent with assessments.

Treatment teams that are recipient-centered must develop treatment plans that are consistent with a recipient's identified strengths, abilities, needs, and preferences.

Treatment plans must include the following:

- Amount, frequency, and duration of each service for the six-month duration of the treatment plan
  - Providers may not specify that services will be provided "as needed" or within a given date range.
- Dated signature of the recipient or recipient's guardian if the recipient is under the age of 18 years
- Diagnoses consistent with assessments
- Discharge criteria
- Individualized and strength-based goals that are appropriate to each recipient
- List of services to be provided
- Measurable objectives with target completion dates listed for each goal
- Treating practitioner statement that services are medically necessary
- Treatment team member signatures

Treatment plans become effective on the date of the treating practitioner's signature. Florida Medicaid reimburses for services provided within 45 days of the signature.

Providers may use addendums to modify treatment plans when significant changes have not occurred. Addendums may add or modify services and must be signed by the treating practitioner and recipient.

4.2.9 Treatment Plan Review

Treatment plan reviews occur once per six months, or when significant changes occur; and consist of the treatment team and recipient reviewing the goals, objectives, and services to determine whether they continue to be appropriate for the recipient's needs and progress.

Treatment plan reviews must consist of the following:

- Dated signature of the recipient, or recipient's guardian, if the recipient is under the age of 18 years

- Diagnosis and justification for changes in diagnosis
- Findings
- Recipient's progress toward meeting individualized goals, objectives, and discharge criteria
- Recommendations
- Treatment team member signatures
- Treating practitioner statement that services are medically necessary
- Updates to aftercare plan

Treatment teams must document activities, notations of discussions, findings, conclusions, and modifications. If a recipient does not meet treatment goals, the treatment team must provide justification if it makes no changes to the treatment plan.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Activities performed to maintain and review records for facility utilization, continuous quality improvement, recipient eligibility status processing, and staff training purposes
- Behavior analysis assessments or reassessments on the same day as behavioral health assessments
- Bio-psychosocial evaluation for the same recipient after an in-depth assessment has been completed, unless there is a documented change in the recipient's status and additional information must be gathered to modify the recipient's treatment plan
- Brief behavioral assessment on the same day that a psychiatric evaluation, bio-psychosocial assessment, or in-depth assessment has been completed
- Case management 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
- Services rendered to individuals residing in an institution for mental diseases
- Services rendered to institutionalized individuals, as defined in 42 CFR 435.1009
- Travel time

6.0 Documentation

6.1 General Criteria

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

6.2 Specific Criteria

Providers must maintain the following in the recipient's file:

- Copy of the assessment
- Daily progress notes that list each service and activity provided
- Record of a mental health diagnosis from a licensed practitioner

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

There are no specific authorization criteria for this service.

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, incorporated by reference in Rule 59G-4.002, F.A.C.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.5.1 Nursing Facilities

Florida Medicaid reimburses separately for all covered behavioral health assessment services provided to recipients who reside in a nursing facility that is reimbursed per diem.