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1.0 Introduction

1.1 Description
Florida Medicaid provides behavioral health therapy services to recipients, their families, or other responsible persons to improve the symptoms of mental health or substance use disorders through the use of evidence-based, insight-oriented, therapeutic interventions.

1.1.1 Florida Medicaid Policies
This policy is intended for use by providers that render behavioral health therapy 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.


1.1.2 Statewide Medicaid Managed Care Plans
Florida Medicaid managed care plans must comply with the 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 coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority
Behavioral health therapy 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.)
- Rule 59G-4.052, F.A.C.

1.3 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.

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

1.3.2 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.

1.3.3 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.

1.3.4 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.

1.3.5 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.
1.3.6 **Recipient**
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

1.3.7 **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 therapy 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 General Policies on copayment and coinsurance.

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 therapy services.

3.2 **Who Can Provide**
Services must be rendered by one of the following:

- Practitioners licensed within the scope of their practice in accordance with Chapters 490 or 491, F.S.
- Community behavioral health agencies that employ or contract with practitioners who perform services under the supervision of a treating practitioner, including:
  - Certified addiction professionals
  - Certified psychiatric rehabilitation practitioners
  - Practitioners with a bachelor’s or master’s degree from an accredited college in a human services related field

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 behavioral health therapy services, including documentation, education, and referrals, in accordance with the applicable Florida Medicaid fee schedule, or as specified in this policy:
4.2.1 Individual and Family Therapy
Up to 104 units of individual and family therapy per state fiscal year, per recipient (maximum of four units per day)

4.2.2 Group Therapy
Up to 156 units of group therapy per state fiscal year, per recipient, for a group of two to fifteen participants (two to ten participants for recipients under the age of six years)
A recipient must be the primary focus of services if the recipient is not present during family or group therapy.

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 General Policies on authorization requirements.

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:

- Individual, family, or group therapy services provided on the same day as behavior analysis services
- Services for a recipient receiving any 24-hour Florida Medicaid residential or institutional service

6.0 Documentation

6.1 General Criteria
For information on general documentation requirements, please refer to Florida Medicaid’s General Policies on recordkeeping and documentation.

6.2 Specific Criteria
Providers must document the approved services on the treatment plan developed and maintained in accordance with Rule 59G-4.028, F.A.C.

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 General Policies on authorization requirements.

7.2 Specific Criteria
There are no service specific authorization criteria for this service.
8.0 Reimbursement

8.1 General Criteria
The reimbursement information in this section 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