



Florida Medicaid

Therapeutic Group Care Services Coverage Policy

Agency for Health Care Administration
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1.0 Introduction

1.1 Description

Florida Medicaid therapeutic group care (TGC) services provide community-based residential, behavioral health treatment to increase coping skills and functional abilities and reduce psychiatric symptoms or disruptive behaviors, enabling recipients to return to a less restrictive environment.

1.1.1 Florida Medicaid Policies

This policy is intended for use by TGC providers that render 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>.

1.1.2 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 coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Therapeutic group care services are authorized by the following:

- Chapter 394, Florida Statutes (F.S.)
- Section 409.906, F.S.
- Rule 59G-4.295, 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 adopted 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 adopted 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 Therapeutic Home Assignment

Clinical interventions that allow a recipient to practice acquired skills in an identified discharge setting.

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 under the age of 21 years requiring medically necessary TGC services and who meet the following:

- Have an emotional disturbance or serious emotional disturbance as defined in Chapter 394, F.S. which requires treatment in a residential setting.

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

2.3 Coinsurance and Copayments

There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. 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 TGC services.

3.2 Who Can Provide

Services must be rendered by residential treatment centers for children and adolescents licensed in accordance with Chapter 394, F.S., and Rule Chapter 65E-9, F.A.C.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for 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 up to 365/6 days of TGC treatment services per year, per recipient.

Providers must provide the care and services required for a recipient to attain or restore the highest practicable physical, mental, and psychosocial well-being in accordance with Rule Chapter 65E-9, F.A.C., as follows:

- Aftercare and follow-up services
- Behavior analysis services

- Coordination with the recipient's primary care physician(s)
- Education services in accordance with Rule 6A-6.0361, F.A.C.
- Family therapy services
- Individualized treatment plan developed within 14 days after admission
- Individual and group therapy services
- Psychiatric, psychological, substance abuse, and biopsychosocial assessments and monitoring
- Recreational services
- Rehabilitative services
- Therapeutic home assignment
- Vocational services (for recipients ages 16 years and older)

Therapeutic home assignments require daily clinical intervention with the family by the recipient's physician, primary therapist, certified behavior analyst, or other licensed practitioner.

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 reimbursed 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 reimburse for the following:

- Individual, family or group therapy, or behavior analysis services, reimbursed separately
- Room and board
- Services on days when a recipient is on therapeutic home assignment and no clinical intervention is provided
- Services provided to a recipient on the day of admission into the Statewide Inpatient Psychiatric Program
- Services when the recipient is receiving any other 24-hour per day Florida Medicaid residential or institutional service
- Services on the date of discharge

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 maintain documentation in accordance with Rules 65E-9.006, 65E-9.008-9.009, and 65E-9.013-9.014, F.A.C.

Providers must document informed consent in accordance with section 39.407, F.S. Any changes in psychotropic medication not covered on the original informed consent order require a new order or informed consent.

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 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 Specific Criteria

Florida Medicaid reimburses on an all-inclusive per diem basis for recipients present in the facility at 11:59 p.m. or for recipients receiving therapeutic home assignment services.

8.3 Claim Type

Professional (837P/CMS-1500)

8.4 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, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.5 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.

8.6 Rate

For a schedule of rates, as 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>.