Medicaid Behavioral Health Clinical Policies

Topics to be covered:

- SMART goals + objectives
- Individual + group therapy
- Documentation requirements
- Best practices
- Medical necessity
- Assessments
- Treatment plan development
- Treatment plan review

Medical Necessity

Medically Necessary or Medical Necessity
The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
  - This requirement applies only to recipients age 21 years or older.
- 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
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- 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
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Rule 59G-1.010: Definitions (effective 6/17/2024)

Brief Behavioral Health Status Examination – H2010 HO

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.

- Eligible providers:
  - Practitioners licensed in accordance with Chapters 458 or 459, F.S.
  - Psychiatric APRNs licensed in accordance with Chapter 464, F.S.
  - Practitioners licensed in accordance with Chapters 490 or 491, F.S.
  - Master's level certified addiction professionals (MCAP)
- Not reimbursable on the same day that a psychiatric evaluation, bio-psychosocial evaluation, or in-depth assessment has been completed

Rule 59G-4.028: Behavioral Health Assessment Services (effective 11/28/2019)

In-Depth Assessment – H0031 (HO/TS) & H0001 (HO/TS)

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 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.

- Eligible providers
  - Same as brief behavioral health status exam, PLUS
  - Certified addiction professionals (CAP)
  - Master's level practitioners
- Not reimbursable on the same day as a bio-psychosocial evaluation

Rule 59G-4.028: Behavioral Health Assessment Services (effective 11/28/2019)

In-Depth Assessment – H0031 (HO/TS) & H0001 (HO/TS)

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 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

Rule 59G-4.028: Behavioral Health Assessment Services (effective 11/28/2019)

Bio-Psychosocial Evaluation – H0031 HN & H0001 HN

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.

- Not reimbursable on the same day as an in-depth assessment
- Not reimbursable 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 treatment plan
- Eligible providers
  - Same as in-depth assessment, PLUS
  - Bachelor's level practitioners

Rule 59G-4.028: Behavioral Health Assessment Services (effective 11/28/2019)

Treatment Plan Development – H0032 & T1007

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.

- Example services:
  - Individual therapy (H2019 HR)
    - Duration: 1 hour
    - Frequency: 2x per month
  - Group therapy (H2019 HQ)
    - Duration: 1 hour
    - Frequency: once per week
  - Treatment plan review (H0032 TS)
    - Duration: 1 hour
    - Frequency: once per treatment plan

Rule 59G-4.028: Behavioral Health Assessment Services (effective 11/28/2019)

Treatment Plan Review – H0032 TS & T1007 TS

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:

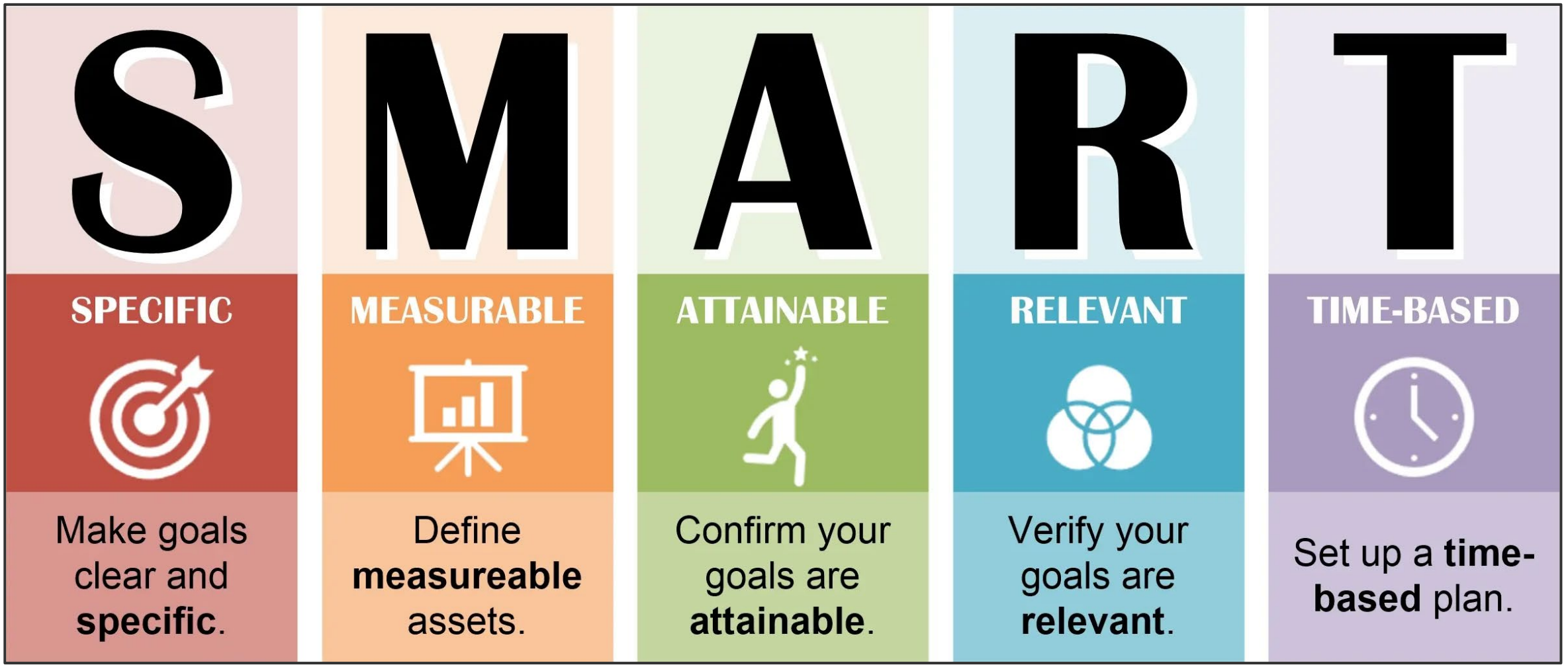
- Dated signature of the recipient, or recipient's guardian, if the recipient is under the age of 18 years

- 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.

Rule 59G-4.028: Behavioral Health Assessment Services (effective 11/28/2019)

SMART Goals and Objectives



SMART Goals and Objectives

Examples:

- “I will practice guided meditation for five minutes, five days a week for the next 3 months.”
- “I will actively practice socializing in at least one new setting each week for the next month.”
- “I will journal every day for the next 6 weeks to help process my emotions and identify triggers related to anxiety.”
- “I will reduce the frequency of anxiety attacks from 3 per week to 1 per week within 2 months.”
- “I will reduce feelings of hopelessness from 7 to 5 on a scale of 10 within 2 months.”
- “I will reduce intrusive thoughts and flashbacks by 50% within 3 months.”

Therapy – Individual (H2019 HR) & Group (H2019 HQ)

Individual and Family Therapy
Individual and family therapy services may include the recipient, the recipient's family, or a combination of both. When the recipient is not present, the services must always focus on the recipient.

Recipients residing in a nursing facility, reimbursed on a per diem basis, can receive individual and family therapy services reimbursed under this benefit.

Group Therapy
Group therapy services delivered to individuals and their families can include the following in addition to therapy:

- Education related to the recipient's behavioral health issues
- Sharing of clinical information
- Guidance on how to assist the recipient

Groups may include participants who are not Medicaid eligible and must be between two and 15 participants.

Who Can Provide
All providers that deliver behavioral health therapy services must be either employed or contracted with a community behavioral health agency.

- 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 can deliver individual and group therapy services:

- Practitioners licensed in accordance with Chapters 490 or 491, F.S.
- Master's level certified addiction professionals
- Master's level practitioners

The following providers can only deliver group therapy services:

- Bachelor's level practitioners
- Certified addiction professionals

The following providers can only deliver brief group medical therapy:

- Psychiatric nurses licensed in accordance with Chapter 464, F.S.

Rule 59G-4.052: Behavioral Health Therapy Services (effective 11/28/2019)

Therapy – Individual (H2019 HR) & Group (H2019 HQ)

Specific Non-Covered Criteria
Florida Medicaid does not cover the following as part of this service benefit:

- Behavior analysis services
- Case management services
- Childcare programs for developmental delays, preschool, or enrichment programs
- Non-therapy related interactions (e.g., socializing)
- Services for a recipient receiving any 24-hour a day Florida Medicaid-funded residential or institutional service
- Services for a recipient residing in an institution for mental diseases
- 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 institutionalized individuals as defined in 42 CFR 435.1009
- Travel time

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

Specific Criteria
Providers must maintain the following documentation in the recipient's file:

- Daily progress notes that address each service provided
- Documentation of approved services on the treatment plan developed and maintained in accordance with Rule 59G-4.028, F.A.C.

Florida Medicaid's General Policies on recordkeeping and documentation are addressed in detail on the next slide.

Rule 59G-4.052: Behavioral Health Therapy Services (effective 11/28/2019)

Documentation Requirements

(1) This rule applies to providers rendering Florida Medicaid services to recipients.
(2) Documentation Requirements.
(a) All Florida Medicaid providers must:
1. Ensure medical records establish the medical necessity for and the extent of services provided.
2. Sign and date each medical record within two business days from the date and time of service, or otherwise authenticate the record by signature, written initials, or computer entry. Electronic signatures are permissible as defined in Chapter 668, Part I, F.S.
3. Initial rubber stamped signatures.
(b) Unless otherwise specified in Florida Medicaid coverage policies, providers must document the following information for each service visit or encounter with a Florida Medicaid recipient:
1. Chief complaint of the visit.
2. Date(s) of service.
3. Description of services rendered (as applicable).
4. Diagnosis.
5. Diagnostic tests and results (as applicable).
6. History and physical assessment (as applicable).
7. Prescribed or provided medications and supplies (as applicable).
8. Progress reports.
9. Referrals to other services (as applicable).
10. Scheduling frequency for follow-up or other services (as applicable).
11. Treatment plan (as applicable).
(3) Electronic Records.
(a) Providers that create or maintain electronic records must develop and implement an electronic records policy to comply with the applicable state and federal laws, rules, and regulations to ensure the validity and security of electronic records. Electronic record policies must address the technical safeguards required by Title 45, Code of Federal Regulations, section 164.312, where applicable.
(b) Providers that maintain electronic records must have the ability to produce electronic records in a paper format within a reasonable time, upon AHCA's request.
(4) Recordkeeping Requirements. Providers must retain all business records, medical-related records, and medical records, as defined in Rule 59G-1.010, F.A.C., according to the requirements specified below, as applicable:
(a) Providers may maintain records on paper, magnetic material, film, or other media including electronic storage, except as otherwise required by law or Florida Medicaid requirements. All records must be accessible, legible, and comprehensible.
(b) Providers must retain all records related to services rendered to Florida Medicaid recipients for a period of at least five years from the date of service. Medicare crossover-only providers must retain health care service records for six years.

Rule 59G-1.054: Recordkeeping and Documentation Requirements (effective 5/8/2017)

Best Practices – Care Coordination

- **Care coordination:** the intentional exchange of information between two or more participants who are involved in the member's care to facilitate appropriate delivery of healthcare services
  - Care coordination consists of anything that bridges gaps in recovery
- Care coordination assists in the development of comprehensive treatment planning that leads to more appropriate service titration and/or referrals
  - Follow up on referrals and other recommendations should be clearly documented
- Care coordination includes a variety of individuals on the treatment team:
  - Behavioral health providers (e.g. therapists, psychiatrists, ABA professionals)
  - Physical health providers (e.g. PCPs, neurologists)
  - Specialty care services (e.g. physical therapy, occupational therapy, speech therapy)
  - Educational and community supports (e.g. school staff, religious leaders, mentors)
  - Family members (e.g. parent, sibling, spouse or significant other)

For more info, visit: SunshineHealth.com/pic

Best Practices – Care Coordination

- Request and review records from previous and/or current providers to align care and member needs
- Release of information must be signed by the member/guardian prior to any outreach
  - Document any declination to sign release of information
  - Document any unsuccessful outreach attempts
- Method of care coordination (phone, fax, email, meeting) is based on member needs

- What could happen if care coordination does NOT occur?
  - Multiple providers may be treating different diagnoses or presenting problems
  - Multiple treatment plans with competing goals can complicate or impede the treatment process
  - Duplication of efforts and services provided may occur
  - Symptoms may become exacerbated

Best Practices – Titration of Services

- **Titration of services:** decreasing the frequency and duration of services to match member's clinical presentation, progress, baseline, and supports
  - *Ex: decreasing services from 4x per month (or once per week) to 2x per month*
- Services can also be titrated up to increase the frequency and duration if symptoms worsen as long as documentation supports medical necessity
  - Referrals for new or additional services and higher levels of care should be considered at this time
- Titration should occur slowly during recovery to avoid feelings of abandonment and/or worsening of symptoms as well as to empower the use of skills learned
- Why is titration of services important?
  - Promotes independence and working towards effective independent functioning
  - Can help members identify their natural support systems
  - Helps ensure treatment is individualized to match member needs
  - Discourages unhealthy attachments to or dependence on treatment providers

Best Practices – Discharge Planning

- Discharge planning is not a one-time event
  - Discharge should be openly discussed with members at the start and throughout treatment
- Discharge planning requires collaboration with the entire treatment team including providers, members, their family, and additional supports
  - Titration of services also helps identify when discharge is appropriate
- The discharge plan should be written clearly and agreed to by the member
- Discharge should occur when:
  - All treatment goals and needs have been addressed
  - Member has reached their baseline
  - Member has reached the maximum benefit of services for the current level of care

Best Practices – Discharge Planning

- Recommend potential referrals to connect the member to natural supports prior to discharge to allow practice using the following services:
  - AA/NA and sponsors
  - Senior centers or respite
  - Employment programs
  - Spiritual or religious supports
  - Community mentors or peer support specialists
  - Sports/hobby groups
  - Online supports (e.g. apps, online groups)

Questions?