Clinical Policy: Therapeutic Behavioral On-site Services

Reference Number: FL.CP.BH.08
Date of Last Revision: 02/26

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy describes the clinical criteria on which to review requests for Therapeutic Behavioral On-site Services (TBOS) for Sunshine Health's Managed Medical Assistance (MMA), Serious Mental Illness (SMI), HIV/AIDS, Children's Medical Services (CMS), and Child Welfare (CW) members.

Policy/Criteria

I. It is the policy of Sunshine Health that Therapeutic Behavioral On-site services are considered **medically necessary** when one or more of the following criteria are met:
- A. Enrolled in a special education program for the seriously emotionally disturbed (SED) or the emotionally handicapped;
- B. Scored 60 or below on the Axis V Children's Global Assessment of Functioning Scale within the last six months;
- C. There is evidence to indicate that the recipient is at risk for a more intensive, restrictive, and costly behavioral health placement;
- D. There is evidence to indicate that the recipient's condition and functional level cannot be improved with a less intensive service such as individual or family therapy or group therapy.
- E. The treating provider must submit the following information and documentation to support any request for Therapeutic Behavioral On-site Services:
  1. Member is < 21 years of age;
  2. Problem focused history and documentation, including assessment of all of the following:
     a. Functional and cognitive deficits;
     b. Mental and emotional health;
     c. High risk behaviors;
     d. Support system in the home and community;
     e. Past history of outpatient treatment;
     f. Member strengths and limitations;
  3. S.M.A.R.T. treatment goals with expected completion dates, and clinical notes from each visit;
  4. Treatment goal and objective updates at each concurrent review.

II. It is the policy of Sunshine Health that Therapeutic Behavioral On-site Services are **not medically necessary** when the following criteria are met:
- A. The member no longer meets criteria as defined in Criteria I.;
- B. The member is not an active participant or fails to make adequate progress toward treatment goals;
- C. The member requires a different level of treatment or more specialized treatment;

D. Treatment goals are achieved;
E. Lack of participation from the member and/or member's family;
F. Member no longer meets eligibility requirements;
G. The service unnecessarily duplicates another provider's service;
H. Member is ≥ 21 years of age.

Background

Therapeutic Behavioral On-Site (TBOS) Services are designed to stabilize the symptoms of behavioral health disorders to provide transitional treatment after an acute episode or to reduce or eliminate the need for more intensive levels of care. TBOS services assist complex-need enrollees under the age of 21 and their families in an effort to prevent the need for a more intensive, restrictive behavioral health placement. Services may include therapy, behavior management and/or support services. Therapy includes a strength-based, clinical assessment of the mental health, substance abuse, or behavioral disorders in order to evaluate, define, and delineate treatment needs; individual and family therapy as agreed to by the child and family; assessment and engagement of the child or adolescent and family's natural support system to assist in implementation of the treatment plan; and development, implementation, and monitoring of behavior programming for the child or adolescent.

Behavior management includes an assessment of behavior problems and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the client's behaviors and the interactions that motivate, maintain or improve behavior; development of an individual behavior plan with measurable goals and objectives; training for caregivers and other involved persons in the implementation of the behavior plan; monitoring of the child and caregiver progress and revision as needed; and, coordination of services on the treatment plan with the treatment team.

Support Services must be related to the enrollee's treatment goals and objectives and must include one or more of the following services: one-to-one supervision and intervention with the child or adolescent during therapeutic activities in accordance with the child's treatment plan; skill training of the child or adolescent for restoration of those basic living and social skills necessary to function in the child or adolescent's own environment; or, assistance to the child or adolescent and family in implementing the behavioral goals identified through family counseling and development of the treatment plan.[1]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description	Modifier
H2019	Therapeutic behavioral services, per 15 min	HO
H2019	Therapeutic behavioral services, per 15 min	HN
H2019	Therapeutic behavioral services, per 15 min	HM

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		08/19
Annual review; MNC updated to include GAF score; special considerations removed; exclusion criteria revised.		08/20
Annual review; updated LOB, minor language adjustments		02/22
Annual review; expanded LOB to include SMI and CMS		02/23
Transitioned policy to new state specific template and sent to market for approval; policy number changed from FL.UM.68 to FL.CP.BH.08	01/24	
Annual review; minor grammatical changes; no criteria changes	02/24	
Annual review; HIV/AIDS added to Description. Reformatted Criteria II. and added to Criteria I. as I.E. Background updated with no impact on criteria. HCPCS codes added. References reviewed and updated.	02/25	
Annual review. Added Criteria III. to II. for clarity and flow with no change to criteria meaning. References reviewed and updated.	2/26	

References

1. Agency for Health Care Administration. Specialized Therapeutic Services Coverage and Limitations Handbook. https://ahca.myflorida.com/content/download/5964/file/59G-4.295_Specialized_Therapeutic_Services_and_Limitations_Handbook_Adoption.pdf. Published March 2014. Accessed January 21, 2026.
2. Agency for Health Care Administration. Behavioral Health Intervention Services Coverage Policy Manual. https://ahca.myflorida.com/content/download/5968/file/59G-4.370.pdf. Published November 2019. Accessed January 22, 2026.

Important Reminder

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.