Clinical Policy: Drop-In Services in Lieu of Services

Reference Number: FL.CP.BH.13
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 Drop-In Services In Lieu of Services for Sunshine Health's Managed Medical Assistance (MMA), HIV/AIDS, Serious Mental Illness (SMI), and Children's Medical Services (CMS), and Child Welfare (CW) members. The goal is to provide Drop-In Services when medically necessary, as an alternative to an existing state benefit and to define criteria and limitations established for the use of Drop-In Services.

Policy/Criteria

I. It is the policy of Sunshine Health that Drop-In Services in Lieu of Services are **medically necessary** when the following criteria are met:
- A. The member must have a mental health diagnosis;
- B. Member needs help with improving activities of daily living, socialization, and employment skills;
- C. Member must be willing to actively participate and able to benefit from the program.
- D. The treating provider must submit the following information and documentation with any *initial* request for Drop-In Services in Lieu of Services:
  1. Medical documentation to support the criteria as noted in I.A. through I.C;
  2. Documentation that the member has consented to the In Lieu of Services as an alternative to a covered state benefit.

Redetermination
Prior to the expiration of the initial authorization period, the requesting practitioner must submit information on the member's status to Sunshine Health's utilization management department for a review to determine if subsequent approval is medically necessary using *Criteria I.A. through I.C.* as stated in this policy.

II. It is the policy of Sunshine Health that **discharge** from Drop-In Services in Lieu of Services is appropriate when one or more of the following criteria are met:
- A. Member can sustain on their own and meet their basic human needs and supports, initiating and engaging in activities that enable them to continue to maintain tenure in the community;
- B. Member refuses to participate or continue the service.

III. It is the policy of Sunshine Health that Drop-In Services in Lieu of Services are considered **not medically necessary** when one or more of the following indications are met:
- A. The Member does not have a behavioral health diagnosis;
- B. The Member is not capable of benefitting from the program;
- C. The severity of their mental illness requires a program of higher intensity.

Note: Coverage that exceeds the benefit limit is excluded.

Background
Health plans have the option to offer "in lieu of services" (ILOS), which are alternate services or settings to those required by the state Medicaid plan. These services can be offered when the alternate service or setting is medically appropriate but is more cost effective than the Medicaid alternative; services are optional-members have the right to choose; and providers are contracted with the health plan.[1,2]

This service is a social club offering peer support and a flexible schedule of activities. It is a day program that may operate on weekdays, evenings and/or weekends. Activities focus on support, social and behavioral skills. Services can be provided 365 days a year with a minimum age of 18 years old to access services.[3] Drop-in Centers are easy to access mental health centers providing a variety of peer supported social, recreational, and networking activities.[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	Modifier	Description
S5102	HE	Day care services, adult; per diem

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		06/18
Archer reload to correct system issue; no content reviewed		05/19
Annual review; no changes		06/20
Annual review; Added that decision to deny reduce, suspend, or terminate services may be made by a contracted vendor. Added member refusal to participate in service as Discharge Criteria. Changed psychiatric diagnosis to behavioral health under Exclusions.		07/21
Annual review; added SMI and CMS to products		02/23

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Transitioned policy to new state specific template, references updated and sent to market for approval; policy number changed from FL.UM.48.00 to FL.CP.BH.13.	01/24	
Annual review; minor grammatical changes, no changes to criteria	02/24	
Annual review. Added note under description that services are available to members with HIV. Minor grammatical changes with no clinical significance. References reviewed and updated. Reviewed by FL BH team.	02/25	
Annual review. Note following description removed; HIV/AIDS added to description section. Rewording to III. to change limitations/exclusions to not medically necessary criteria for clarity. III.D. changed to a note. Background updated. HCPCS code S5102 added. References reviewed and updated.	02/26	

References

1. Florida Agency for Health Care Administration (AHCA). Statewide Medicaid Managed Care In Lieu of Services (ILOS). https://ahca.myflorida.com/content/download/27219/file/SMMC_Highlight_ILOS_Chart_08062025.pdf. Published July 16, 2025. Accessed January 21, 2026.
2. National Conference of State Legislatures (NCSL). Leveraging in lieu of services in Medicaid managed care. https://www.ncsl.org/health/leveraging-in-lieu-of-services-in-medicaid-managed-care. Updated December 20, 2023. Accessed January 21, 2026.
3. Agency for Health Care Administration (AHCA). Florida Medicaid: Community Behavioral Health Services Coverage and Limitations Handbook. https://www.flrules.org/gateway/readRefFile.asp?refId=3749&filename=Community%20Behavioral%20Health%20Services%20Coverage%20and%20Limitations%20Handbook_Adoption.pdf. Published March 2014. Accessed January 21, 2026.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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.