Clinical Policy: Infant Mental Health Pre and Post Testing In Lieu of Services

Reference Number: FL.CP.BH.15
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 Infant Mental Health Pre and Post Testing In Lieu of Services (ILOS) for Sunshine Health's Managed Medical Assistance (MMA), Long Term Care (LTC), HIV/AIDS, Serious Mental Illness (SMI), Children's Medical Services (CMS), and Child Welfare (CW) members. The goal is to provide Infant Mental Health Pre and Post Testing when medically necessary, as an alternative to Psychological Testing and to define criteria and limitations established for the use of Infant Mental Health Pre and Post Testing for members from birth up to age five.

Policy/Criteria

I. It is the policy of Sunshine Health that Infant Mental Health Pre and Post Testing in Lieu of Services is **medically necessary** when all of the following criteria are met:
- A. One or more of the following:
  1. Child has developmental delays, or a clinician or medical doctor has concerns about child bonding with parents or caregivers;
  2. Parents are struggling with child rearing;
  3. Child has received screening services that are used to determine consideration for the child/family to participate in a specified program for the treatment of children ages birth up to age five;
- B. The treating provider must submit the following information and documentation with any *initial* request for Infant Mental Health Pre and Post Testing in Lieu of Services:
  1. Medical information and documentation to support I.A.1. through I.A.3. above;
  2. Documentation that the parent/caregiver has consented to the In Lieu of Service 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.1 through I.A.3.* as stated above in this policy.

II. It is the policy of Sunshine Health that **discharge** from Infant Mental Health Pre and Post Testing in Lieu of Services is appropriate when one or more of the following criteria are met:
- A. Member no longer meets criteria for ILOS service;
- B. Parent or caregiver is not willing to participate in the assessments or infant mental health treatment;
- C. Parent or caregiver no longer expresses difficulty with child rearing.

III. It is the policy of Sunshine Health that Infant Mental Health Pre and Post Testing in Lieu of Services are considered **not medically necessary** when at least one of the following indications is met:

A. The child is not between the age of birth to five years old;
B. The parent or caregiver is not willing to participate in the assessments or Infant Mental Health treatment.

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.[1,3]

According to the World Association for Infant Mental Health (WAIMH), mental health disorders among young children, especially infants, often go unrecognized. This failure to identify, diagnose and initiate early treatment can have long term effects, since infancy is an important foundational component of development.[4] Infant Mental Health Pre and Post Testing includes tests, inventories, questionnaires, structured interviews, structured observations, and systematic assessments that are administered to help assess the caregiver-child relationship and to help aid in the development of the treatment plan.[2]

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
T1023	HA	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		06/18
Archer system update; no content review or revision		05/19

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Annual review; no changes		06/20
Integration; Added Comprehensive, SMI and CMS. Minor rewording		09/20
Annual review; Updated LOB-removed Comprehensive		09/21
Policy update; Added discharge criteria of "member no longer meets criteria for ILOS service and exclusion criteria have developed.		01/22
Annual review; no changes		01/23
Annual review; no changes		02/23
Transitioned policy to new state specific template, references updated and sent to market for approval; policy number changed from FL.UM.45.00 to FL.CP.BH.15.	01/24	
Annual review; minor grammatical changes	02/24	
Annual review; Added note under description that services are available to members with HIV. Minor rewording with no impact on criteria. Background updated. 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 Criteria I. for clarity. II.C. removed. II.C. added. Rewording of III. policy statement to not medically necessary criteria. III.C. changed to a note. I.A. and I.C. updated to I.A.1. and I.A.3. in I.B. and Redetermination sections. HCPCS code T1023 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 22, 2026.
2. Agency for Health Care Administration (AHCA). Florida Medicaid Behavioral Health Assessment Services Coverage Policy Handbook. Subsection 4.2.7 Psychological testing. https://ahca.myflorida.com/content/download/5937/file/59G-4.028.pdf. Published November 2019. Accessed January 22, 2026.
3. 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 22, 2026.
4. Lyons-Ruth K, Todd Manly J, Von Klitzing K, et al. The worldwide burden of infant mental and emotional disorder: report of the task force of the world association for infant mental health. *Infant Ment Health J*. 2017;38(6):695-705. doi:10.1002/imhj.21674

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.