Florida Medicaid Community Behavioral Health Services for Substance Use Disorders

Train-the-Trainer Program

Presenter: Mary Herkert, M.A.
Central Florida Behavioral Health Network, Inc.

Sponsored by:
Robert Wood Johnson Grant,
Florida Agency for Health Care Administration,
Department of Children and Families, and
Louis De La Parte Florida Mental Health Institute

Florida Medicaid Community Behavioral Health Services for Substance Use Disorders

Train-the-Trainer Program

Introduction

Florida Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists people who are aged and disabled with the costs of nursing facility care and other medical expenses. In an effort to increase access to care and to increase substance abuse services to Medicaid eligible citizens, the Agency for Health Care Administration (AHCA), in partnership with the Department for Children and Families (DCF) Substance Abuse Office and the Florida Alcohol and Drug Association (FAADA) applied for a Robert Wood Johnson (RWJ) Grant to address issues related to increasing Florida's utilization of federal funds for treating substance abuse disorders. The overall goals of this initiative include the following:

- Increase access to care
- Increase service capacity
- Increase Medicaid-enrolled providers
- Increase Medicaid billings for substance abuse disorders
- Increase the number of Medicaid reimbursable substance abuse services

The development of a training program to provide assistance to service providers is an important part of achieving the goals for this initiative. The Central Florida Behavioral Health Network (CFBHN) and the Florida Mental Health Institute at the University of South Florida (FMHI) worked under contract to AHCA to develop a train-the-trainer program to help Florida's substance abuse providers better identify reimbursable Medicaid services and to develop strategies to maximize Medicaid revenue. The train-the-trainer approach includes a training conference for the instruction of critical information and provides for a training manual that can be used to replicate the training experience in provider agencies whenever it is needed.

How to Use This Train-the-Trainer Program

This train-the-trainer program provides a description of the step-by-step process for conducting the training conference and all of the required background documents, including the manual, copies of the Power Point slides, handouts, and reference materials. The materials are organized into three sections, Manual, Power Point Slides, and Handouts. The following is a description of each section.

1. Manual

The manual is set up with two columns. The left column is under the heading Facilitator Notes and includes direction for when a slide should be shown or a handout distributed, and has space for trainers to insert their own written notes. The right column is under the heading Outline and includes all of the content for facilitating the training. Presentation points are typed in standard font. Notes are typed in italics and are provided as background information to the trainer, and are not intended to be presented to the audience. The instruction to ask a question or facilitate a discussion is listed in bold type. All of the material in the right column relates directly to the information on the Power Point sidle listed in the left column.

2. Power Point Slides

The package includes copies of the Power Point sides for participants to follow during the presentation and for taking notes.

3. Handouts

The handouts section includes all of the materials that will be distributed as part of the training session, including the following:

a. Pre and Post -Test Questionnaire
b. Medicaid Services for Substance Abuse Handout2.pdf (copies of all slides in the presentation)
c. Medicaid CBH Services 10-01-04
d. Medicaid Billable Units – CBHS 2004
e. Medicaid Revenue Exercise 2004.pdf
f. Medicaid CBHS Matrix October 2004
g. Evaluation Form

The Florida Medicaid Summary of Services document published by AHCA provides a background summary of Medicaid coverages and may be obtained at the AHCA website at www.myflorida.com. In addition, persons attending the training should be familiar with the Florida Medicaid Coverage and Limitations Handbooks and the Provider Reimbursement Handbooks, which are available from the Medicaid fiscal agent or on the fiscal agent's website at http://floridamedicaid.acs-inc.com.

Power Point Slides

Medicaid Services for Substance Abuse

Community Behavioral Health Services

Presented by: Mary Herkert – Central Florida Behavioral Health Network

04/05

Goals of Florida's RWJ Initiative

- Increase access to care
- Increase service capacity
- Increase Medicaid-enrolled providers
- Increase Medicaid billings for substance abuse disorders
- Increase the number of Medicaid reimbursable substance abuse services.

Intro slide #1

Objectives for Training

- Understand reimbursable Medicaid services
- Analyze previous Medicaid billing patterns
- Develop Medicaid revenue maximization strategies

Intro slide #2

Keys for a Successful Training

- Understand the Florida Medicaid System
- Be familiar with Medicaid Handbook
- Adjust pace, intensity, and content focus based on audience need
- Use examples – personalize the information
- Allow time for hands-on learning
- Acknowledge expertise in audience

Intro slide #3

AGENDA

- Overview – General Medicaid Rules
- Specific CBH Services & Requirements
- Revenue Max Strategies
- Discussions/Q&A

1

General Medicaid Guidelines

Reimbursement Information

- Units of Service
  - For services defined in 15-minute increments, The total of the units of service for the entire day must be entered on the claim form. For multiple units on the same day, total the actual time spent and round up to the nearest 15-minute increment.

2

General Medicaid Guidelines

Free Health Care

- Medicaid will not reimburse services for Medicaid recipients if non-Medicaid recipients are provided the same services free of charge

Billing for Missed Appointments

- Providers may not bill recipients for missed appointments.

3

General Medicaid Guidelines

Medicaid Payment is Payment in Full

- Provider who bills Medicaid must accept payment from Medicaid as payment in full. This does not include Medicaid copayments and coinsurance.
- A provider who fails to bill Medicaid correctly and in a timely manner may not bill the recipient.
- A provider who bills Medicaid for reimbursement of a Medicaid covered service may not:
  - Apply any money received from any non-Medicaid source to charges related to a claim paid by Medicaid.
  - Bill the recipient, relatives or any person acting as recipient's designated representative; or
  - Turn the account over to a collection agency (except in certain defined situations)

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General Medicaid Guidelines

Billing the recipient

- Prior to rendering a service, a provider must inform the recipient of his responsibility for the payment of any services received that are not covered by Medicaid. This must be documented in the medical record. Only services that are not listed in the Medicaid fee schedule in the handbook are non-covered services.
- Other than copayments/coinsurance, the provider cannot seek payment from a recipient for a compensable service for which a claim has been submitted, regardless of whether the claim has been approved, partially approved or denied except under the following circumstances:

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General Medicaid Guidelines

Billing the recipient (exceptions)

- Recipient is not Medicaid eligible on date of service or service is not covered by Medicaid
- Provider verifies recipient has exceeded the Medicaid limits or cap for service; Provider must inform recipient of this before rendering the service
- Recipient is enrolled in HMO, PSN or MediPass and has been informed that service has not been authorized by the HMO, PSN or MediPass PCP
- Recipient is enrolled in HMO or PSN and has been informed that the treating provider is not a member of the HMO or PSN Network.
- Provider has informed the recipient in advance that he/she does not accept Medicaid payment for the specific service to be rendered. Documentation must be in the medical record that recipient was informed and agreed to the service.

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General Medicaid Guidelines

Medicaid Copayment

- A copayment is a predetermined amount of money specified by Medicaid that the recipient pays to a provider.
- Services that require a Copayment:
  - Community Behavioral Health Services, per provider, per day = $2.00
- Recipients Exempt from Copayments:
  - Children under 21 years of age
  - Pregnant women when services relate to pregnancy or any medical condition that may complicate the pregnancy
  - Recipients who are enrolled in Medicaid HMOs

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General Medicaid Guidelines

Medicaid Copayment

- Recipients unable to pay
  - Provider cannot deny service to recipient based solely on the inability to pay a Medicaid copayment amount.
  - If recipient is unable to pay at the time services are rendered, the provider may bill the recipient for the unpaid charge.

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General Medicaid Guidelines

Third Party Liability

- TPL is the obligation of any entity other than Medicaid or the recipient to pay all or part of the cost of the recipient's medical care. If the recipient has other coverage through a TPL source, the provider must bill the TPL source prior to billing Medicaid.
- Providers must verify recipient eligibility prior to serving the recipient and verify TPL sources prior to billing Medicaid.

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General Medicaid Guidelines

Third Party Liability

- Medicaid is payer of last resort. If recipient has other insurance coverage through TPL source provider is responsible for exhausting TPL sources

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General Medicaid Guidelines

Exceptions to Medicaid Being Payer of Last Resort

- Federal funds from I.D.E.A., Part B or C;
- Victim's Compensation
- Programs funded through state and county funds such as CMS, DOH indigent drug programs, SAMH and Developmental disabilities programs funded by DCF, and Voc Rehab programs
- Funds from these programs may be accessed after Medicaid; A provider may bill Medicaid for a service prior to billing these programs.

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CBHS Provider Qualifications

- Current contract with DCF district program office for provision of community behavioral health services
- Employ or have under contract a Medicaid enrolled psychiatrist or other physician.
- Substance Abuse providers – must have a regular (not probationary or interim) license per F.S. 397

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CBHS Treating Practitioners

- Must be independently enrolled in Medicaid
- Treating physicians are enrolled as a provider type 25
- Treating licensed practitioners of the healing arts enroll as provider type 07 and must be affiliated with a group provider

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Clinical Record Requirements

- Evaluations/Assessment
- Copies of relevant reports or tests
- Service notes
- Documentation of service eligibility (if applicable)
- Current treatment plans, reviews and addenda

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Clinical Record Requirements

- Written description of face-to-face interview of recipient conducted by psychiatrist, physician, or licensed practitioner or master's CAP who conducted the interview
- Copies of all certification forms
- Doctor's orders and results of diagnostic and lab test, medication assessment, prescriptions, etc.

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General Documentation Requirements

Written documentation must be maintained to support each service for which Medicaid reimbursement is requested.

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General Documentation Requirements

- Service documentation must contain all of the following:
  - Recipient's name
  - Date service was rendered
  - Start and end times for services with minimum time frames and services billed on a per unit basis
  - Identification of the setting where service was rendered

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General Documentation Requirements

- Identification of problem, behavior, or skill deficit for which service is provided
- Identification of the service rendered, including the specific intervention
- Updates re: recipient's progress toward meeting goals on treatment plan
- Original, legible signature and credential or functional title of person rendering the service.

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Service Limits

- Service Limits are per recipient per state fiscal year.
- Exception – Treatment Plan Development is reimbursed once per provider per state fiscal year per recipient for a total of two per state fiscal year.

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Face-to face Interactions

Interactions must be face-to-face with the recipient in order to be eligible for reimbursement by Medicaid. Some exceptions are:

- Comprehensive medication services when providing review of records
- Therapeutic Behavioral On-Site services when provided family counseling or developing and monitoring the BH management plan
- Individual and Family Therapy services when assisting recipient's families and significant others in achieving treatment objectives.

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Assessment Requirements

- Before authorization of services, recipient must receive an assessment of mental status, functional capacity, strengths and service needs. ***A Brief Behavioral Health Status Exam or a Psychiatric Evaluation must be completed prior to the development of the Treatment Plan.***

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Assessment Requirements

General Documentation Requirements for Assessments

- Individual rendering the service must sign and date a report or progress note of the assessment
- Documentation is part of all assessment services and the recipient need not be present during the documentation
- Written report of evaluation and testing results must be done by the individual rendering the service and be included in the medical record for all evaluation and testing services.

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Evaluation and Assessments Service Codes

- ***Psychiatric Evaluation by physician – H2000HP*** or ***Psychiatric Evaluation by non-physician – H2000HO***

See description of service for details of what should be in documentation and refer to general requirements for assessments.

- ***Brief Behavioral Health Status – H2010HO*** Documentation must include the purpose of the exam, setting, mental status of recipient, findings and plan

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Evaluation and Assessments Service Codes

- ***Psychiatric Review of Records – H2000*** May be documented in report format or by a progress note in the record. Sole use of checklists or fill in the blank forms is not allowed.

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Evaluation and Assessments Service Codes

- ***In-Depth Assessment – H0001HO, H0001TS (substance abuse)*** Must include an integrated summary written to evaluate, integrate and interpret information collected. There is eligibility criteria for recipients who may receive the service:
  - Recipients with a need for higher level of treatment beyond outpatient;
  - Recipients identified as high risk;
  - Recipients receiving intensive services for 6 months or longer and there is lack of significant progress; or
  - Recipients identified through the UM process as being high risk or high utilizers.

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Evaluation and Assessments Service Codes

- ***Bio-psychosocial Evaluation – H0001HN (substance abuse)***
  Evaluation must be reviewed, signed and dated by a master's level practitioner or bachelor's level CAP prior to completion of the treatment planning process. Review must include clinical impressions, provisional diagnosis and statement by the review that indicates concurrence or alternative recommendations

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Evaluation and Assessments Service Codes

- ***Psychological Testing – H2019***
  Requires a written report of evaluation and testing results by the individual who rendered the service in the medical record.
- ***Limited Functional Assessment – H0001 (substance abuse)***
  A copy of the assessment must be placed in the record. This service does not require authorization in the treatment plan.

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Treatment Plan Requirements

A Brief Behavioral Health Status Exam or a Psychiatric Evaluation must be completed prior to the development of the Treatment Plan.

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Treatment Plan Requirements

Treatment Plan Development – T1007 (substance abuse)

- Required Components:
  - ICD-9 CM diagnosis code
  - Goals appropriate to diagnosis, age, culture, strengths, abilities, preferences and needs
  - Measurable objectives and target dates
  - List of services to be provided (TP Development, TP Review, Comp BH Assessment and Limited Fx. Assessment need not be listed)

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Treatment Plan Requirements

- Required Components (cont.):
  - Amount, frequency and duration of each service for the 6 month duration of the plan
  - NOT permissible – “as needed”, “PRN” or “x to y times per week”
  - Signature of recipient, parent/guardian or legal custodian (if under age 18), and signatures of treatment team members who develop the plan
  - Signed statement by treating practitioner that services are medically necessary and appropriate
  - Transition or discontinuation of services

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Treatment Plan Requirements

- **Authorization and Effective Date of Plan**
  - Treatment plan is effective the date it is authorized (signed & dated) by the treating practitioner
  - Medicaid will reimburse services 45 days prior to the authorization date.
- **Addenda**
  - May be used to make changes to the plan – becomes part of the treatment plan – must be signed and dated by the treating practitioner and recipient.
  - *NOT REIMBURSABLE*

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Limited Service Authorization

- Used for Temporary deviation from the treatment plan
- Also used for documenting the need for services already provided when a recipient leaves treatment prior to completion of the plan.
- Must be completed within 45 days of intake and placed in medical record.

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Treatment Plan Review – T1007TS

- Must be conducted at least every six months; may be more frequently if significant changes occur.
- Documentation must include:
  - Activities, notations of discussions, findings, conclusions and recommendations that result from the review.
  - Modifications or additions to the plan;
  - If there are goals/objectives that have not been met, include tx. team's re-assessment of services & justification if no change in services are made
  - Signature, certification, date by the treating physician or treating licensed practitioner
  - Signature and date of recipient and parent/legal guardian (if under age 18)

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BREAK

Medical and Psychiatric Services

Medication Management – T1015

Brief Individual Medical Psychotherapy - H2010HF (substance abuse)

- Specific Documentation Requirements
  - Results of the assessment, findings and plan must be in the record

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Medical and Psychiatric Services

Group Medical Therapy – H2010HQ

- Specific Documentation Requirements
  - **Must include:**
    - Group topic
    - Assessment of the group
    - Level of participation
    - Findings
    - Plan

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Medical and Psychiatric Services

Behavioral Health Screening – T1023HF

- Specific Documentation Requirements
  - The assessment must minimally include:
    - Vital signs
    - Medication concerns including side effects
    - Brief mental status assessment and
    - Plan for follow-up

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Medical and Psychiatric Services

Behavioral Health Services – Verbal interaction – H0047

Behavioral Health Services – Specimen Collection – T1015HF

- Specific Documentation Requirements
  - Service must be directly related to behavioral health disorder or to monitoring side effects associated with medication
  - Must describe the need and the recipient's interaction

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Medical and Psychiatric Services

Methadone Administration H0020

- Specific Documentation Requirements
  - Documentation that complies with state and federal regulations must be in the medical record

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Behavioral Health Therapy Services

Individual and Family Therapy H2019HR
Group Therapy H2019HQ

- Specific Documentation Requirements

  Documentation for each service must include:
  - Topic
  - Assessment of recipient
  - Level of participation
  - Findings
  - Plan

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Behavioral Health Therapy Services

Requires Prior Authorization

Behavioral Health Day Services H2012HF (substance abuse)

Specific Documentation Requirements

At least a weekly summary progress note with the following components:

- Exact dates and times of attendance
- Description of the clinical services, including length of time of each service and the name & credentials of the rendering practitioner
- The recipient's response to services
- A focus on measurable outcomes and overall progress toward treatment goals

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Community Support and Rehabilitative Services

Requires Prior Authorization

Psychosocial Rehabilitation Services H2017

- Specific Documentation Requirements
  - Daily service note that describes activities provided by counselor
  - Description of how services enhanced/support the recipient's skills of daily medication use, independent living and social skills, housing, pre-vocational and transitional employment training, social support and networking, food planning, money and life management
  - Monthly progress note that reflects how services are linked to goals and objectives of treatment plan and describes progress relative to the plan

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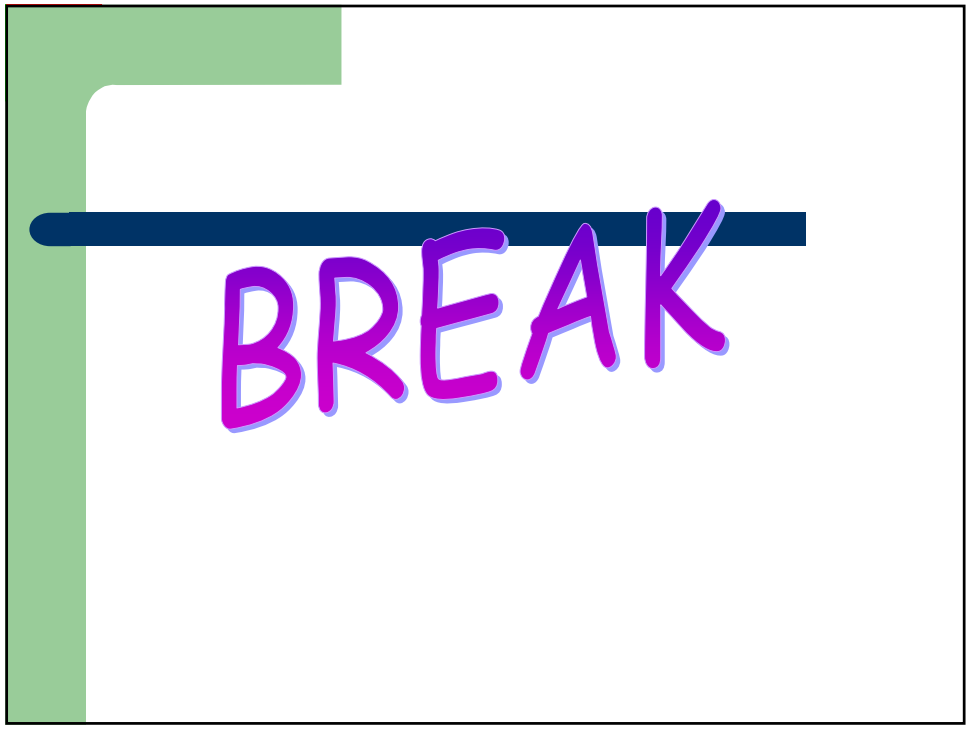

Central Florida Behavioral Health Network, Inc.

Therapeutic Behavioral On-Site Services for Children & Adolescents

Requires Prior Authorization

TBOS Services – Therapy H2019HO

TBOS Services – Behavior Management H2019HM

- May not be billed for services provided to a group of recipients

If more than 9 hours services billed in one month, an exception to the limit request is required REGARDLESS of provider's exemption status

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Therapeutic Behavioral On-Site Services for Children & Adolescents

TBOS Services – Therapeutic Support H2019HN

Specific Agency requirements include:

- Provider must be able to recruit qualified practitioners
- Must have adequate administrative ability to assure availability
- Must assure adequate staff pre-service and in-service training and appropriate supervision

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Therapeutic Behavioral On-Site Services for Children & Adolescents

TBOS Services – Therapeutic Support H2019HN (cont)

- Provider must maintain the following documentation related to practitioners:
  - Clinical supervision
  - Practitioners' experience treating children with SED or SA Disorders
  - Practitioners' capabilities to provide appropriate service for the population
  - Practitioners' demonstrated skills and abilities to deliver rehab services to the population being served

Practitioners may not be relatives of the recipient

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Therapeutic Behavioral On-Site Services for Children & Adolescents

TBOS Services – Therapeutic Support H2019HN (cont)

Special Documentation requirements for Therapeutic Support Services

- Must include the following:
- Description of the intervention
- How the intervention addresses the progress toward tx plan goals/objectives
- How the child responded to the intervention

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Therapeutic Behavioral On-Site Services for Children & Adolescents

Additional Documentation Requirements for all TBOS Services

- Assessments and treatment plans must meet all requirements in Chapter 2, Section 1 and must address the need for individual and family therapy, behavior management and therapeutic support services
- Plan must include the frequency and duration for all services as well as the person or agency responsible for delivering the services

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Therapeutic Behavioral On-Site Services for Children & Adolescents

Additional Documentation Requirements for all TBOS Services (cont)

- If any component of TBOS services is provided by a different agency, the plan must include the name of the agency
- The plan and progress notes must reflect ongoing coordination with the other agency for provision of services to the same child
- The treatment plan must include a specific schedule for review of the plan with the child and family, others on the treatment team and other agencies providing services

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Therapeutic Behavioral On-Site Services for Children & Adolescents

Eligibility Criteria

- Documentation must be present in the medical record indicating that the child meets all of the following criteria:
- Has an ICD-9-CM diagnosis in the following range: 294.8, 294.9, 300 through 305.9, 307.1, 307.23, 307.5 through 307.7, 308.0 through 312.4, 312.81 through 314.9; and
- Is enrolled in a special education program for the seriously emotionally disturbed (SED) or the emotionally handicapped; or
- Has scored a 60 or below on the Axis V Children's Global Assessment of Functioning Scale within the last 6 months

OR

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Therapeutic Behavioral On-Site Services for Children & Adolescents

Eligibility Criteria (cont)

- Has an ICD-9-CM diagnosis of 295 through 298.9 or 303.0 through 305.9; and, prior to receipt of services, a licensed practitioner of the healing arts experienced in the diagnosis of behavioral health disorders documents that:
- The child or adolescent meets the criteria defined above;
- There is adequate evidence to indicate that the child or adolescent is at risk for a more intensive, restrictive costly behavioral health placement; and
- There is adequate evidence to indicate that the child's or adolescent's condition and functional level cannot be improved with a less intensive service such as individual or family therapy or group therapy

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Therapeutic Behavioral On-Site Services for Children & Adolescents

Continued Eligibility for Services

- Within six months of the original determination of eligibility for services and every six months thereafter, treatment team must document that the child continues to meet the eligibility criteria stated above. Services may be authorized for less than six months

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Therapeutic Behavioral On-Site Services for Children & Adolescents

Discharge Criteria

- Within 45 days of admission to TBOS services, a plan must be developed which contains specific discharge criteria. The discharge plan must be in clinical record.
- If the recipient is found to no longer meet eligibility criteria, services are not Medicaid reimbursable

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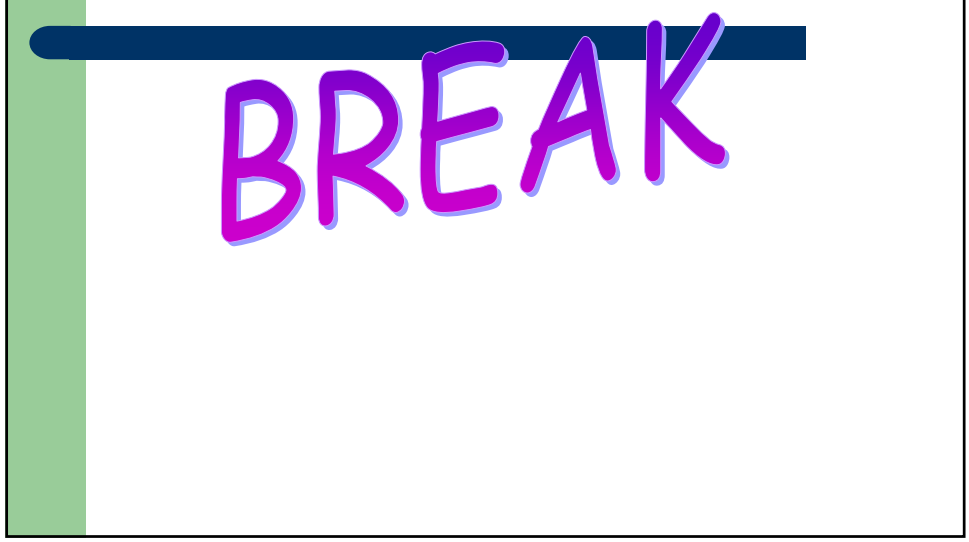

Medicaid Rev Max

- Identification of Funding
- Licensure & Medicaid Services
- Episodes of Care
- Identification of Opportunities

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Identify Funding Sources & Verify Eligibility

MULTI-SYSTEM FUNDING FOR BEHAVIORAL HEALTH SERVICES

	Medicaid/ Insurance	TANF	County	DCF/SAMH	DCF/Family Safety or CBC
Payment Mechanism	FFS or Capitation (HMO/ PMHP)	UOS	Contract	UOS/Rate Agree-ment	UOS
Priority	1	2	3	4	5

- Medicaid/Insurance
  - Managed Care Enrollment
  - Prior authorization issues

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Medicaid Covered Services Required by SA Licensure

DCF Substance Abuse Licensure rules require that client records include assessment, treatment plan, treatment plan reviews and progress notes

Documentation	Licensure Time frame	Medicaid Regs
Assessment	OP - 30 days	Must be completed prior to development of Tx. Plan
	Day/Night - 10 days	
	Med/Meth - 15 days	
Treatment Plans	OP - 30 days	Must be completed within 45 days of services
	Day/Night - 10 days	
	Med/Meth - 30 days	
Treatment Plan Reviews	OP, Day/Night - q 30 days	Reimbursable 4x per FY - Required at least q 6 mos
	Med/Meth - q 90 days x1yr then q 6 months	
Progress Notes	Day/Night - weekly	Weekly for Day Tx.; Per service event for all others
	OP - weekly or freq of sessions	
	Med/Meth - freq of sessions	

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DCF Licensure related to Medicaid

DCF/SAMH Definitions

Clinical Services - **screening**, **assessment**, placement, **treatment planning**, **counseling**, and case management
Clinical Staff - Employees of a provider who are responsible for providing clinical services
Counseling - the process of engaging a client in a discussion of issues associated with the client's substance abuse and associated problems to work toward a constructive resolution of those problems and toward recovery.
Counselor - a member of the clinical staff who conducts and documents services such as **counseling**, psycho-educational groups, **psychosocial assessment**, **treatment planning** and case management
Progress Notes - **documentation of progress or lack thereof toward meeting treatment plan objectives and that addresses the provision of services, the client's response to services** and significant events.

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DCF Licensure related to Medicaid

Service/Program Descriptions

Psychosocial Assessment - a series of evaluative measures designed to identify the behavioral and social factors involved in substance abuse and its symptoms and is used in the determination of placement and development of the treatment plan.
Treatment Plan - an individualized written plan of action that directs all treatment services and is based upon information from the assessment and input from the client served; Establishes goals and measurable objectives, time frames for completing objectives, and the type and frequency of services to be provided.
Day or Night Treatment - Services may include **individual/family/group counseling**, SA education, **life skills training**, training or advising in health/medical issues, **mental health services related to managing stable disorders, evaluating needs for in-depth mental health assessments, or symptom management**; at least three hours per day and at least 12 hours each week

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DCF Licensure related to Medicaid

Service/Program Descriptions

Intensive Outpatient Treatment - Structured services each day that may include ancillary **psychiatric and medical services**, **individual/family/group counseling**, SA education, **life skills training**, training or advising in health/medical issues, **mental health services related to managing stable disorders, evaluating needs for in-depth mental health assessments, or symptom management**
Outpatient Treatment - Weekly services that minimally include one counseling session but may also include **individual/family/group counseling** or SA education services

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Reimbursable Services by Episode of Care

Outpatient Episode of Care (6 months) per client - Indiv, Med Mgmt, Drug Screens					
Service	**Code**	**UOS**	**Rate**	**Total Revenue**	**% Total**
Alcohol/Drug Assessment	H0001HN	1	$ 48.00	$ 48.00	1.80%
Treatment Plan Dev.	T1007	1	$ 97.00	$ 97.00	3.64%
Individual/Family Therapy	H2019HR	96	$ 18.33	$ 1,759.68	66.11%
Treatment Plan Review	T1007TS	2	$ 48.50	$ 97.00	3.64%
Limited Func. Assess	H0001	2	$ 15.00	$ 30.00	1.13%
Psychiatric Eval.	H2000HP	1	$ 210.00	$ 210.00	7.89%
Medication Management	T1015	6	$ 60.00	$ 360.00	13.53%
Clinic visit	T1015HF	6	$ 10.00	$ 60.00	2.25%
				$ 2,661.68	

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Reimbursable Services by Episode of Care

Outpatient Episode of Care (6 months) per client - Group, Med Mgmt, Drug Screens					
Service	**Code**	**UOS**	**Rate**	**Total Revenue**	**% Total**
Alcohol/Drug Assessment	H0001HN	1	$ 48.00	$ 48.00	3.11%
Treatment Plan Dev.	T1007	1	$ 97.00	$ 97.00	6.29%
Group Therapy	H2019HQ	96	$ 6.67	$ 640.32	41.52%
Treatment Plan Review	T1007TS	2	$ 48.50	$ 97.00	6.29%
Limited Func. Assess	H0001	2	$ 15.00	$ 30.00	1.95%
Psychiatric Eval.	H2000HP	1	$ 210.00	$ 210.00	13.62%
Medication Management	T1015	6	$ 60.00	$ 360.00	23.34%
Clinic visit	T1015HF	6	$ 10.00	$ 60.00	3.89%
				$ 1,542.32	

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Reimbursable Services by Episode of Care

Rehab Episode of Care (6 months) per client - DTX (4hrs/wk), Med Mgmt, Drug Screens					
Service	**Code**	**UOS**	**Rate**	**Total Revenue**	**% Total**
Alcohol/Drug Assessment	H0001HN	1	$ 48.00	$ 48.00	0.83%
Treatment Plan Dev.	T1007	1	$ 97.00	$ 97.00	1.67%
Substance Abuse Day Tx.	H2012HF	104	$ 12.50	$ 1,300.00	56.67%
Treatment Plan Review	T1007TS	3	$ 48.50	$ 145.50	2.51%
Limited Func. Assess	H0001	2	$ 15.00	$ 30.00	0.52%
Psychiatric Eval.	H2000HP	1	$ 210.00	$ 210.00	3.62%
BH Screening/substance abuse	T1023HF	1	$ 43.62	$ 43.62	0.75%
Medication Management	T1015	6	$ 60.00	$ 360.00	6.21%
Clinic visit	T1015HF	6	$ 10.00	$ 60.00	1.04%
				$ 2,294.12	

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Reimbursable Services by Episode of Care

Rehab Episode of Care (6 months) per client - BLS/SRC (2hrs/wk), Med Mgmt, Drug Screens					
Service	**Code**	**UOS**	**Rate**	**Total Revenue**	**% Total**
Alcohol/Drug Assessment	H0001HN	1	$ 48.00	$ 48.00	1.76%
Treatment Plan Dev.	T1007	1	$ 97.00	$ 97.00	3.56%
Living skills/Rehab Counseling	H2017	192	$ 9.00	$ 1,728.00	63.48%
Treatment Plan Review	T1007TS	3	$ 48.50	$ 145.50	5.35%
Limited Func. Assess	H0001	2	$ 15.00	$ 30.00	1.10%
Psychiatric Eval.	H2000HP	1	$ 210.00	$ 210.00	7.71%
BH Screening/substance abuse	T1023HF	1	$ 43.62	$ 43.62	1.60%
Medication Management	T1015	6	$ 60.00	$ 360.00	13.22%
Clinic visit	T1015HF	6	$ 10.00	$ 60.00	2.20%
				$ 2,722.12	

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Reimbursable Services by Episode of Care

Child Episode of Care (6 months) per client - TBOS (1.5hr/wk), Family Tpy, Med Mgmt, Drug Screens

Service	Code	UOS	Rate	Total Rev	% Total
Alcohol/Drug Assessment (In-depth)	H0001HO	1	$ 125.00	$ 125.00	3.69%
Treatment Plan Dev.	T1007	1	$ 97.00	$ 97.00	2.86%
Ther. Beh. On-Site (therapy)	H2019HO	72	$ 16.00	$ 1,152.00	33.97%
Ther. Beh. On-Site (support)	H2019HN	72	$ 4.00	$ 288.00	8.49%
Individual/Family Therapy	H2019HR	48	$ 18.33	$ 879.84	25.95%
Treatment Plan Review	T1007TS	3	$ 48.50	$ 145.50	4.29%
Limited Func. Assess	H0001	2	$ 15.00	$ 30.00	0.88%
Psychiatric Eval.	H2000HP	1	$ 210.00	$ 210.00	6.19%
BH Screening/substance abuse	T1023HF	1	$ 43.62	$ 43.62	1.29%
Medication Management	T1015	6	$ 60.00	$ 360.00	10.62%
Clinic visit	T1015HF	6	$ 10.00	$ 60.00	1.77%
				$ 3,390.96	

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Potential Medicaid Revenue by Level of Care

Level of Care	# Clients	6 month Reimb Amt.	Total Revenue
OP Indiv	**20**	**$2,661.68**	**$53,233.60**
OP Group	**20**	**$1,542.32**	**$30,846.40**
Rehab-DTX	**20**	**$2,294.12**	**$45,882.40**
Rehab-BLS	**20**	**$2,722.12**	**$54,442.40**
Child	**20**	**$3,390.96**	**$67,819.20**
			$252,224.00

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Central Florida Behavioral Health Network, Inc.

Rev Max Opportunities

- Review provider data
- Identify billing patterns
- Look for opportunities missed
- Discussions/Q&A

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Training Manual

Facilitator Notes	Outline
	Introduction to Florida Medicaid RWJ Project: Medicaid billings for services related to substance use disorders are extremely low within Florida. In an effort to respond, AHCA/DCF/FADAA applied for a Robert Wood Johnson (RWJ) Grant to address issues related to increasing Florida's utilization of federal funds for treating these disorders. Florida Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged and disables people with the costs of nursing facility care and other medical expenses. Eligibility for Medicaid is usually based on the family's or individual's income or assets. Medicaid serves approximately 2.3 million people in Florida, with over half of those being children and adolescents under the age of 21. It important to have a basic understanding of the Florida Medicaid program before conducting this training. ***NOTE:*** *Refer the attendees to the Florida Medicaid Summary of Services FY 2004 – 2005 that is available at the AHCA website at www.myflorida.com.*
	Introductory Discussion: **Ask** attendees to discuss their work role and experiences in working with Medicaid. **Facilitate** a discussion about core activities related to Medicaid billing.
Pre-Test Questionnaire	**Ask** the attendees to complete the Pre-Test questionnaire. They will complete this same questionnaire at the conclusion to determine the knowledge gained from participating in the training.
Introductory Slide 1: Goals	**I. Goals of Florida's RWJ Initiative:** • Increase access to care, • Increase service capacity, • Increase Medicaid-enrolled providers, • Increase Medicaid billings for SA disorders, and • Increase the number of Medicaid reimbursable SA services.
Introductory Slide 2: Objectives	**Objectives of Training** This training is designed to assist providers in achieving the following objectives: a) Understand the reimbursable Medicaid services available within the Community Behavioral Health Services Handbook.

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Introductory Slide 3: Keys to a Successful Training Session	b) Analyze previous Medicaid billing patterns. c) Develop Medicaid revenue maximization strategies. **Keys to a Successful Training Session** • Make sure that you have a basic understanding of the Florida Medicaid system • You should be familiar with the codes in the Medicaid Handbook and with Medicaid billing processes. • Adjust the pace, intensity, and content focus of the training based on the needs of the provider agencies. • Good presentations involve more than just reading the slides. Prepare examples to highlight important points. Use personal experiences and anecdotes to bring life into the session. Ask for examples from the audience whenever you need to personalize the information. • Be sure to allot sufficient time for the exercises at the end of the session. People learn the most when they have the opportunity to apply the information in a "hands on" experience. • Always respect and acknowledge the expertise in the audience. Give participants the opportunity to suggest successful strategies. **Ask:** What would you most like to gain from this training session? ***NOTE:*** *Take about 5 minutes to discuss the expectations that the attendees bring to the session. Clarify those things that can and cannot be addressed as part of this training. If you identify expectations that cannot be addressed, be sure to write them down and to refer individuals to sources that can be of assistance.*
Distribute Handouts	Briefly review all handouts that are available for this training session. Make sure everyone has a copy of each handout. Give a brief explanation for each as listed below. The handouts are: • PowerPoint Presentation Handout o This is a copy of all the slides the trainer will be presenting. • Medicaid Community Behavioral Health (CBH) Services for SA Diagnosis Summary o A brief "reader's digest" version of the services listed in the handbook • Medicaid CBH Reimbursement Limitations Matrix o A useful tool especially for billing staff to identify which services cannot be billed on the same date. • Medicaid Billable Units Chart

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	○ A tool to use as a shortcut for determining how many units to bill for services provided within one day • Medicaid Revenue Max Exercise ○ This tool will be used at the end of the session to help providers analyze current billing patterns and identify areas for improvement.
Slide 1 – Agenda	**II. Review the Agenda** **1) Overview – General Medicaid Rules** These rules are applicable to all Medicaid enrolled providers. The trainer should be familiar with the guidelines found in the General Medicaid Provider Handbook. The providers must be compliant with the General handbook as well as the handbook that applies to the specific provider type in which they are enrolled. **2) Specific CBH Services and Requirements** Each service available within the CBHS Handbook for reimbursement to SA providers will be reviewed along with limitations, staffing requirements and specific documentation requirements. **3) Revenue Max Strategies** There will be a review of different episodes of care as well as an analysis of previous billing patterns. Providers will be assisted in identifying areas where they "missed" out on billing for services and developing a specific strategy for increasing Medicaid billings within their own agency. **4) Discussions/Q&A** Questions should be encouraged throughout the training as this is a more effective method than making people wait until the end of a presentation. Any questions that cannot be answered should be researched after the training and the answer then provided to the interested parties as soon as possible.
Slides 2 thru 11 – General Medicaid Guidelines	**III. Review of General Medicaid Guidelines** ***NOTE:*** *For each of the following topics, the trainer should be familiar with the Medicaid rules found in the General Provider Handbook and should explain these rules for the providers. Pages to focus on are listed next to each topic.* **1) Units of Service** (CBHS Handbook-pg.3-2) **2) Free Health Care** (GP Handbook-pg. 1-4) **3) Billing for Missed Appointments** (GP-pg. 1-4) **4) Medicaid Payment is Payment in Full** (GP-pg. 1-5) **5) Billing the recipient** (GP-pgs. 1-5, 1-6) **6) Copayments** (GP-pgs. 1-7, 1-9) **7) Third Party Liability** (GP-pgs. 1-9 thru 1-12) **8) Exceptions to Payer of Last Resort** (GP-pg. 1-11)

Facilitator Notes	Outline
Slides 12 & 13 – CBHS Provider Qualifications	**IV. Review of specific Provider Qualifications** The CBHS Handbook lists specific qualifications that providers must meet to be enrolled as a Medicaid CBHS provider. Focus on the following items for SA providers: • Current contract with DCF for provision of CBH services ***NOTE:*** *This does not say that the contract has to match the services that the provider is billing to Medicaid – it simply says the provider has to have a current contract with the department for the provision of community behavioral health services.* • Employ or have under contract a Medicaid enrolled psychiatrist or other physician • Substance abuse providers MUST have a regular (not probationary or interim) license to provide substance abuse services ***NOTE:*** *The Medicaid requirement is generic – i.e., it does not say it has to be a Treatment license or an Intervention License or a Prevention license, etc. – Just a license under F.S. 397* • Treating licensed practitioners must enroll independently as a provider type 07 and must have their number affiliated with the provider's group number. • Treating licensed practitioners are the individuals who are qualified to sign off on treatment plans – Their provider number must be used on claim forms for reimbursement of services. • Providers must discontinue using an individual practitioner's number on claims if the individual is no longer employed with them.
Slides 14 – 15: Clinical Record Requirements	**V. Review Medicaid requirements for Clinical Records** Review the Medicaid specific documentation requirements for what must be kept in a Clinical Record on page 2-1-2 of the CBHS Handbook. ***NOTE:*** *There may be questions about the requirement of face-to-face interview documentation. At one point in time Medicaid agreed that they would drop this requirement, however – they were not able to do so and this continues to be a requirement.*
Slides 16 – 18: General Documentation Requirements	**VI. Review of Medicaid's requirements for ALL services reimbursed** Written documentation MUST be maintained in the clinical record to adequately support each service for which the provider is reimbursed. Review the list of what service documentation must include that is present on page 2-1-2 of the CBHS Handbook. Specifically emphasize that the provider must adequately document a description of the service rendered which includes specific

Facilitator Notes	Outline
	interventions. Medicaid is interested in what the "counselor, therapist, doctor" rendered – i.e., what was the staff activity involved in provision of this service? Did they assist the recipient in some treatment-related activity such as completing an exercise, worksheet or other activity related to a goal on the treatment plan? Specific interventions provided will be the focus of any outside review of the documentation. Medicaid still requires original, legible signatures and credentials – electronic signatures have NOT been approved for CBHS Providers (yet).
Slides 19-20: General Information about CBH Services	**VII. Review of Service Limits and Face-to-face requirements** Service limits that are stated in the CBHS Handbook reflect limits per recipient per state fiscal year. There is one exception to this rule, which is Treatment Plan Development – reimbursed once per provider per state fiscal year per recipient with a total limit of two per state fiscal year. ***NOTE:*** *The only method available to providers for determining if the recipient has met their limits for the year is to bill for the service and wait to see if the claim is paid or denied – If the limit has been met the claim will be denied and an EOB (Explanation of Benefits) denial code that states limit has been met will be issued. Once the recipient has exhausted their annual Medicaid limits the provider can then pursue the use of other funding sources such as General Revenue, county funds, TANF, etc. (if the recipient is eligible for use of any other funds).* Medicaid requires that services provided under the CBHS program be face-to-face with the recipient in order for the services to be considered reimbursable. There are some exceptions to this rule as well, which are: • Medication services when providing review of records *(When the doctor is reviewing previous treatment records, the recipient does not need to be present for this service to be billed to Medicaid)* • Therapeutic Behavioral On-Site services when providing family counseling or developing and monitoring the BH Management plan *(Family counseling done without the recipient present must still be focused on treatment plan goals and issues related to the recipient's needs – make sure documentation reflects this)* • Individual and Family Therapy services when assisting the recipient's family or significant others in achieving treatment objectives *(Again, make sure documentation reflects that the service is related to the recipient's treatment plan)*

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Slides 21 – 22: Assessment Requirements	**VIII. Review of General Requirements for Assessments** Medicaid lists some general requirements for all Medicaid reimbursable assessments. Requirements are related to documentation that must be present as well as time frame for completion of an assessment. • BEFORE authorization of services, recipient must receive an assessment of mental status, functional capacity, strengths and service needs. • Medicaid policy states that provision of either a Brief Behavioral Health Status Exam or a Psychiatric Evaluation meets this requirement. ***NOTE:*** *"Authorization of services" refers to the Treatment Plan. Medicaid considers the treatment plan to be the authorization of services; therefore the assessment must be completed BEFORE the treatment plan.* General documentation requirements for all assessments include: • The individual rendering the service must sign and date the documentation of the assessment • Time spent preparing the documentation of the assessment is part of all assessment services and the recipient does not need to be present during this time • A written report of testing results must be done by the individual rendering the service
Slides 23 – 27: Specific Evaluation and Assessment Service Codes	**IX. Review of the CBHS Service codes for Assessments** This section begins the review of specific requirements for providing Medicaid-reimbursable services under each designated code. Each code lists a specific description of the service, details of specific documentation requirements, levels of staff qualified to provide the service, reimbursement limitations, eligibility requirements for recipients who may receive the service and sometimes specific other limits or restrictions on the service. ***NOTE:*** *Even though some service codes list specific documentation requirements, Medicaid policy states on page 2-1-2 some general documentation requirements that are required of all services billed. Emphasize to providers that their documentation must comply with the general requirements on page 2-1-2 AND the specific documentation requirements listed under each service code in order to comply with policy and pass any external audit.* **Service Codes Reviewed:** Review each code and emphasize any specific requirements that are noted in the handbook.

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	• Psychiatric Evaluation by physician or non-physician There are two different modifiers for this code – one for the service if done by a physician and one if done by a non-physician. The description in the handbook indicates that the service by physician can be provided by a psychiatrist, other physician or psychiatric ARNP. Appendix P of the Handbook states the description of the non-physician code as provided by a masters degree level staff. • Brief Behavioral Health Status Exam – NEW Service Includes specific documentation requirements and is billed in 15 minute increments. Must be provided by a licensed practitioner or Master's level CAP. • Psychiatric Review of Records Medicaid requires documentation of this event to be in a report format or progress note. The use of checklists is generally not allowed, especially if not accompanied by some type of narrative note. • In-Depth Assessment There are specific eligibility criteria for recipients who may receive this service. The bulleted list in the handbook reflects that a recipient must meet ONE (not ALL) of the four criteria detailed. • Bio-Psychosocial Evaluation The description of this service states that it must be reviewed, signed and dated by a master's level practitioner or Bachelor's level CAP prior to completion of the treatment plan. If a staff of this level provides the service, it does not require that another practitioner of this level complete a separate review as long as all the documentation requirements are present. ***NOTE:*** *Some providers have stated that AHCA staff told them during a training that this service could be provided to meet the requirement of an assessment being completed prior to the development of the treatment plan. However, Medicaid policy in the handbook specifically states that a Brief Behavioral Health Status Exam or a Psychiatric Evaluation must be done to meet this requirement. Encourage the providers to follow Medicaid policy as it is written in the handbook or policy updates that are issued by AHCA – these are the documents that the external reviewers will use in determining compliance with policy.* • Psychological Testing Per AHCA – The assessor or individual completing the psychological test must be a licensed psychologist who is

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	trained in specific areas of testing. An LMHC can assist the licensed psychologist with providing objective data; however, the licensed psychologist MUST conduct the actual test and compose the summary. A licensed psychologist should supervise the LMHC. Major change from previous handbook – billed in 15-minute increments. • Limited Functional Assessment The only documentation required to justify this service is the assessment form used. The functional assessments approved for use in documenting this service are: MCAS, FARS, C-FARS and the ASAM. The service does NOT have to be included on the treatment plan.
Slides 28-33: Treatment Planning	**X. Review of Medicaid Treatment Plan Requirements** This section includes the review of requirements for two services – Treatment Plan Development and Treatment Plan Review. ***NOTE:*** *It is at this point in the presentation that questions or issues related to co-occurring disorders usually arise. AHCA allows only one diagnosis code to be submitted on claim forms, therefore if an individual is diagnosed with both a mental health and a substance use disorder, the provider must choose which diagnosis and corresponding procedure code to submit. Current treatment philosophy for co-occurring disorders states that both diagnoses are primary and treatment should be integrated to address both issues. For Medicaid purposes, providers will need to choose a primary diagnosis when billing for the Development of the Treatment Plan and Treatment Plan Reviews. For other services, providers should use the diagnosis code that most accurately reflects which diagnosis the service addressed and assure that the documentation accurately reflects what was billed.* • Emphasize again to providers that one of the two required assessments must be completed before the development of the treatment plan. • Review the required components of the treatment plan on page 2-1-15 of the handbook. • The treatment plan effective date is the date that it is authorized (signed and dated) by the treating practitioner. This is the date that should be billed. • Services are considered reimbursable 45 days prior to the authorization date ***Note:*** *Illustrate this to providers by the following:* *If the provider admitted an individual to treatment on January 1st, provided services beginning Jan. 5th , but did not*

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	complete and authorize the treatment plan until March 20th, services provided prior to Feb. 3rd are not covered on the treatment plan and are therefore not reimbursable. (45 days from Jan. 5th is Feb. 19th) • An addendum may be used to make changes to the plan but this is not reimbursable. ***Recommendation:*** *If significant events have occurred that require changes in the treatment plan, complete a Treatment Plan Review and document appropriately so that reimbursement is allowed.* • Limited Service Authorization – can be used for temporary deviation from the treatment plan. ***Example:*** *Treatment plan has group therapy authorized but a stressful event has occurred that warrants the provision of individual therapy for a short period of time.* • The limited service authorization is also appropriately used for documenting services already provided to an individual when the recipient leaves treatment prior to completion of a treatment plan *(before the 45 day period expires)*. ***Example:*** *Individual is admitted for treatment on March 1st, receives 3 group therapy sessions and voluntarily drops out of treatment as of March 28th. Complete a Limited Service Authorization form by April 14th to cover the services provided – this is in lieu of completion of the Treatment Plan.* • Treatment Plan Reviews – required at least every six months Review specific documentation requirements Focus on the fact that Medicaid expects to see documentation of the activities that occurred during the review, such as discussions, conclusions and recommendations from the treatment team regarding the status of goals/objectives on the plan. Also, if there are goals that have not been met or no progress is being made, the team should re-assess the services being provided and give rationale for continuing them on the plan if no change in services are made **BREAK**
Slides 34 – 38: Medical and Psychiatric Services	**XI. Review of specific requirements for Medical/Psychiatric Service Codes**

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	Generally these are services that are rendered by medical staff such as psychiatrists, other physicians and nurses. Each service description in the handbook (pages 2-1-19 through 2-1-24) includes specific intervention definitions and documentation requirements. Some of the services have reimbursement limitations and group size restrictions. ***NOTE:*** *Since most of these services will be provided by medical personnel and those individuals will most likely NOT be part of the training event audience, remind providers that it is their responsibility to make sure that the doctors/nurses are aware of the documentation requirements and that all documentation meet Medicaid criteria for reimbursement. A good suggestion may be that the providers' Medical records department or QI department create "cheat sheets" for the medical staff to assure adequate documentation.* **Ask:** How do you ensure that doctors/nurses are aware of documentation requirements and that they are meeting Medicaid criteria for reimbursement? **Facilitate** a brief discussion. Review the following: • Medication Management • Brief Individual Medical Psychotherapy – billed in 15-minute increments. • Group Medical Therapy – includes specific documentation content requirements an a limitation on size of the group; billed in 15 minute increments • Behavioral Health Screening This service may the appropriate one to use in lieu of the "old" Office Visit code (which has been deleted). Make sure the documentation includes the minimum requirements listed • Behavioral Health Services – Verbal Interaction • Behavioral Health Services – Specimen Collection ***Note:*** *These two codes (BH Services – Verbal Interaction and Specimen Collection) were created out of the old "clinic visit" code. There are specific documentation requirements for each and a vague description of the level of staff that must provide.* • Methadone Administration – NEW Service Code The specific documentation requirements refer only to compliance with state and federal regulations. If a provider is licensed to provide Methadone Administration services, they should be in compliance with those regulations and therefore in compliance with Medicaid requirements.

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Slides 39 – 40: Behavioral Health Therapy Services	**XII. Review of requirements for Behavioral Health Therapy Services** These services include Individual/Family Therapy, Group Therapy and Behavioral Health Day Services. The way that these services are billed has changed from previous handbook. Emphasize these changes: • Individual and Family Therapy Now billable in 15 minute increments with a limitation of 104 quarter hours (26 hours) per recipient per state fiscal year. Maximum daily limit of 4 units (1 hour). ***NOTE**: Previous handbook limitations stated that the service was billed by event, the event had to be at least 45 minutes long, and the reimbursement limitation was 26 times per recipient per state fiscal year. Under the old rule, the limitation would have been 78 quarter hours per state fiscal year.* • Group Therapy Now billable in 15 minute increments with a limitation of 156 quarter hours (39 hours) per recipient per state fiscal year. Previous handbook limitations stated the services was billed by event, the event had to be at least 45 minutes long, and the reimbursement limitation was 52 times per recipient per state fiscal year. The number of quarter hours per state fiscal year is the same under both the handbooks. ***NOTE:** For both Individual/Family Therapy and Group Therapy, some restrictions on reimbursement for these services on the same day as other services has been lifted in the new policy.* ***Example**: Both procedure codes are now reimbursable on the same day as Behavioral Health Day Services – in the previous handbook the services were not reimbursable on the same day as Day Treatment Services.* Both Individual/Family Therapy and Group Therapy services have specific requirements for documentation above the standard general documentation requirements. Please review and assure that staff is aware and documenting all required components. • Behavioral Health Day Services – Created from the old Day Treatment Services code **(Important to note that this service requires prior authorization.)**

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	Now billable by the hour – However, the service requires a minimum of two hours per day, per recipient. Reimbursement limitation of 190-hour units per recipient per state fiscal year. Given the requirement that services must be at least 2 hours in duration, this equates to 95 days per state fiscal year. The previous limitation was 192 days per state fiscal year, but the length of service requirement was 4 hours per day. BH Day Services have specific documentation requirements that are pretty much the same as the previous handbook. Review these and focus on the requirement for a description of the clinical services. Even though this is a weekly summary note, the requirement is that every service provided throughout the week be documented in detail. It seems that it would almost be more time effective and efficient to just complete a daily note of services and summarize at the end of the week, but Medicaid will be looking for that weekly note that details the services that were provided each day for which the provider was reimbursed.
Slide 41: Community Support and Rehabilitative Services	**XIII. Review of requirements for Community Support and Rehab Services** **(Important to note that this service requires prior authorization.)** The service under this category that is applicable to substance abuse diagnoses is Psychosocial Rehabilitation Services, which was created by combining the "old" codes of Basic Living Skills Training and Social Rehabilitation and Counseling. ***NOTE:*** *The requirement of Prior Authorization has been added to this service, which was not a requirement of the old services.* Specific documentation requirements have been added to this service which include: • Daily service notes and • Monthly progress notes Review the specific documentation requirements listed on page 2-1-31 of the handbook. The service is billed in 15 minute increments. Reimbursement limitations are 1920 units (480 hours) per recipient per state fiscal year. It is not reimbursable on the same day as BH Day Services and the units reimbursed for this service count against the limit for Clubhouse Services (and vice versa). ***NOTE:*** *Previously, the services covered under this procedure code were limited to 11 units/month each and the service duration*

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	required was 30 minutes. Combining the two services would have allowed 22 units/month – which is equivalent to 44 15-minute units or an annual limitation of 528 units. The limitations on the new procedure code appear to have increased capacity for this service; however there is also an administrative requirement of prior authorization and increased documentation requirements for this service that was not in place for the previous services. **BREAK**
Slides 42 – 51: Therapeutic Behavioral On-Site Services for Children & Adolescents	**XIV. Review of requirements for TBOS Services** **(Important to note that the Therapy and Behavior Management services require prior authorization, but the Support Services code does not.)** The "old" procedure code for Intensive Therapeutic On-site Services was used to create two new codes – • Therapeutic Behavioral On-Site Services – Therapy • Therapeutic Behavioral On-Site Services – Behavior Management. The services are billable in 15-minute increments and a master's level practitioner must provide the therapy service. Reimbursement is a maximum combined limit of 36 quarter-hour units per month. This means that the limitation applies to BOTH codes combined; i.e., if the recipient receives 30 quarter-hour units of the Therapy service, then only 6 quarter-hour units remain for the provision of the Behavior Management service. The services may not be billed for services provided to a group of recipients. The other TBOS Service which mirrors the "old" Home and Community Based Rehabilitative Service is: • Therapeutic Behavioral On-Site Services – Therapeutic Support Service This service has specific agency requirements related to the ability of the provider agency to recruit, staff, train and supervise the individuals rendering the service. Review the requirements on page 2-1-41 in detail. Special documentation requirements are included on page 2-1-42 and there is a special notation that practitioners rendering the service may NOT be relatives of the recipient. ***NOTE:*** *Page 2-1-35 details additional documentation requirements for ALL Therapeutic Behavioral On-Site Services that must be met in addition to the standard requirements in Chapter 2, Section 1 of the handbook. These requirements are reviewed on slides 46 and 47 of the presentation.*

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	Eligibility Criteria for TBOS Services: In order to receive any of the TBOS services, recipients must meet eligibility criteria as listed in Medicaid policy. The criteria includes several components: • Diagnosis • Educational placement • CGAS Score • Level of care at-risk status Review the eligibility criteria in detail on slides 48 and 49. Emphasize to providers that it is their responsibility to maintain documentation in the record that shows that the recipient meets the eligibility criteria in order to justify provision of the services. Discharge criteria is an additional documentation requirement of this service. Within 45 days of admission the provider must document in the record a discharge plan that states criteria that will be used to determine when the recipient is ready for discharge from the TBOS Services. Note that this is a discharge plan from the particular service – not from the provider agency in general. A recipient could be discharged from TBOS services and stepped down to a less restrictive service such as Individual/Family or Group therapy on an outpatient basis. If at any time during treatment the recipient no longer meets eligibility criteria for the service, Medicaid reimbursement for services provided when eligibility is not in place may be recouped from the provider. **BREAK**
Slide 52: Medicaid Rev Max	**XV. Overview of Medicaid Revenue Maximization Topics** The first parts of this training focused providers on looking at the procedure codes and services available for Medicaid reimbursement. We will now focus the way in which providers use different funding streams and at the options available for changing revenue utilization. ***Note:*** *Slide 52 lists the general topics that will be discussed during this last part of the training. Briefly review what the topics will be:* • Identification of Funding – Different funding sources that are available to Community Behavioral Health providers are listed and prioritized. Opportunities for discussion include issues related to the different types of Medicaid coverage, general revenue/block grant funding, TANF, county funds and Child Welfare. • Licensure and Medicaid Services – Each CBH provider who provides Substance Abuse services is required to be licensed

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	by the state to do so. The similarities between licensure requirements and Medicaid policy will be discussed and reviewed. • Episodes of Care – Different Episodes of Care should be developed for review and discussion with providers. Development of these episodes of care will help the trainer understand the procedure codes and Medicaid policy in a more practical way so that they can present the information confidently and effectively. • Identification of Revenue Max Opportunities – By reviewing the individual providers' billing histories the providers will be able to identify opportunities that were missed in accessing Medicaid revenue.
Slide 53: Identification of Funding Sources	**XVI. Funding Source Issues** The grid on this slide reflects how providers are encouraged to prioritize funding sources. Using the principles already discussed in the beginning of this presentation, Medicaid should be the first fund source utilized when at all possible. Issues to discuss related to the utilization of funding sources include: • It is imperative that the provider establishes the client's eligibility for funding each month. The recipient's Medicaid eligibility can change from month to month. It is also important to determine the type of Medicaid coverage – i.e., HMO or Fee-for-Service. It is the provider's responsibility to obtain any required authorization before rendering the service. • Both the client AND the service provided must meet Medicaid eligibility requirements. The client may have active Medicaid coverage, but if the service provided does not meet all the requirements listed in the Medicaid handbook for reimbursement, the provider can not bill Medicaid for provision of the service. ***NOTE:*** *Community Behavioral Health Substance abuse services are NOT covered by the Medicaid managed care plans – these services remain Fee-for-service at this time. However, AHCA's PA Vendor must authorize the services listed in this presentation as requiring a prior authorization, unless the provider has been determined exempt from the requirement.* • Use of TANF funds should be next priority if Medicaid eligibility is not a factor. Most providers who have a contract with the department for the use of TANF funds are very aware of all the requirements for utilizing this fund source. • Many providers have contracts with counties in which they

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	are located to render SA Treatment services. These funds should be utilized in compliance with those contracts. • The utilization of General Revenue or Block Grant funds that are contracted through DCF/SAMH Program offices should be done after Medicaid, Insurance, and TANF funds are excluded as an option for reimbursement. Providers may NOT use GR/Block Grant funds to supplement the services billed to other sources. Example: If the provider is reimbursed $50 from Medicaid for an individual therapy session for which the standard cost is $80, the provider may NOT bill the difference of $30 to DCF under GR. Medicaid payment is payment in full. ***NOTE:*** *Some providers have contracts with Child Welfare Community Based Care Lead agencies for the provision of MH or SA services. These are generally DCF funds that should be used after Medicaid, Insurance or TANF are exhausted. In most cases however these services are specialty services that may not meet the definition of any of the Medicaid or TANF services available for reimbursement so the CBC funds may end up being used before any of the other sources.*
Slides 54 – 57: Medicaid and SA Licensure	**XVII. Comparison of SA Licensure and Medicaid requirements** ***Note:*** *It is important that the trainer is familiar with both the SA Licensure requirements as well as the Medicaid requirements.* These slides show the differences between what the SA providers are required to do in order to maintain their SA Licenses and what Medicaid requires for reimbursement of services. Since all SA Providers are required to have a valid DCF License in order to provide SA services, compliance with licensure requirements is an assumption for those receiving DCF substance abuse funding. Comparison of the licensure and Medicaid requirements allows an opportunity to dispel the myth that it is difficult for SA Providers to meet Medicaid requirements. • Slide 54 reflects that for the most part, licensure requirements are more restrictive than Medicaid – therefore SA Licensed providers should be able to meet the minimum Medicaid guidelines. • Slides 55-57 show that the terminology used by both Medicaid and the DCF Licensure requirements are not only similar but in some cases identical – again reinforcing the fact that the two entities are not that far apart for compliance to be impossible. • The biggest difference between the two regulatory entities (Medicaid and DCF), and perhaps the barrier that most providers will have to struggle with, is the staffing requirements for services. Licensure regulations do NOT

Facilitator Notes	Outline
	state what level of staff must be available to provide different types of services; in contrast, Medicaid is very clear about staffing credentials required for each service to be reimbursed. Some SA providers may not be able to afford to hire some of the higher level staff required for provision of Medicaid services. ***NOTE:*** *The implications of having licensed staff can be a topic for discussion and brainstorming of solutions in the last part of the training.*
Slides 58 – 63: Episodes of Care Exercise	**XVIII. Review of Reimbursable Services by Episode of Care** Show the slides and explain the examples of reimbursable services by episodes of care. **Exercise:** **NOTE:** *You need to have knowledge of the Medicaid reimbursable substance abuse services, the types of programs or treatment regimes available and the different populations being treated for these disorders to effectively facilitate this Episodes of Care exercise.* **Hand out** the instructions. **Ask** attendees to develop sample episodes of care that reflects services typically provided by their programs. These sample Episodes of Care should show the providers the different services that could be reimbursed over a six-month period of time for different populations entered treatment. Units of service should follow Medicaid policy allowables as well as what would be considered a best practice or medically necessary. Steps: • Identify populations such as: Children, Outpatient Adult, Adults who require intensive Rehabilitation, Adults/Families who need Basic Living Skills or Rehab., etc. • Identify Medicaid services that are appropriate for treatment of each population • Determine the "best" level of care that includes units of service that would be needed to address the condition • Prepare a grid that includes the following information for each Episode of Care for a 6 month period: o Medicaid Services appropriate to address the condition o Units of Service needed

Facilitator Notes	Outline
	o Rate of reimbursement o Total possible revenue for each service o Total possible revenue for all services (Grand Total) **Facilitate** discussion of the sample episodes of care with the group. ***NOTE:*** *Preparation of these Episodes of Care will help trainers become more comfortable and aware of all the Medicaid reimbursable services that could possibly be billed by a substance abuse provider. Services that are typically overlooked in the development of these episodes include treatment planning and assessments. This exercise lays the foundation for the next section of the training, which involves analysis of provider-specific revenue maximization opportunities.* Encourage providers to come up with alternative Episodes of Care that fit into specific programs or treatment modalities at their facility.
Slide 64: Rev Max Opportunities Exercise	**XIX. Medicaid Revenue Maximization Opportunities Exercise** ***NOTE:*** *In the Medicaid Revenue Maximization Opportunities exercise, you will ask attendees to analyze service utilization and billing data. Prior to the training, the trainer should attempt to collect provider-specific Medicaid paid claims data related to substance abuse diagnoses. If the trainer does not have access to this data through the Medicaid office or another state agency, he/she may be able to obtain the information directly from providers' internal systems.* **Preparation for Facilitating the Exercise** There are two possible scenarios for facilitating the Medicaid Revenue Maximization Opportunities exercise: **Scenario 1:** Provider-specific data available from the Medicaid office or another state agency. • In preparation for the training, review the data received. Make sure the data is formatted so that it is separated out by procedure code and sorted by provider. You want only the total amount of funds reimbursed to each provider by each procedure code and then you can total each column and row at the end of the spreadsheet (see example). • Identify gaps and opportunities reflected in the data. Keep this information as a reference that you will refer to during the exercise. **Scenario 2:** Provider-specific data is not available. In the event that the trainer can not obtain any real Medicaid paid claims data from any source, utilize the following strategy:

Facilitator Notes	Outline
	• In preparation for the training, develop a spreadsheet that reflects several "fictitious" providers' Medicaid paid claims data broken out by provider and service code similar to the description above (see example spreadsheet). Make up reimbursed dollar amounts that seem like they might be reasonable. You may chose to show one or two providers that are using only one or two select procedure codes in moderate amounts and other providers that seem to be maximizing all the codes. The idea here is to put numbers in the grid that reflect the low rates that substance abuse providers in Florida are typically billing Medicaid for services. This hypothetical example will be used as the basis for the analysis and discussion. • Identify gaps and opportunities reflected in the data. Keep this information as a reference that you will refer to during the exercise. **Facilitate the Exercise:** **Hand out** the sample spreadsheets. **Ask** the attendees to review the data and identify procedure codes that should have been utilized more often. **Ask** the attendees to use the information learned from this training to develop their own strategy for increasing the utilization of Medicaid revenue funds for services. **Brainstorm** barriers to using Medicaid funds and **identify** solutions. **Facilitate** a discussion of the identified issues. ***NOTE:*** *It is important to keep good notes regarding barriers that cannot be addressed so that these issues can be passed on to Medicaid and the Department.* ***NOTE:*** *The trainer may use the gaps and opportunities that were identified prior to the training to help facilitate the discussion. But it is important to have providers attempt to analyze the data using the knowledge they have gained from the training.* End the training with additional opportunities for discussion and questions. Always encourage attendees to contact you later if questions arise and respond promptly to any follow up issues.
Post-Test Questionnaire	**Ask** the attendees to complete the Post-Test Questionnaire. The results will be compared to the Pre-Test to determine the knowledge gained from participating in the training.

Handouts

Medicaid CBHS Training – Pre/Post Test

1. Which of the following is reimbursable by Medicaid for substance abuse diagnoses?
    a) individual therapy
    b) group therapy
    c) prevention services
    d) all of the above
    e) items a) and b) only

2. Providers may be reimbursed by Medicaid for appointments that a recipient misses.
    a) True
    b) False
    c) Only if the appropriate documentation is present in the chart

3. Per Medicaid, it is the responsibility of the provider to verify recipient eligibility and determine if there is a TPL source available for services rendered.
    a) True
    b) False

4. Medicaid requires providers to have what type of regular (not probationary or interim) SA License in order to bill for substance use treatment services?
    a) Prevention
    b) Intervention
    c) Treatment
    d) Residential
    e) Any of the above

5. Per Medicaid policy, the effective date of the treatment plan is:
    a) the date that the recipient signs it
    b) the date that the treating practitioner signs it
    c) the date listed on the top of the plan
    d) 45 days after the first day of service

6. An individual is admitted to outpatient treatment on April 3rd. The provider completes a Psychiatric evaluation on April 6th, and a medication management service on April 10th. In order to bill Medicaid for these services (which are now included on the Medicaid treatment plan), what is the latest date that the treatment plan can be authorized?
    a) April 30th
    b) May 7th
    c) May 21st
    d) June 1st
    e) None of the above

7. Which of the following Medicaid Community Behavioral Health Services do NOT require prior authorization? (assuming that the provider is not exempt from PA)
    a) Behavioral Health Day Services
    b) Psychosocial Rehabilitation Services
    c) Individual/Family Therapy
    d) Therapeutic Behavioral On-Site Services – Therapy
    e) Items a) and b)

8. It is important for providers to verify client eligibility for funding sources before rendering services.
    a) True
    b) False

9. DCF Licensure requirements have very little in common with Medicaid policy requirements.
    a) True
    b) False

10. If a provider is reimbursed $50 from Medicaid for an individual therapy services for which the standard cost is $80, the provider may bill the difference of $30 to DCF under general revenue sources for the same service.
    a) True
    b) False

11. What is the biggest difference between DCF licensure and Medicaid requirements for the provision of substance use services?
    a) Documentation requirements
    b) Billing forms
    c) Staffing level requirements
    d) None of the above

12. Steps toward maximization of Medicaid revenue include:
    a) Identification of funding sources
    b) Clarification of Medicaid-reimbursable services
    c) Previous billing patterns analysis
    d) All of the above

Medicaid CBHS Training – Pre/Post Test

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    c) Treatment
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    a) Identification of funding sources
    b) Clarification of Medicaid-reimbursable services
    c) Previous billing patterns analysis
    d) All of the above

Florida Medicaid CBH Services for SA Diagnoses - Effective 10/1/04

Medicaid New Code (HIPAA)	Modifier	Medicaid Code Name	Medicaid Service Description	Unit of Service	Who Must Provide	Specific Documentation Requirements (in addition to those on pg. 2-1-2 of Handbook)	Reimbursement Limitations	Max Fee (per unit)
H2000	HP	Psychiatric Evaluation by physician	A comprehensive evaluation that investigates the clinical status including presenting problem, history of the present illness, previous psychiatric, physical, medciation history, relevant personal and family history, personal stregths and assets, and a mental status exam.	NA	Psychiatrist, other physician, or psychiatric ARNP	All items in description must be documented; Individual rendering service must complete, sign and date the report/note and all eval or testing results must be in record.	Two evaluations per recipient per state fiscal year	$210.00
H2000	HO	Psychiatric Evaluation by non-physician	A comprehensive evaluation that investigates the clinical status including presenting problem, history of the present illness, previous psychiatric, physical, medciation history, relevant personal and family history, personal stregths and assets, and a mental status exam.		Licensed practitioner of the healing arts or master's level CAP			$150.00
H2010	HO	Brief Behavioral Health Status Examination	A brief clinical, psychiatric, diagnostic, or evaluative interview to assess behavioral stability or treatment status.	15 min.	Licensed practitioner of the healing arts or master's level CAP	Includes above requirements plus must include purpose of the exam, setting, mental status, findings, and plan.	10 quarter-hour units per recipient per state fiscal year	$14.66
H2000		Psychiatric Review of Records	A review of hospital records, psychiatric reports, psychometric or projective tests, clinial and psychological evaluation data for diagnostic use in evaluating and planning for recipient care.	NA	Psychiatrist, other physician or psychiatric ARNP	Report format or progress note; Sole use of checklists or fill in the blank not allowed.	Two reviews per recipient per state fiscal year.	$26.00
H0001	HO	In-depth assessment, new pt., substance abuse	A diagnostic tool for gathering information and to provide the basis for the devlopment of an effective, comprehensive, individualized treatment plan.	NA	Master's level practitioner	Includes above requirements plus must include an integrated summary that evaluates, integrates and interprets info collected.	One assessment per recipient per state fiscal year; Not reimbursable on the same day as a bio-psychosocial assessment or Therapeutic Group Care Services	$125.00
H0001	TS	In-depth assessment, est. pt., substance abuse						$100.00

Medicaid New Code (HIPAA)	Modifier	Medicaid Code Name	Medicaid Service Description	Unit of Service	Who Must Provide	Specific Documentation Requirements (in addition to those on pg. 2-1-2 of Handbook)	Reimbursement Limitations	Max Fee (per unit)
H0001	HN	Bio-psychosocial evaluation (substance abuse)	An assessment of the biological, psychological and social factors that underlie or may have contributed to the recipient's need for services. It includes a brief mental status, clinical impressions and treatment recommendations.	NA	Provided by a bachelor's level practitioner or CAP; Must be reviewed, signed and dated by a master's level practitioner or BA level CAP.	Evaluation must be reviewed, signed and dated by a master's level practitioner or bachelor's level CAP prior to completion of the treatment planning process. Review must include clinical impressions, provisional diagnosis and statement by the review that indicates concurrence or alternative recommendations.	One assessment per recipient per state fiscal year; Not reimbursable on the same day as an in-depth assessment or Therapeutic Group Care Services	$48.00
H2019		Psychological Testing	Involves the assessment, evaluation, and diagnosis of the recipient's mental status through use of standardized testing methodologies.	15 min.	Individual practitioner within the scope of professional licensure, training, protocol, and competence in accordance w/ applicable statutes.	Requires a written report of evaluation and testing results by the individual who rendered the service in the medical record.	40 quarter hour units per recipient per state fiscal year.	$15.00
H0001		Limited Functional Assessment (substance abuse)	The administration of the Multnomah Community Ability Scale, Functional Assessment Rating Scale, and the Children's Functional Assessment Rating Scale or any other functional assessment required by DCF.	NA	An individual authorized by DCF to administer the assessment	A copy of the assessment must be placed in the record. This service does not require authorization in the treatment plan.	Three assessments per recipient per state fiscal year; Not reimbursable on the same day as Therapeutic Group Care Services	$15.00

Medicaid New Code (HIPAA)	Modifier	Medicaid Code Name	Medicaid Service Description	Unit of Service	Who Must Provide	Specific Documentation Requirements (in addition to those on pg. 2-1-2 of Handbook)	Reimbursement Limitations	Max Fee (per unit)
T1007		Treatment Plan Development (substance abuse)	The individualized treatment plan is a structured, goal-oriented schedule of services developed jointly by the recipient and the treatment team. It must contain written treatment-related goals and measurable objectives.	NA	Must be signed by Treating practitioner and team members participating in development; A brief BH Status Exam or Psych. Eval must be completed prior to development of the plan	**A Brief Behavioral Health Status Exam or a Psychiatric Evaluation must be completed prior to the development of the Treatment Plan**. Plan must contain: ICD-9 CM diagnosis code; Goals appropriate to diagnosis, age, culture, strengths, abilities, preferences and needs, Measurable objectives and target dates, List of services to be provided (TP Development, TP Review, Comp BH Assessment and Limited Fx. Assessment need not be listed); Amount, frequency and duration of each service for the 6 month duration of the plan; NOT permissible – "as needed", "PRN" or "x to y times per week"; Signature of recipient, parent/guardian or legal custodian (if under age 18), and signatures of treatment team members who develop the plan; Signed statement by treating practitioner that services are medically necessary and appropriate	One treatment plan development per provider per state fiscal year - max total of two per fiscal year; not reimbursable for recipients receiving Therapeutic Group Care Services	$97.00
T1007	TS	Treatment Plan Review (substance abuse)	The treatment plan review is a process conducted to ensure that services and treatment goals and objectives continue to be appropriate and to assess progress and continued need for services.	NA	Requires the participation of the recipient and treatment team. Must be signed, certified and dated by the treating physician or practitioner.	Documentation must include: Activities, notations of discussions, findings, conclusions and recommendations; Modifications or additions ot the plan; Re-assessment of services if goals are not met and justification if no change in services are made; Signature, certifcation and date by the treating physician or practitioner; Signature and date of recipient/parent/guardian.	Max of four treatment plan reviews per recipient per state fiscal year.; Not reimbursable for recipients receiving Therapeutic Group Care Services	$48.50

Medicaid New Code (HIPAA)	Modifier	Medicaid Code Name	Medicaid Service Description	Unit of Service	Who Must Provide	Specific Documentation Requirements (in addition to those on pg. 2-1-2 of Handbook)	Reimbursement Limitations	Max Fee (per unit)
T1015		Medication Management	The review of relevant lab test results, prior pharmacy interventions and current medication usage. Includes the discussion of indications and contraindications for treatment, risks and management strategies with the recipient or other responsible persons	NA	Psychiatrist, other physician, physician assistant, or psychiatric ARNP	Results of the assessment, findings and plan must be in the record	As medically necessary. Not reimbursable on same day as Group Medical Therapy	$60.00
H2010	HF	Brief Individual Medical Psychotherapy (substance abuse)	Treatment activity designed to reduce maladaptive behaviors related to a behavioral health disorder; Includes insight oriented cognitive behavioral, or supportive therapy.	15 min.	Psychiatrist, other physician, physician assistant, or psychiatric ARNP	Results of the assessment, findings and plan must be in the record	Max of 16 quarter hour units per recipient per state fiscal year; Not reimbursable on same day as Group Medical Therapy	$15.00
H2010	HQ	Group Medical Therapy	Treatment activity designed to reduce maladaptive behaviors related to a behavioral health disorder; Includes continuing medical diagnostic eval and drug management and may include insight oriented, cognitive behavioral, or supportive therapy.	15 min.	Psychiatrist or psychiatric ARNP	Documentation must include: Group topic; Assessment of the group; Level of participation; Findings; Plan	Group size may not exceed 10 participants; Max of 18 quarter hour units per recipient per state fiscal year; not reimbursable on same day as medical and psychiatric services, behavioral health day services, therapeutic behavioral on-site services or therapeutic group care services.	$8.65
T1023	HF	Behavioral Health Screening Service (substance abuse)	Must include a face-to-face assessment of physical status, brief history, and decision making of low complexity; Minimally includes Vital signs, Medication concerns (side effects), Brief mental status, and Plan for follow-up	NA	Psychiatrist, other physician, physician assistant, ARNP or registered nurse	Assessment must include: Vital signs; Medication concerns including side effects; Brief mental status assessment; and Plan for follow-up	Two per recipient per state fiscal year. Not reimbursable on same day as Group Medical Therapy or Therapeutic Group Care Services	$43.62

Medicaid New Code (HIPAA)	Modifier	Medicaid Code Name	Medicaid Service Description	Unit of Service	Who Must Provide	Specific Documentation Requirements (in addition to those on pg. 2-1-2 of Handbook)	Reimbursement Limitations	Max Fee (per unit)
H0047		Behavioral Health Services; verbal interaction substance abuse	Outpatient services provided to persons with a behavioral health illness; A verbal interaction (15-minute minimum) between the practitioner and recipient	NA	Physician's assistant, ARNP or RN	Documentation must describe the need and the recipient's interaction	Not reimbursable on the same day as behavioral health screening services, group medical therapy or therapeutic group care services; Not reimbursable for Methadone or Buprenorphine administration	$15.00
T1015	HF	Behavioral Health Services; specimen collection substance abuse	Outpatient services provided to persons with a behavioral health illness; Specimen collection, taking of vital signs, administering injections	NA	An individual qualified by professional licensure, training, protocols and in compliance with the statutes.	Documentation must describe the need and the recipient's interaction	Not reimbursable on the same day as behavioral health screening services, group medical therapy or therapeutic group care services; Not reimbursable for Methadone or Buprenorphine administration	$10.00
H0020		Methadone or Buprenorphine Administration	Administration of methadone or buprenorphine for opiod addiction treatment by a program licensed by the state and certified by SAMHSA	Weekly rate	An individual qualified by professional licensure, training, protocols and in compliance with the statutes.	Must comply with state and federal regulations	52 times per recipient per state fiscal year; Reimbursable once every seven days; Not reimbursable using any other procedure code; Not reimbursable on same day as group medical therapy or therapeutic group care services.	$67.48
H2019	HR	Individual/Family Therapy	Includes provision of insight oriented, cognitive behavioral, or supportive therapy to an individual or family; May involve the recipient, family, or a combination of therapy with the recipient and family.	15 min.	Master's level practitioner	Must include: Topic; Assessment of recipient; level of participation; findings; plan	104 quarter hour units (26 hours) per recipient per state fiscal year; Maximum daily limit of 4 quarter hour units; Not reimbursable on same day as Therapeutic Behavioral On-site Services or Therapeutic Group Care Services	$18.33

Medicaid New Code (HIPAA)	Modifier	Medicaid Code Name	Medicaid Service Description	Unit of Service	Who Must Provide	Specific Documentation Requirements (in addition to those on pg. 2-1-2 of Handbook)	Reimbursement Limitations	Max Fee (per unit)
H2019	HQ	Group Therapy	Includes provision of insight oriented, cognitive behavioral, or supportive therapy to an individuals or families and consultation with family or others; Includes education, counseling or advising family or others on how to assist the client; Group size limit is 10 for mental health and 15 for substance abuse	15 min.	Bachelor's level practitioner or CAP	Must include: Topic; Assessment of recipient; level of participation; findings; plan	Max of 156 quarter hour units (39 hrs) per recipient per state fiscal year; no daily limit; Not reimbursable on same day as Therapeutic Behavioral On-site services or Therapeutic Group Care Services.	$6.67
H2012	HF	Behavioral Health Day Services (substance abuse)	Primary functions are stabilization of the symptoms related to a BH disorder to reduce or eliminate the need for more intensive levels of care; provide trasition after an acute episode; or provide a level of intensity not possible in a traditional outpt. setting. Includes Individual/family or group therapy/counseling.	1 hour	Individual/family therapy requires masters level practitioner; Individual or group substance abuse counseling requires a SA Counselor or CAP; Licensed pract or Masters CAP must be avail during all hours	At least a weekly summary progress note that includes: Exact dates and times of attendance; Description of clinical services, including length of time of each service and the name & credentials of the rendering practitioner; Recipient's response to services; Focus on measurable outcomes and overall progress toward treatment goals.	**REQUIRES PA**: Svcs must be provided for a min. of two hours per day per recipient; At least one hour per day mus be indiv/group/family therapy; Max. of 190 hour units per recipient per state fiscal year; Group size limit is 10 for MH and 15 for SA; Not reimbursable on same day as Group Medical Therapy, Therapeutic Behavioral On-site Services, Psychosocial Rehab Services, Therapeutic Foster Care, Therapeutic Group Care Services or Behavioral Health Overlay Services.	$12.50
H2017		Psychosocial Rehabilitation Services	Psychosocial rehabilitation services combine daily medication use, independent living and social skills training, support to clients and their families, housing, pre-vocational and transitional employment rehabilitation training, social support and network enhancement, structured activities to diminish tendencies towards isolation and withdrawal and teaching of the recipient and family about symptom management, medication and treatment options.	15 min.	Behavioral health technician under the supervision of a bachelor's level practitioner; Bachelor's level prac under supervision of Master's level; Substance abuse technician; or CAP	Daily service note that describes activities provided by counselor; Description of how services enhanced/support the recipient's skills of daily medicaiton use, independent living and social skills, housing, pre-vocatinal and transitional employment training, social support and networking, food planning, money and life management; Monthly progress note that reflects how services are linked to goals and objectives of plan and describes progress relative to the plan.	**REQUIRES PA:** Max of 1920 units (480 hrs) per recipient per state fiscal year; **Units count against the clubhouse service units**; Group size limit is 12 for MH and 15 for SA; Not reimbursable on same day as Therapeutic Behavioral On-Site Services or Therapeutic Group Care Services	$9.00

Florida Medicaid CBH Services for SA Diagnoses - Effective 10/1/04

Medicaid New Code (HIPAA)	Modifier	Medicaid Code Name	Medicaid Service Description	Unit of Service	Who Must Provide	Specific Documentation Requirements (in addition to those on pg. 2-1-2 of Handbook)	Reimbursement Limitations	Max Fee (per unit)
H2019	HO	Therapeutic Behavioral On-Site Services - Therapy	Includes the following: Strength-based, clinical assessment of MH, SA, or behavioral disorders to determine treatment needs; Indiv/Family therapy; Assessment/engagement of child and family's natural support system; and Development, implementation and monitoring of behavior programming for the child	15 min.	Master's level practitioner supervised by a licensed practitioner	Assessments and treatment plans must address the need for individual and family therapy, behavior management and therapeutic support services; Plan must include frequency and duration for all services as well as the person/agency responsible for delivering the services; Plan and progress notes must reflect ongoing coordination with other agencies for provision of services to the same child; Treatment plan must include a specific schedule for review of the plan with the child/family, others on treatment team and other agencies.	**REQUIRES PA:** TBOS Behavior Management and Therapy Services are reimbursable for a Maximum combined limit of a total of 36 quarter hour units (9 hrs) per month by a master's level practitioner, CBA or Certified Associate Behavior Analyst; minimum of 8 units must be provided by a master's level practitioner; May not be reimbursed on the same day as: Therapy services, Group Medical therapy, Behavioral health day service, Psychosocial rehabilitation, Therapeutic foster care, Therapeutic group care, or Behavioral Health Overlay Services	$16.00
H2019	HM	Therapeutic Behavioral On-Site Services - Behavior Management Services	Includes the following: Assessment of behavior problems, related skill deficits and assets, identifying primary and other caregiver skill deficits/assets related to behaviors and related interactions; Development of an individual behavior plan; Training caregivers in implementation of the behavior plan; Monitoring child and caregiver progress; Coordinate services on treatment plan with treatment team	15 min.	Certified Behavior Analyst or Certified Associate Behavioral Analyst; Bachelor's level prac may continue to provide services while completing requirements for CBA until April 2006			$10.00
H2019	HN	Therapeutic Behavioral On-Site Services - Therapeutic Support Services	Includes one or more of the following: One-to-one supervision/intervention with child during therapeutic activities; Skill training of child for restoration of basic living skills/social skills or; Assistance to child and family in implementing behavioral goals	15 min.	Behavioral health technician supervised by a master's level practitioner		**REQUIRES PA:** Maximum of 128 quarter hour units (32 hrs) per month per recipient; Not reimbursable on same day as group medical therapy, Therapeutic Foster Care, Therapeutic Group Care or Behavioral Health Overlay Services	$4.00

Mcaid Billable Units - CBHS 2004

Total Minutes of the Service Provided during the Date of Service	Calculation formula	Extra Minutes (over 15 min increment)	Billable Units
8	Total / 15 = 0.53		1
9	Total / 15 = 0.60		1
10	Total / 15 = 0.67		1
11	Total / 15 = 0.73		1
12	Total / 15 = 0.80		1
13	Total / 15 = 0.87		1
14	Total / 15 = 0.93		1
15	Total / 15 = 1.00		1
16	Total / 15 = 1.07	1 minute	1
17	Total / 15 = 1.13	2 minutes	1
18	Total / 15 = 1.20	3 minutes	1
19	Total / 15 = 1.27	4 minutes	1
20	Total / 15 = 1.33	5 minutes	1
21	Total / 15 = 1.40	6 minutes	1
22	Total / 15 = 1.47	7 minutes	1
23	Total / 15 = 1.53	8 minutes	2
24	Total / 15 = 1.60	9 minutes	2
25	Total / 15 = 1.67	10 minutes	2
26	Total / 15 = 1.73	11 minutes	2
27	Total / 15 = 1.80	12 minutes	2
28	Total / 15 = 1.87	13 minutes	2
29	Total / 15 = 1.93	14 minutes	2
30	Total / 15 = 2.00		2
31	Total / 15 = 2.07	1 minute	2
32	Total / 15 = 2.13	2 minutes	2
33	Total / 15 = 2.20	3 minutes	2
34	Total / 15 = 2.27	4 minutes	2
35	Total / 15 = 2.33	5 minutes	2
36	Total / 15 = 2.40	6 minutes	2
37	Total / 15 = 2.47	7 minutes	2
38	Total / 15 = 2.53	8 minutes	3
39	Total / 15 = 2.60	9 minutes	3
40	Total / 15 = 2.67	10 minutes	3
41	Total / 15 = 2.73	11 minutes	3
42	Total / 15 = 2.80	12 minutes	3
43	Total / 15 = 2.87	13 minutes	3
44	Total / 15 = 2.93	14 minutes	3
45	Total / 15 = 3.00		3
46	Total / 15 = 3.07	1 minute	3
47	Total / 15 = 3.13	2 minutes	3

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If extra minutes are 7 or less, round down to the nearest 15 min. increment;
If extra minutes are 8 or more, round up to nearest 15 min. increment

Mcaid Billable Units - CBHS 2004

Total Minutes of the Service Provided during the Date of Service	Calculation formula	Extra Minutes (over 15 min increment)	Billable Units
48	Total / 15 = 3.20	3 minutes	3
49	Total / 15 = 3.27	4 minutes	3
50	Total / 15 = 3.33	5 minutes	3
51	Total / 15 = 3.40	6 minutes	3
52	Total / 15 = 3.47	7 minutes	3
53	Total / 15 = 3.53	8 minutes	4
54	Total / 15 = 3.60	9 minutes	4
55	Total / 15 = 3.67	10 minutes	4
56	Total / 15 = 3.73	11 minutes	4
57	Total / 15 = 3.80	12 minutes	4
58	Total / 15 = 3.87	13 minutes	4
59	Total / 15 = 3.93	14 minutes	4
60	Total / 15 = 4.00		4
61	Total / 15 = 4.07	1 minute	4
62	Total / 15 = 4.13	2 minutes	4
63	Total / 15 = 4.20	3 minutes	4
64	Total / 15 = 4.27	4 minutes	4
65	Total / 15 = 4.33	5 minutes	4
66	Total / 15 = 4.40	6 minutes	4
67	Total / 15 = 4.47	7 minutes	4
68	Total / 15 = 4.53	8 minutes	5
69	Total / 15 = 4.60	9 minutes	5
70	Total / 15 = 4.67	10 minutes	5
71	Total / 15 = 4.73	11 minutes	5
72	Total / 15 = 4.80	12 minutes	5
73	Total / 15 = 4.87	13 minutes	5
74	Total / 15 = 4.93	14 minutes	5
75	Total / 15 = 5.00		5
76	Total / 15 = 5.07	1 minute	5
77	Total / 15 = 5.13	2 minutes	5
78	Total / 15 = 5.20	3 minutes	5
79	Total / 15 = 5.27	4 minutes	5
80	Total / 15 = 5.33	5 minutes	5
81	Total / 15 = 5.40	6 minutes	5
82	Total / 15 = 5.47	7 minutes	5
83	Total / 15 = 5.53	8 minutes	6
84	Total / 15 = 5.60	9 minutes	6
85	Total / 15 = 5.67	10 minutes	6
86	Total / 15 = 5.73	11 minutes	6
87	Total / 15 = 5.80	12 minutes	6
88	Total / 15 = 5.87	13 minutes	6
89	Total / 15 = 5.93	14 minutes	6
90	Total / 15 = 6.00		6

Central Florida Behavioral Health Network, Inc.

If extra minutes are 7 or less, round down to the nearest 15 min. increment;
If extra minutes are 8 or more, round up to nearest 15 min. increment

Medicaid Revenue for Substance Abuse Services -
FY 2002/2003

Procedure codes highlighted in YELLOW/GREEN would be included in capitation calculations for HMOs/PBHP when substance abuse is included in the Medicaid BH waiver.

Providers/Reimbursements

Mcaid Old Code	*M'caid HIPAA Code*	*Medicaid Code Description*					**Total by Code FY02/03**
W1030	H2000HP	Psychiatric Evaluation by physician					$0.00
	H2000HO	Psychiatric Evaluation by non MD					$0.00
	H2010HO	Brief BH Status Exam					$0.00
W1031	H2000	Psychiatric Review of Hospital Records					$0.00
W1048	H0001HO	In-Depth Assessment (SA) - New Patient					$0.00
W1049	H0001TS	In-Depth Assessment (SA) - Established Patient					$0.00
W1027	H0001HN	Bio-Psychosocial Eval (SA)					$0.00
W1073	H2019	Psychological Testing					$0.00
W1039	H0001	Limited Functional Assessment (SA)					$0.00
W1067	T1007	Development of the Individ. Tx Plan (SA) new					$0.00
W1068	T1007	Development of the Individ. Tx Plan (SA) est					$0.00
W1069	T1007TS	Treatment Plan Review (SA)					$0.00
W1050	T1015	Medication Management					$0.00
	H2010HF	Brief Indiv Medical Psytherapy (SA)					$0.00
	H2010HQ	Group Medical Therapy					$0.00
	T1023HF	BH Screening (SA)					$0.00
W1070	H0047	BH Services - verbal interaction SA (clinic visit)					$0.00
W1070	T1015HF	BH Services - spec coll. SA (clinic visit)					$0.00
	H0020	Methadone Maintenance					$0.00

Medicaid Revenue for Substance Abuse Services -
FY 2002/2003

Procedure codes highlighted in YELLOW/GREEN would be included in capitation calculations for HMOs/PBHP when substance abuse is included in the Medicaid BH waiver.

Providers/Reimbursements

Mcaid Old Code	*M'caid HIPAA Code*	*Medicaid Code Description*					**Total by Code FY02/03**
W1036		Medical/Psychiatric Service Interpretation of the Results of Psychiatric Exam					$0.00
W1034		Group Medical Therapy					$0.00
W1037		Office and Outpatient Visit					$0.00
W1038							$0.00
W1074	H2019HR	Individual/Family Therapy					$0.00
W1075	H2019HQ	Group Therapy					$0.00
W1023	H2012HF	Behavioral Health Day Treatment - Substance Abuse					$0.00
W1044	H2017	Psychosocial Rehab. Services (Living Skills and Rehabilitation Counseling)					$0.00
W1046							$0.00
W1064		Rehabilitation Day Treatment					$0.00
W1071	H2019HO	Therapeutic Behavioral On-Site Services - Therapy (ITOS)					$0.00
	H2019HM	Therapeutic Behavioral On-Site Services - Beh Mgmt (ITOS)					$0.00
W1072	H2019HN	Therapeutic Behavioral On-Site Services - Support (HCBRS)					$0.00
W1041	H2020HA	Behavioral Health Overlay Services (Child Welfare)					$0.00
W1040	H2020HK	Behavioral Health Overlay Services (Juvenile Justice)					$0.00
			$0.00	***$0.00***	***$0.00***	***$0.00***	***$0.00***

Data Source: Medicaid Paid Claims System - AHCA/FMHI

Evaluation

Date: _____ **Location:** _____

Workshop: _____

Trainer: _____

Using the scale, please rate items #1 through #8 by circling **one** number for each item, then provide answers for the remaining items accordingly.

		Strongly **Disagree**		Not Sure		**Agree**
1.	The presenter(s) appeared knowledgeable with respect to the subject covered.	1	2	3	4	5
2.	The presenter(s) was (were) well prepared.	1	2	3	4	5
3.	The objectives were made clear.	1	2	3	4	5
4.	The objectives of the program were met.	1	2	3	4	5
5.	The speaker(s) presented materials in a clear and effective manner.	1	2	3	4	5
6.	The information presented was appropriate for the content and level of the presentation.	1	2	3	4	5
7.	You will be able to apply the learned information.	1	2	3	4	5
8.	Overall, this workshop was well organized.	1	2	3	4	5

9. How did you learn about this workshop?
   - ❑ Word of mouth
   - ❑ Received brochure in mail
   - ❑ Other _____

10. The presenter(s) should spend more time on the following:

11. The presenter(s) should spend less time on the following:

12. I would recommend this workshop to my friends and colleagues:
    Why/Why not?

13. Comments about the meeting facilities:

14. What prompted you to take this particular workshop?
    Check the most important one only:
    - ☐ Subject matter is interesting
    - ☐ Professional development
    - ☐ Required by employer
    - ☐ Location convenient
    - ☐ Network with others

Please use other side of page for additional comments.

Thank You.

RWJ – Resources for Recovery Grant
2004/2005

Date: _____ **Location:** _____

Workshop: **Train the Trainer – Florida Medicaid for Substance Use Disorders**

Trainer: **Mary Herkert – CFBHN**

Using the scale, please rate items #1 through #8 by circling **one** number for each item, then providing answers for the remaining items accordingly.

		Strongly **Disagree**		Not Sure		**Agree**
1.	The presenter(s) appeared knowledgeable with respect to the subject covered.	1	2	3	4	5
2.	The presenter(s) was (were) well prepared.	1	2	3	4	5
3.	The objectives were made clear.	1	2	3	4	5
4.	The objectives of the program were met.	1	2	3	4	5
5.	The speaker(s) presented materials in a clear and effective manner.	1	2	3	4	5
6.	The information presented was appropriate for the content and level of the presentation.	1	2	3	4	5
7.	You will be able to apply the learned information.	1	2	3	4	5
8.	Overall, this workshop was well organized.	1	2	3	4	5

9. How did you learn about this workshop?
   - ❑ Word of mouth
   - ❑ Received brochure in mail
   - ❑ Other _____

10. The presenter(s) should spend more time on the following:

11. The presenter(s) should spend less time on the following:

12. I would recommend this workshop to my friends and colleagues:
    Why/Why not?

13. Comments about the meeting facilities:

14. What prompted you to take this particular workshop? Check the most important one only:
    - ☐ Subject matter is interesting
    - ☐ Professional development
    - ☐ Required by employer
    - ☐ Location convenient
    - ☐ Network with others

Please use other side of page for additional comments.

Thank You.