MOLINA HEALTHCARE of FLORIDA

Behavioral Health

Behavioral Analysis Services:

Authorization & Documentation Guide

Comprehensive Provider Quick Reference Guide

Based in: AHCA BA Services Coverage Policy (December 2024)
Effective: July 2026

This guide helps BA providers submit complete, clinically sound authorization requests; reducing delays, denials, and rework, and supporting timely access to care for our members.

About This Guide

This guide is designed to help Behavior Analysis (BA) providers working with Molina Healthcare of Florida and the Children's Medical Services (CMS) Plan submit complete, clinically sound authorization requests, bill accurately, and access the right Molina resources quickly. It consolidates AHCA policy requirements, Molina submission standards, billing criteria, claims guidance, and contact information into a single comprehensive reference.

BA services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors. Molina covers Members under the age of 21 years requiring medically necessary BA services. All BA services require prior authorization.

> *A complete request -not just a checklist- clinically, tells the reviewer who this member is, what they need, why they need it now, and how the services requested will address that need.*

Important Links & Resources

The following Molina and AHCA resources are referenced throughout this guide:

Molina Florida Provider Home (includes Prior Authorization Code Lookup Tool): Prior Auth Look Up Tool

Availity Essentials Provider Portal (authorizations, claims, eligibility): Molina Availity Provider Portal

AHCA Behavior Analysis Services Information: Behavior Analysis Services Information | Florida Agency for Health Care Administration

AHCA BA Services Coverage Policy (December 2024, PDF): Behavior Analysis Coverage Policy

Medicaid Fee Schedule, Rule 59G-4.002, Provider Reimbursement Schedules and Billing Codes: Rule 59G-4.002, Provider Reimbursement Schedules and Billing Codes

AHCA Rule 59G-1.010, Florida Medicaid Definitions Policy: 59G-1.010 Definitions Policy_FINAL.pdf

Molina Provider Manual and Orientation: Provider Manual and Orientation

Coverage & Prior Authorization Basics

- Coverage: Members under age 21 requiring medically necessary BA services
- Prior authorization: Required for most BA services before initiation and at each reauthorization (at least every 180 days). Providers may submit reauthorization requests as early as 30 days prior to the authorization end date, but no later than 10 days before the end date.
- To verify code-specific authorization requirements, use the Prior Authorization Code Lookup Tool at Prior Auth Look Up Tool

Standard Authorization Decision Turnaround Times by Product Line

Product Line	Population Served	Standard Auth Timeline
MMA	Medicaid Managed Care	**4 business days**
SMI	Serious Mental Illness- children and adults with severe psychiatric conditions	**4 business days**
CMS Title 19	Children's Medicaid- standard Medicaid children	**3 business days**
CMS Title 21	Children's Health Insurance Program (CHIP)	**3 business days**
MKP	Molina Marketplace Plan	**15 business day**

Need to Know:
An expedited (or Urgent) Request is a prior-authorization or service request that requires a faster-than-standard decision due to a potential serious risk to the member's health or safety.
Routine BA reauthorizations generally do not meet this standard and should be submitted as standard requests within the timeframes above. Submitting routine requests as expedited can cause unnecessary review delays.

Do not initiate services before receiving written authorization from Molina. Services rendered without authorization are not reimbursable.

Section 1: The Comprehensive Diagnostic Evaluation (CDE)

What Is a CDE and Why Does It Matter?

The Comprehensive Diagnostic Evaluation (CDE) is the clinical foundation of every BA authorization request. It establishes why a member needs BA services, what the diagnosis is, and what treatment is clinically indicated. Per AHCA policy, the CDE must be performed according to national evidence-based practice standards and led by a licensed practitioner working within their medical, developmental, or psychological scope of practice. Providers must also hold certification and demonstrate competency in the administration, scoring, and interpretation of standardized psychological assessment tools used in ASD evaluation.

Who Can Perform a CDE?

- Primary Care Physician (PCP) with specialty in family practice, internal medicine, or pediatrics
- Board-certified or board-eligible physician with specialty in developmental behavioral pediatrics, neurodevelopmental pediatrics, pediatric neurology, or adult/child psychiatry
- Child psychologist (PhD or PsyD)
- Licensed School Psychologist (an unlicensed school psychologist may not conduct a CDE)
- Multidisciplinary team led by one of the above practitioners

Common Snag: A CDE performed outside this practitioner list will not satisfy authorization requirements. Verify practitioner credentials before submitting.

What Must the CDE Include?

✓	Required Element	What This Means
☐	**Formal Diagnosis**	A formal diagnosis made by the evaluating practitioner, not just a score from a screening tool such as CARS or ADOS. The diagnosis must be stated explicitly by the clinician.
☐	**Background & Presenting Concerns**	Developmental, behavioral, and medical history including relevant family history. Should reflect a thorough understanding of the individual child, not a generic template.
☐	**Direct Observation**	Documentation that the evaluating clinician directly observed the member. Virtual-only assessments may miss critical behavioral cues; **in-person evaluation is best practice for children**.
☐	**Diagnostic Testing**	Results of standardized diagnostic tools used: including scoring, interpretation, and clinical significance. School accommodation letters alone are not sufficient. Assessment Tool examples: Autism Diagnostic Interview-Revised [ADI-R], Autism Diagnostic Observation Schedule [ADOS-2], Childhood Autism Rating Scale [CARS-2], or Diagnostic Interview for Social and Communication Disorders [DISCO]).
☐	**Appropriate Assessment Instruments**	All screening and assessment instruments used must align with the current standard of care for diagnosing the relevant condition(s).
☐	**Treatment Recommendations**	Specific, individualized recommendations for BA services. Must justify that BA is clinically appropriate and medically necessary. **Generic recommendations are insufficient.** If there is **indication the member may be better served by a different evidence-based treatment, see Section 12: Alternative Evidence-Based Programs.**
☐	**Practitioner Signature & Date**	The CDE must be **signed** and **dated by** the **qualified licensed practitioner who led the evaluation**.
☐	**Parent/Guardian Input**	Background and status from a parent or guardian interview must be reflected in the evaluation findings.

What Distinguishes a Thorough CDE

Beyond the required components above, the strongest CDEs share characteristics that make the clinical picture immediately clear to any reviewer, and give the member's authorization the strongest possible foundation:

- The diagnosis is mapped to DSM-5 criteria: the clinician states which specific criteria the member meets, with examples drawn from this child's actual presentation, rather than relying on an instrument score alone.
- A severity level is specified for ASD, the DSM-5 level (1, 2, or 3) with support needs described. Severity context directly supports individualized treatment planning and the intensity of services requested.
- Functional impairment is documented across more than one environment, how the behaviors affect daily life at home AND at school or in the community. A diagnosis without documented functional impairment does not by itself establish the need for intensive services.

- Differential diagnosis reasoning is visible, the clinician considered and ruled out (or identified as co-occurring) conditions such as ADHD, language disorder, intellectual disability, or trauma response.
- Treatment recommendations are individualized, reflecting this member's specific presentation, strengths, and needs, including consideration of complementary services (speech, OT, behavioral therapy, parent training) where indicated.

> *A thorough, individualized evaluation is more impactful than a high volume of brief or incomplete assessments and it moves through authorization review faster, because it answers the reviewer's questions before they are asked.*

CDE Validity: What You Need to Know

Per AHCA Florida Medicaid BA Services Coverage Policy, the CDE does not carry a defined expiration date for Medicaid Members. **However, clinical circumstances may indicate that a new or updated CDE would better support the medical necessity determination**.

> *A new or updated CDE may support medical necessity when a member has experienced a significant developmental transition, change in functional presentation, or change in diagnosis, including but not limited to school entry, puberty onset, or transition to adolescent services.*

Important: CDE vs. Behavior Assessment, two Separate Requirements

Providers sometimes submit a CDE that was obtained privately or paid out of pocket. Molina accepts CDEs regardless of how they were obtained, provided they meet the qualifications and content standards above. However, Molina recommends using an **In-Network preferred provider to help** ensure the CDE meets all required standards. In addition, a CDE (even one that includes Vineland-3 or BASC-3 scores within the diagnostic evaluation) does not satisfy the separate AHCA requirement for a behavior assessment submitted with the authorization request:

The CDE	The Behavior Assessment (Authorization Requirement)
• Broad, multi-disciplinary diagnostic evaluation • Establishes the diagnosis and confirms clinical indication for BA • May include Vineland-3 / BASC-3 as supporting diagnostic instruments • Performed by a qualified licensed physician or psychologist • Required once at initiation (no expiration for Medicaid Members)	• Standardized assessment of current adaptive and behavioral functioning • Supports the medical necessity determination at each authorization • Requires complete Vineland-3 and BASC-3 PRQ scoring reports with outcome measure scores • Administered and scored by the BA provider or authorized evaluator • Required at every initial authorization and every 12-month reassessment

If Vineland-3 or BASC-3 scores appear only within a privately obtained CDE, a separate behavior assessment with complete scoring reports must still be submitted with the authorization request. Both documents are required; one does not replace the other.

Section 2: Common Snags What Delays or Returns a Request

The following are the most frequent documentation issues that result in authorization requests being returned, pended, or denied. Reviewing this list before submitting can significantly reduce processing delays for your members.

CDE-Related Snags

- Missing or unclear diagnosis: Scoring tools alone (CARS, ADOS, BASC-3) do not constitute a formal diagnosis. A clinician must state the diagnosis explicitly.
- Diagnosis not connected to DSM-5 criteria: The strongest CDEs show which criteria the member meets with examples from their presentation.
- No severity level specified: Severity context supports individualized treatment planning; its absence leaves the intensity request without diagnostic grounding.
- Functional impairment described in only one setting, or not at all: Impairment evidenced across home, school, and community paints the complete clinical picture.
- Insufficient background and history: The CDE reads as generic or template-based rather than individualized to the specific member.
- Lack of direct observation: No documentation that the evaluating clinician directly observed the member's behavior.
- School accommodation letters submitted in place of treatment recommendations.
- Treatment recommendations not individualized to the member: Identical recommendations across reports do not reflect individualized clinical judgment.
- CDE performed by a practitioner outside the qualified list.
- Overly brief reports that do not demonstrate thorough clinical assessment of the individual member.
- Overlooking alternative treatments: The CDE should reflect that the evaluating clinician considered other treatment options and determined BA is clinically indicated.

Authorization Request Snags

- Treatment goals that are not observable or measurable. Goals must include a definition of the behavior in observable terms, baseline data, mastery criteria, and anticipated date of mastery.
- FBA or treatment plan without individualized member data. Naming the function of a behavior (attention, escape, sensory, tangible) is not sufficient by itself. The documentation must show this member's actual data: how often the behavior occurs, at what rate or duration, and at what severity (for example, frequency of self-injurious episodes per hour or day, intensity, and resulting impact). Function definitions without member-specific measurement do not establish severity or support the requested intensity.
- Missing FBA/BIP for any behavior reduction goal.
- Behavior plan does not cover the full authorization period being requested (up to six months).
- Reassessment missing required instruments. Vineland-3 and BASC-3 PRQ must be included with every 12-month reassessment.
- No data tables or graphs per behavior. Each behavior under treatment must have its own data table and corresponding graph for reauthorization requests.
- No narrative justification for continuation at the intensity level requested.

- Parent/guardian participation not documented. If a parent or guardian cannot participate, this must be documented with explanation and a plan to mitigate impacts.
- No reauthorization request service documentation. Other therapies must be listed, and the BA request must explain how services complement rather than duplicate each other.

Section 3: What to Submit By Request Type

Initial Authorization Request

✓	Required Element	What This Means
☐	**CDE**	Complete CDE meeting all requirements in Section 1. Performed by a qualified licensed practitioner.
☐	**Referral / Physician Order**	Signed referral from the member's assigned Primary Care Provider (PCP). The PCP must be qualified to assess and diagnose disorders related to functional impairment, and the referral must specify ABA services.
☐	**Behavior Assessment**	Vineland-3 Comprehensive Parent Interview Form (all members) and BASC-3 PRQ (ages 2- 18). Full administered and scored, including complete scoring reports with outcome measure scores.
☐	**Behavior Plan**	Covers the full requested authorization period (up to 6 months). All goals in observable, measurable terms with baselines, mastery criteria, and anticipated end dates.
☐	**FBA/BIP**	Required for any behavior reduction goal, with member-specific data on frequency, rate, duration, and severity of each targeted behavior.
☐	**Treatment Schedule**	Proposed weekly schedule including all BA service codes, frequency, and units requested. Must reflect member's actual availability.
☐	**Place of Service & Schedule**	Clearly identify the place(s) of service (home, clinic, school) and a clear weekly schedule. A clear schedule also helps confirm school-setting requirements and supports the intensity determination (for example, an RBT scheduled after a full school day from 3-9 PM may signal a clinical concern). See Section 5: Service Intensity for full detail.
☐	**Reauthorization Request Services**	All other services the member receives. i.e., School-based services, OT, PT, ST, counseling, psychiatric medication management, and how BA coordinates with them.
☐	**Caregiver Training Goals**	Proposed caregiver training targets, procedures, anticipated mastery dates, and parent/guardian signature on the behavior plan.
☐	**Supervision Plan**	Name(s) of authorized supervisor(s): BCBA for RBTs and BCaBAs.
☐	**Transition/Discharge Plan**	Established at initiation with objective criteria, not deferred to a later date.

Reauthorization Request

✓	Required Element	What This Means
☐	**Updated Behavior Assessment**	Vineland-3 and BASC-3 PRQ required every 12 months; updated assessment findings required for shorter periods.
☐	**Data Tables & Graphs**	Each behavior under treatment has its own data table and graph showing progress from baseline to current.
☐	**Progress Narrative**	Progress on all goals, barriers identified, and explanation of goals not achieved during the prior period.
☐	**Intensity Justification**	Written statement of why continuation at the requested service level remains medically necessary based on clinical presentation and progress data.
☐	**Updated Goals**	Mastered goals noted; new goals meet the same measurable standard as initial goals.
☐	**Updated FBA/BIP**	Updated as often as necessary to achieve socially significant outcomes, any change in challenging behavior requires an updated BIP.
☐	**Updated Caregiver Training**	Progress toward caregiver goals, barriers encountered, updated targets.
☐	**Attendance Documentation**	Member and caregiver attendance; explanation and barrier-mitigation plan if attendance falls below expectations.
☐	**Transition Plan Update**	Progress toward step-down goals and how hours are projected to be titrated.
☐	**Reauthorization Request Services Update**	Updated list of all other services the member is receiving.

Section 4: Behavior Assessment Requirements

This section covers two distinct required clinical components. The standardized behavior assessment and the FBA/BIP. Although both relate to assessing the member, they serve different purposes, are built from different tools, and are submitted as separate documents. Understanding the difference helps ensure each authorization request is complete.

Part A: The Standardized Behavior Assessment for Authorization

The standardized behavior assessment is a required submission document that establishes the member's current adaptive and behavioral functioning. It supports the medical necessity determination by documenting where the member stands clinically at the time of each request. It consists of two core standardized instruments:

- Vineland-3 Comprehensive Parent Interview Form, required for ALL Members regardless of age; the Maladaptive Behavior Domain is required for members ages 3 and older; a complete scoring report including outcome measure scores must be submitted.
- BASC-3 PRQ (Parenting Relationship Questionnaire), required for members ages 2 through 18; a complete scoring report including outcome measure scores must be submitted.
- Additional assessment tools may be used at the Lead Analyst's discretion.

This is a required document for BOTH initial and Reauthorization requests:

The standardized behavior assessment is a required submission document for both initial and reauthorization requests. The Vineland-3 Comprehensive Parent Interview Form and BASC-3 PRQ (with complete scoring reports including outcome measure scores) must be submitted with the initial request and at each reassessment (complete scoring reports at least every 12 months; updated assessment findings for shorter reauthorization periods). This requirement is separate from and not satisfied by the CDE, the FBA, the BIP, or any other supporting document. A CDE that happens to contain Vineland-3 or BASC-3 scores does not fulfill this requirement, and these instruments are never used to construct the FBA or BIP.

> *The standardized behavior assessment is one of several required components for reauthorization requests. See Section 3: Reauthorization Request for the complete list of documents required at each ongoing authorization, which also includes updated data tables and graphs, a progress narrative, intensity justification, an updated FBA/BIP, caregiver training updates, attendance documentation, a transition plan update, and a reauthorization services update.*

Part B: Understanding the Role of Assessment Tools

Not all assessment tools serve the same clinical purpose. The standardized behavior assessment (Part A) and the FBA tools (Part C) capture different kinds of information. This contrast helps ensure the right information is submitted in the right context:

Standardized Behavior Assessment (Vineland-3 & BASC-3 PRQ)	FBA-Level Tools (Direct Observational Methodology)
• Establish global adaptive functioning across communication, daily living, and socialization domains • Identify co-occurring emotional or behavioral concerns at a broad level • Support the medical necessity determination for the authorization request • Required as a submission document at initial authorization AND every reauthorization request (every 12-month reassessment)	• Capture real-time, behavior-specific data, i.e., antecedents, behavior, consequences; in the environments where behavior occurs • Identify the function of each specific targeted behavior • Form the clinical foundation of the Behavior Intervention Plan • **Examples:** ABC data collection, FAST, MAS, FAI, scatterplots, functional analysis

> **Vineland-3 and BASC-3 scores alone do not constitute an FBA. These instruments fulfill the standardized behavior assessment requirement (Part A) and establish the broad clinical picture. They do not capture the specific, real-time behavioral data needed to build a clinically defensible Behavior Intervention Plan, and they are never used to construct the FBA or BIP.**

Part C: FBA/BIP Requirements

The Functional Behavior Assessment (FBA) and Behavior Intervention Plan (BIP) are distinct from the standardized behavior assessment. They are built from direct observational tools and are required for any goal targeting reduction of a maladaptive behavior.

Functional Behavior Assessment (FBA) must include:

- Informed consent and clear rationale for the intervention
- Assessment methodology both direct (observation) and indirect (interviews, record review) methods
- **Operational definitions of each targeted behavior with member-specific baseline data, frequency (how often), rate (how quickly it repeats), duration, and intensity or severity (for example, number of self-injurious episodes per hour and resulting harm). The function alone is not an assessment.**
- Hypothesized functions of the problem behavior including antecedents and consequences
- Functionally equivalent replacement behaviors identified

Behavior Intervention Plan (BIP) must include:

- Informed consent; date of initiation and all subsequent revisions
- Individualized plan tailored to the specific member, implementer(s), and setting
- Stakeholder ability to implement the interventions
- Specific alternative/replacement behaviors targeted for increase in the skill acquisition section

> **The BIP must be updated as often as necessary to achieve socially significant outcomes, not just at reassessment. Any new challenging behavior or change in behavior function requires a BIP update.**

Section 5: Service Intensity Building a Clinically Complete Picture

Every member's clinical presentation is unique. The hours requested, the goals targeted, and the intensity of services should reflect the individual member's needs informed by their specific diagnosis, functional level, environment, and progress, not a standard package applied uniformly across cases.

> *A clinically complete intensity request tells the member's individual story across multiple dimensions: who they are, where they struggle, how they are progressing, and why this level of service is what they need right now.*

Evidencing Impairment Across Multiple Environments

One of the strongest elements of a well-documented authorization request is evidence that the member's functional impairment is present across more than one setting. Supporting documentation may include:

- School-based observations or teacher reports reflecting behavioral challenges in the educational setting
- IEP documentation: Required when services will be delivered in a school setting (see Section 7); when no IEP exists, supporting documentation evidencing school-based impairment is still valuable
- Progress reports from other treating providers: OT, PT, ST, psychiatry
- Parent or caregiver accounts of behavior at home, in the community, and in social settings
- Direct observation data collected across different settings and times of day

The goal is a complete clinical picture. Avoid paperwork checklist. Any documentation that helps the reviewer understand how this member's behaviors affect daily life across settings strengthens the individualized case for the requested level of service.

What Makes a Clinically Complete Intensity Request?

- Current level of functioning: adaptive behavior, communication, social skills, self-care, and safety, informed by Vineland-3 and BASC-3 scores
- Scope of treatment: comprehensive (multiple developmental domains) vs. focused (specific skills or behaviors); comprehensive treatment typically requires greater intensity
- Member's actual availability: the schedule must reflect school hours, other therapies, naps, and family availability; hours requested cannot exceed hours the member is actually available
- Reauthorization request services: documented coordination to avoid unnecessary duplication
- Caregiver capacity: ability to participate and implement strategies
- Progress data at reauthorization: trajectory per behavior; if progress is slow, explain why and what will change; if strong, explain the clinical rationale for maintaining intensity
- A detailed & individualized Transition and step-down plan: how hours are projected to be titrated as goals are achieved

Hours Requested vs. Member Availability

If hours requested exceed the member's documented availability, the authorization request must include a written rationale, a coordination plan to address participation barriers, and documentation of efforts to accommodate the member's schedule.

Requests where authorized hours significantly exceed hours actually delivered without documented explanation may prompt a clinical review of the member's ongoing need for the authorized level of service. Document fulfillment barriers proactively in monthly treatment plan updates.

Section 6: Session Note Requirements

Per AHCA policy, all session notes must be signed and dated by the rendering practitioner and include for every session:

- Date, time, location, and duration of the session
- Maladaptive behaviors observed: noted explicitly even if none occurred
- Replacement/compensatory skills targeted, aligned with the authorized behavior plan
- Member's response to treatment interventions: individualized, not templated
- Protocol modifications: any changes to goals, objectives, or therapist directions
- Parent/guardian presence: with documented reason if not present
- Participants: observers, teachers, parents, caregivers, or other providers present

Session notes that are templated, copied forward, or missing individualized clinical detail do not meet documentation requirements and may be flagged during records review.

Section 7: Reauthorization Request Services & Care Coordination

BA providers are expected to function as part of the member's broader treatment team. The treatment team may include behavioral health providers, the assigned Primary Care Physician, other physical health providers, therapy services (OT/PT/ST), educational supports, and community supports, depending on the member's needs.

Coordination Documentation

- Care coordination section listing all current services and providers
- Description of how BA services complement rather than duplicate other services

IEP Requirements When Services Are Delivered in a School Setting

Per AHCA BA Coverage Policy, when an authorization request includes BA services delivered in a school setting:

Situation	What Must Be Submitted
IEP exists and includes BA services	Submit the current IEP with the authorization request.
IEP exists but does not include BA services	Submit the IEP plus documentation justifying the requested BA services and an estimated timeframe for when BA will be added to the IEP. When requested services overlap with school instructional time, the documentation should explain why BA is needed during those hours.
No IEP,school uses a 504 Plan instead	A 504 Plan may be submitted in place of the IEP, along with documentation justifying the requested BA services.
School does not conduct IEPs or 504 Plans	Submit documentation including the name of the school and a written explanation confirming neither plan is available at that institution and why it is not available. And expected date of when an IEP or 504 Plan will be completed.
Member is not yet enrolled in school	Submit documentation confirming enrollment status and estimated timeframe; if school entry is imminent, include a transition plan addressing coordination with the school setting.

> *When BA services are NOT delivered in a school setting, IEP documentation is not required, but school records, IEP, and teacher reports may still be submitted as supporting evidence of functional impairment across environments.*

Section 8: Transition Planning & Discharge Criteria

A transition and discharge plan must be established at the initiation of BA services not deferred until the member is ready to discharge. The transition and discharge plan must be reviewed and updated throughout treatment.

Discharge Criteria (Per AHCA Policy)

- The member no longer meets medical necessity criteria
- The member no longer engages in maladaptive behaviors
- Data indicates the frequency and severity of maladaptive behaviors no longer poses a barrier to participation in major life activities
- The level of functional impairment no longer justifies continued BA services
- Parent or guardian withdraws consent for treatment

What a Strong Transition Plan Includes

- SMART goals outlining the specific skills needed to support a lower level of care, including the caregiver
- Progress toward transition goals documented at each reassessment
- Details on how hours are projected to be titrated as transition goals are achieved
- Community resources and respective supports to maintain gains after discharge
- Increased caregiver training frequency as the member approaches transition criteria
- For school-aged members receiving full-time ABA that prevents school attendance, a documented plan for transitioning to a school-based setting

> **Discharge criteria should be objective and individualized, not vague. 'When clinically appropriate' is not a discharge criterion. Include information on individualized to the specific member, their current skills, realistic criteria to achieve lower support (i.e., 0 instances of aggression for 6 months when current levels are 50 instances/day).**

Section 9: Billing Criteria

Claim Type

Professional CMS 1500.

The 8-Minute Rule for 15-Minute Units

- Providers must only bill for services performed for 8 minutes or more when determining the number of billable 15-minute units.
- For services exceeding 15 minutes: divide the total minutes of service by 15 to obtain the number of units.
- Remaining minutes greater than or equal to 8 count as one additional unit and may be billed as such.
- Remaining minutes less than 8 do not count as a unit and are not billable.

Billing to the Authorized Weekly Hours

Services are authorized based on a weekly hour total. Providers must submit claims that do not exceed the number of hours authorized for that week.

Codes and Modifiers

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C. Refer to the Medicaid Fee Schedule link in the Important Links section. **Modifiers, including telehealth modifiers, should follow the current Medicaid Fee Schedule for the service and place of service rendered.**

BA Procedure Codes & Prior Authorization

Code	Description	Prior Auth Required?
97151	Behavior Identification Assessment, by physician or Qualified Healthcare Professional (QHP), each 15 minutes	**No**
97153	Adaptive Behavior Treatment by Protocol, technician, each 15 minutes	**Yes**
97154	Group Adaptive Behavior Treatment by Protocol, technician, each 15 minutes	**Yes**
97155	Adaptive Behavior Treatment with Protocol Modification, physician or QHP, each 15 minutes	**Yes**
97156	Family Adaptive Behavior Treatment Guidance, physician or QHP, each 15 minutes	**Yes**

Note: Code 97151 (Behavior Identification Assessment) does not require prior authorization. All other BA service codes listed above require prior authorization before services begin. Please review the Prior LookUp Tool for the latest updates: Prior Auth Look Up Tool

Supervision Billing

The supervisor may be reimbursed for observing a supervisee implementing the behavior plan. The supervisee will not be reimbursed when the supervisor is reimbursed for the same time period.

Section 10: Claim Submission

Availity Essentials Portal (Preferred Method)

Portal: https://provider.molinahealthcare.com/

Availity Essentials claims benefits include:

- Submit claims with the ability to add attachments
- Check claims status and receive timely notification of status changes
- Submit corrected claims and easily void claims
- Save incomplete/un-submitted claims and create/manage claim templates

EDI Submission

Submit claims to Molina through your EDI clearinghouse using Payer ID 51062.

Paper Claim Submission

Molina Healthcare of Florida Claims
PO Box 22812, Long Beach, CA 90801

Section 11: Contact Directory

Molina Healthcare of Florida

Department	Phone	Fax
Member Services	866-472-4585 | TTY: 711 (English)	844-834-2155
Utilization Management	855-322-4076 (MMA/LTC/CMS)	—
Behavioral Health	855-322-4076	—
Pharmacy Prior Authorizations	855-322-4076	866-236-8531
Nurse Advice Line (24/7)	English: 888-275-8750 | Spanish: 866-648-3537 | TDD/TTY: 866-735-2929 (Eng), 866-833-4703 (Sp)	—
Provider Services	855-322-4076	—
Claim Recovery Unit	866-642-8999	—
Electronic Funds (EFT), Change Healthcare/ECHO	888-834-3511	—
Appeals & Grievances	866-472-4585	877-553-6504

Department Mailboxes

- Provider Services: mflproviderservicesmanagement@molinahealthcare.com
- Provider Appeals: MFL_ProviderAppeals@MolinaHealthcare.com
- Provider Contracting: MFLProviderNetworkManagement@MolinaHealthCare.com

Section 12: Alternative Evidence-Based Programs

When BA May Not Be the Right Fit

Behavior Analysis is one of several evidence-based treatments available to Molina members. When a comprehensive diagnostic evaluation indicates that a member may not meet medical necessity for BA or may be better served by a different approach these programs exist for the child's and family's benefit. This section is a referral guide for providers to help connect families to the most clinically appropriate care.

Important! How The Programs Work:
These programs require provider certification and fidelity to the specific model. Not every provider can deliver every program, each requires specialized training and certification.
Members are connected to these services by referral to a certified provider. This list is for clinical awareness and referral guidance; it does not represent a billing structure.
Eligibility is determined by the member's clinical presentation and the program's specific criteria (the age ranges below are a starting reference, not the only standards).

Evidence-Based Program Reference: Eligibility at a Glance

Program	Ages Served	Best For
Brief Strategic Family Therapy (BSFT)	6–18	Externalizing and internalizing behaviors in youth where restructuring family interactions is a focus
Functional Family Therapy (FFT)	11–18	At-risk or justice-involved youth with delinquency, substance use, or conduct concerns
Healthy Families (HF)	Prenatal–5	New and expectant families at risk for maltreatment or adverse childhood experiences
HOMEBUILDERS	Birth–18	Families at imminent risk of a child's out-of-home placement; intensive in-home preservation
Motivational Interviewing (MI)	All ages	Strengthening a member's own motivation for behavior change; standalone or alongside other care
Multisystemic Therapy (MST)	12–17	Youth with serious antisocial/conduct behavior across home, school, and community systems
Parents as Teachers (PAT)	Prenatal–5	Early childhood parent education and development; promoting school readiness
Parent-Child Interaction Therapy (PCIT)	2–7	Young children with disruptive/defiant behavior; coached parent-child interaction

Nurse-Family Partnership (NFP)	First-time moms, prenatal–2	First-time, low-income mothers from pregnancy through the child's first two years
Child-Parent Psychotherapy (CPP)	Birth–5	Trauma-exposed young children, delivered with the parent/caregiver
Trauma-Focused CBT (TF-CBT)	3–18	Children with post-traumatic stress and related emotional/behavioral problems

CMS Programs for Children with Intensive Behaviors

For Molina CMS members with more intensive needs, two additional evidence-based programs are available:

Program	Ages Served	Best Suited For
High Fidelity Wraparound (HFW)	Birth–21	Children/youth with complex emotional, behavioral, or mental health needs; team-based coordinated planning
Coordinated Specialty Care (CSC) First Episode Psychosis	Adolescents & young adults	Members experiencing a first episode of psychosis or early stages of a psychotic disorder
Community Action Team (CAT)	11-21	Adolescents at risk of out of home placement, have not responded to less intensive services, history of Baker Act admissions. Coordinate with local Managing Entity for referrals to a provider.

To refer a member to any of these programs, or to confirm certified providers in your area, contact Provider Services at 855-322-4076. Prior authorization requirements vary by program; verify using the Prior Authorization Code Lookup Tool.

Section 13: Frequently Asked Questions

Q: Do all BA services require prior authorization?

A: Most BA service codes require prior authorization before initiation and at each reauthorization (at least every 180 days). The exception is code 97151- Behavior Identification Assessment. Which does not require prior authorization. See the BA Procedure Codes & Prior Authorization table in Section 9 for the full code-level breakdown. Use the Prior Authorization Code Lookup Tool on the Molina Florida provider page to verify current code-specific requirements.

Q: My patient's family paid for a private CDE. Will Molina accept it?

A: Yes, Molina accepts CDEs regardless of how they were obtained, provided the evaluation was performed by a qualified licensed practitioner and meets the content standards in Section 1. Note that a separate behavior assessment (Vineland-3 and BASC-3 PRQ with complete scoring reports) must still be submitted with the authorization request. However, we recommend using an in-network preferred provider to help ensure the CDE meets all required content and quality standards.

Q: Does the CDE expire?

A: Per AHCA policy, the CDE does not carry a defined expiration date for Medicaid/CMS Members. However, a new or updated CDE may support medical necessity when the member has experienced a significant developmental transition, change in functional presentation, or change in diagnosis. Molina reserves the right to request a new CDE if it is determined the member has experienced significant change in any area.

Q: How often must the Vineland-3 and BASC-3 be re-administered?

A: Complete scoring reports for both instruments are required at the initial authorization and at least every 12 months thereafter with the annual reassessment.

Q: What is the most common reason BA authorization requests are delayed?

A: Incomplete documentation. Most often a missing or insufficient CDE component, missing scoring reports, goals that are not measurable, or an FBA that names the function of a behavior without member specific frequency, duration, and severity data. Use the pre-submission checklists in this guide before submitting.

Q: Can I bill for services delivered before the authorization was approved?

A: No. Services rendered without prior authorization are not reimbursable. Do not initiate services until written authorization is received.

Q: How do I submit claims?

A: The preferred method is the Availity Essentials portal (provider.molinahealthcare.com). You may also submit through your EDI clearinghouse using Payer ID 51062, or by paper to Molina Healthcare of Florida Claims, PO Box 22812, Long Beach, CA 90801.

Q: How are 15-minute units calculated?

A: Bill only for services of 8 minutes or more. For services over 15 minutes, divide total minutes by 15; remaining minutes of 8 or more count as one additional unit, while remaining minutes under 8 are not billable.

Q: Can a supervisor and supervisee both bill for the same time period?

A: No. The supervisor may be reimbursed for observing a supervisee implementing the behavior plan, but the supervisee is not reimbursed for the same time period.

Q: Is an IEP required for every school-aged member?

A: No. The IEP is required only when BA services will be delivered in a school setting. If no IEP exists, see the alternatives table in Section 7, including 504 Plans. Outside the school setting, school records and IEP remain valuable as evidence of impairment across environments but are not required.

Q: When should I submit my reauthorization request?

A: Submit reauthorization requests as early as 30 days prior to the authorization end date, but no later than 10 days before the end date. This allows enough time for review before the current authorization expires.

Q: What if my evaluation shows the member may not meet medical necessity for BA?

A: BA is one of several evidence-based treatments available to Molina members. If the clinical picture indicates the member may be better served by a different approach, see Section 12: Alternative Evidence-Based Programs for a reference list of programs and the populations they serve, so the family can be connected to the most appropriate care.

Q: Do the alternative evidence-based programs require special certification?

A: Yes. These programs require provider certification and fidelity to the specific model, not every provider is able to deliver every program. Members are connected to these services by referral to a certified provider.

Q: Who can participate in a peer-to-peer (P2P) review?

A: Peer-to-peer discussions are intended to occur between the member's treating clinician and a Molina Medical Director, as a means of obtaining additional clinical information. They are not intended for CEOs, business owners, UM staff, or other non-treating representatives due to confidentiality concerns. Parties who are not the treating clinician should use the appeal process. Both providers and Medical Directors are expected to maintain professionalism and courtesy throughout the discussion. Our Clinical Directors reserve the right to terminate a P2P discussion if inappropriate behavior occurs, or if individuals other than the treating clinician attempt to lead or redirect the conversation.

Q: How does the peer-to-peer (P2P) process work, and how does it relate to appeals?

A: Peer-to-peer discussions are confidential and conducted in accordance with HIPAA privacy requirements, between the Molina Medical Director and the treating clinician. They may not be recorded or transcribed, including by AI tools. Molina completes either a reconsideration or a peer review, not both. An appeal may be filed without first completing a peer review or reconsideration; however, once an appeal has been filed on a case (or an appeal is already in progress), a peer-to-peer review on that same case cannot be requested.

Q: Can additional records, like notes from the referring provider, help support my request?

A: Yes. While not required, supporting records such as assessment or treatment notes from the referring PCP can help strengthen a request by giving a fuller clinical picture of the member's needs. These are a helpful addition, not to be understood as a submission requirement.

Q: Where can I learn more about what comprehensive ASD evaluation typically includes?

A: Molina does not prescribe which specific instruments a qualified provider must use, that is a clinical judgment guided by the current standard of care for the condition being assessed (see Section 1). For providers who want a general reference on the components of a comprehensive autism spectrum disorder evaluation, the CHOP Research Institute's "Elements of an Evaluation for Autism Spectrum Disorder" is a helpful publicly available resource: **Elements of an Evaluation for Autism Spectrum Disorder | CHOP Research Institute**

This is provided as a clinical-education resource only and does not establish Molina coverage criteria.

Q: Who do I contact with authorization questions?

A: Utilization Management at 855-322-4076 (MMA/LTC/CMS). For general provider questions, Provider Services at 855-322-4076 or mflproviderservicesmanagement@molinahealthcare.com.

Q: How do I file an appeal?

A: Contact Appeals & Grievances at 866-472-4585 (fax 877-553-6504) or MFL_ProviderAppeals@MolinaHealthcare.com.

Document Revision History

Version	Date	Summary of Changes	Author / Reviewer
1.0	July 2026	Initial draft- Comprehensive merged QRG Sections 1-13 covering CDE requirements, common snags, submission checklists, behavior assessment, service intensity, session notes, reauthorization request services, discharge criteria, billing, claims, contacts, Alternative EBP reference table and FAQ. All content grounded in AHCA BA Coverage Policy (December 2024) and Molina BA QRG (Revised 10/14/2025).	Behavioral Health Dpt./ UM Review (Katia Matos, AVP) / VP Review (Kale Baker)

To request a revision or report an error in this document, contact the Behavioral Health Dpt. Through Provider Services at mflproviderservicesmanagement@molinahealthcare.com.