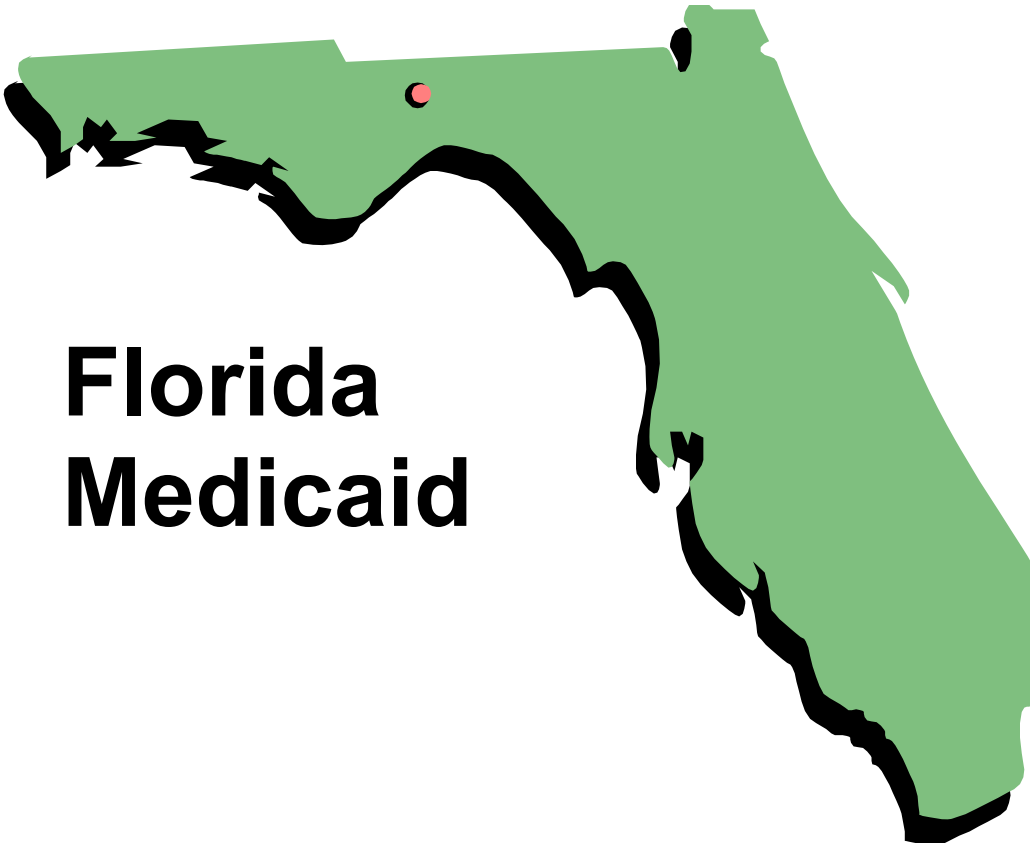

Florida Medicaid

Evaluation and Management Services Coverage Policy

Agency for Health Care Administration

Table of Contents

1.0 Introduction

Florida Medicaid evaluation and management services provide for physician visits to maintain a recipient's health, prevent disease, and treat illness.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render evaluation and management services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Florida Medicaid evaluation and management services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Parts 440 and 441
- Section 409.905, Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Policy.

1.4.1 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.4.2 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.4.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.4 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.4.5 Normal Newborn

A newborn baby with an Apgar score of 7, 8, 9 or 10 and in good health.

1.4.6 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.7 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

1.4.8 Well Child Visit
Services that provide comprehensive, preventative health screenings for recipients under the age of 21 years.

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary evaluation and management services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, the service is covered for recipients of all ages.

2.3 Coinsurance and Copayment
Recipients are responsible for the following copayment in accordance with section 409.9081, F.S., unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

- $2.00 per practitioner office visit, per day
- $3.00 per federally qualified health center visit, per day
- $3.00 per rural health clinic visit, per day

3.0 Eligible Provider

3.1 General Criteria
Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid evaluation and management services.

3.2 Who Can Provide
Services must be rendered by one of the following:

- Practitioners licensed in accordance with Chapters 458, 459, or 464, F.S. and working within the scope of their practice
- County health departments administered by the Department of Health in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Rural health clinics certified by Medicare

4.0 Coverage Information

4.1 General Criteria
Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers services in accordance with the American Medical Association's Current Procedural Terminology and the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

4.2.1 Adult Health Screening Services

One adult health screening every 365 days, for recipients age 21 years and older

4.2.2 Custodial Care Facility Services and Nursing Facility Services

One evaluation and management visit per month, per recipient

4.2.3 Office Visits

- As medically necessary for recipients under the age of 21 years, and pregnant recipients age 21 years and older
- Up to two office visits per month, per specialty, for recipients age 21 years and older

4.2.4 Well Child Visit

Preventative medicine services for recipients under the age of 21 years, in accordance with the American Academy of Pediatrics periodicity schedule. A recipient under the age of 21 years may receive a well child visit whenever it is medically necessary or requested by the recipient, the recipient's parent, or caregiver.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Services for a normal newborn who remains in the hospital more than three days after birth
- Services that are included in the global surgery package for another Florida Medicaid-compensable service
- Speech or comprehensive audiometry threshold evaluations or visual field or intermediate visual field examinations, when performed as part of a well child visit on the same day by the same provider
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with Florida Medicaid's Telemedicine Policy
- Well child visits for recipients residing in an intermediate care facility

6.0 Documentation

6.1 General Criteria
For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Requirements Policy.

6.2 Specific Criteria
There is no coverage-specific documentation requirement for this service.

7.0 Authorization

7.1 General Criteria
The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria
Providers must obtain authorization from the quality improvement organization to exceed the coverage limits specified in sections 4.2.3 and 4.2.4 for recipients age 21 years and older.

8.0 Reimbursement

8.1 General Criteria
The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type
Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit
Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, incorporated by reference in Rule 59G-4.002, F.A.C.

8.3.1 Modifier
Providers must include the following modifiers, as appropriate, on the claim form:

- EP With procedure code for well child visit services for recipients between the ages of 18 to 20 years
- 25 Significant, separately identifiable evaluation and management visit services by the same provider on the same day as another service
- 24 Evaluation and management visit services that are performed during the post-operative global surgery period

8.4 Diagnosis Code
Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate
For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit AHCA's Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

Florida Medicaid reimburses pediatric surgery and urological specialty enrolled providers at the enhanced rate when indicated on the fee schedule.