

# Florida

# Medicaid

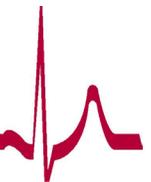
## Summary of Services

### FY 2003 - 2004

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**Agency for Health Care Administration**

**FLORIDA**  
**MEDICAID**



# **FLORIDA MEDICAID PROGRAM**

## **SUMMARY OF SERVICES**

**FY 2003 - 2004**

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### **DISCLAIMER**

The Florida Medicaid Summary of Services provides only brief information on Medicaid coverages. It is not a legally-binding document and is not to be relied upon for specific information on recipient eligibility, service reimbursement, or service limitations. Detailed information may be found in 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>.

This publication may be obtained from the AHCA website at [www.myflorida.com](http://www.myflorida.com). Printed copies may be obtained from the Area Medicaid offices or from Medicaid Contract Management.

*The Agency for Health Care Administration champions accessible, affordable, quality health care for all Floridians.*

# 2003-04 MEDICAID SUMMARY OF SERVICES

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## SECTION I—GENERAL INFORMATION

### Introduction

Florida Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists aged people and disabled 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 2.1 million people in Florida, with about half of those being children and adolescents under the age of 21.

Estimated expenditures for Fiscal Year 2003-04 (July 2003 through June 2004) are approximately \$12.5 billion.

### Purpose of the Summary of Services

The Florida Medicaid Summary of Services booklet is intended to be a quick reference to Medicaid services. This Summary provides an overview of Florida Medicaid services as well as information on Medicaid eligibility and managed care programs.

It is intended as an introduction to Medicaid for new Medicaid employees and for staff working in other programs, agencies, and departments.

Users who do not work in state government may want to contact their local Area Medicaid Office for more details about covered services.

Providers should refer to the Florida Medicaid Provider General Handbook or the service-specific Coverage and Limitations Handbook for more detailed information about Florida Medicaid.

### How This Book is Organized

The Summary of Services is presented in four sections:

- I. General Information
- II. Recipient Eligibility
- III. Managed Care Programs
- IV. Special Medicaid Requirements and Policies
- V. Medicaid Covered Services

### Background

Florida implemented the Medicaid program on January 1, 1970, to provide medical services to low-income people.

Over the years, the Florida Legislature has authorized Medicaid reimbursement for additional services. A major expansion occurred in 1989, when the United States Congress mandated that states provide all Medicaid services allowable under the Social Security Act to children under the age of 21.

The Medicaid program is different in every state. The federal government sets the general guidelines and each state decides how to run the program.

In Florida, the Florida Legislature determines:

- Who qualifies for Medicaid
- What services will be covered
- How much to pay for the services

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**Funding**

The Medicaid program is funded by state and federal funds, with the counties contributing to the cost of inpatient hospital and nursing facility services.

Matching federal funds are contingent upon the state's continued compliance with the federal laws and regulations.

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act
  - Title 42 of the Code of Federal Regulations
  - Chapter 409, Florida Statutes, and
  - Chapter 59G, Florida Administrative Code.
- 

**Administration**

The state agency that administers Florida Medicaid is the Agency for Health Care Administration (AHCA). AHCA develops and carries out policies related to the Florida Medicaid program and contracts with the fiscal agent (ACS State Healthcare) to enroll health care providers and process claims.

AHCA has eleven area offices throughout the state that serve as the local liaisons to providers and recipients. The area offices are responsible for:

- Exceptional claims processing;
  - Provider relations and training;
  - Consumer relations;
  - Managing the Child Health Check-Up program;
  - Transportation and School Match programs on a local level; and
  - Conducting credentialing site visits to MediPass providers.
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**Who Determines Eligibility**

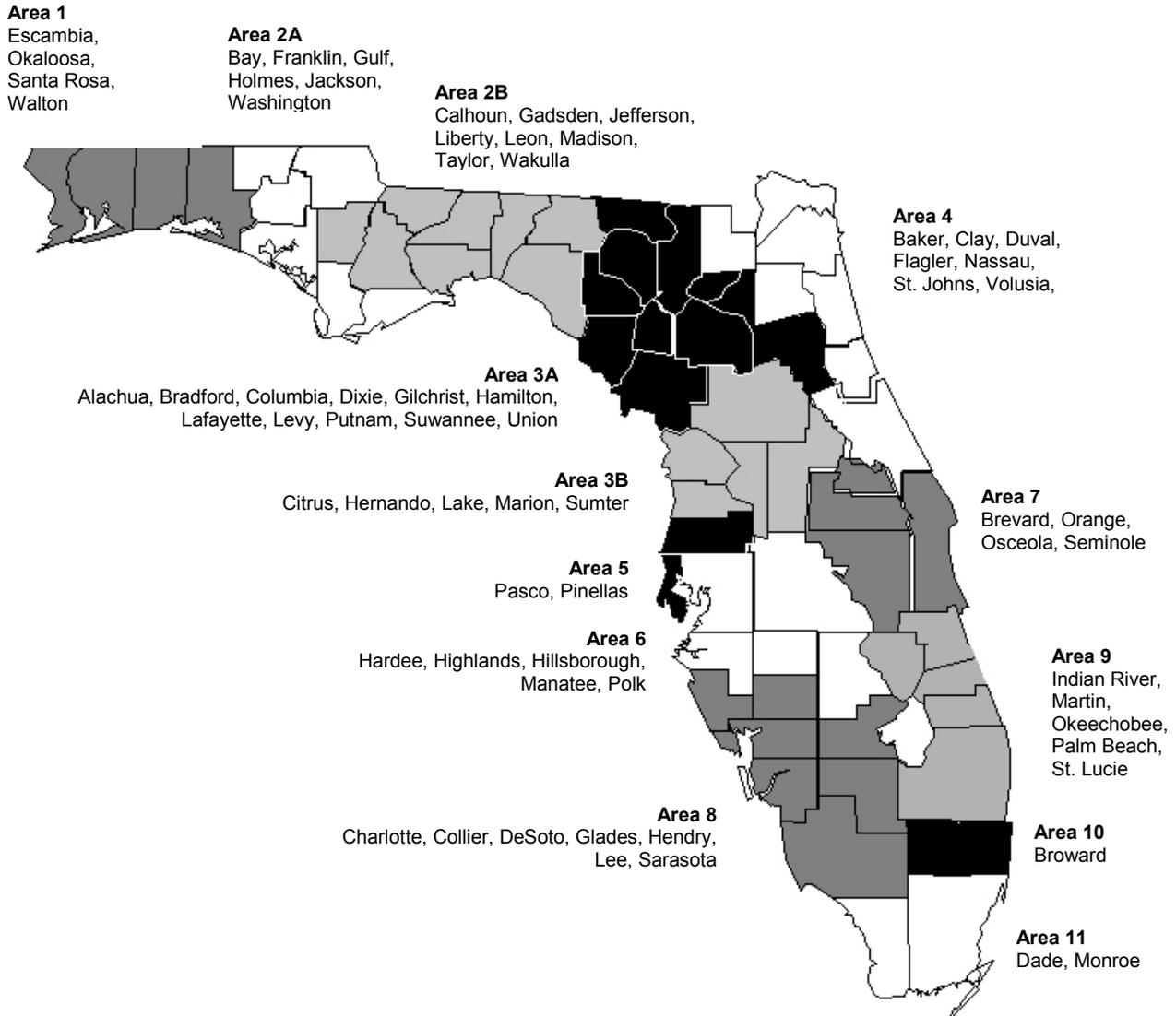
The Agency for Health Care Administration does not determine eligibility for recipients. Eligibility is determined by one of two agencies:

- The Social Security Administration (SSA) determines eligibility for Supplemental Security Income (SSI). Recipients of an SSI check are automatically eligible for Medicaid.
  - The Florida Department of Children and Families (DCF) determines eligibility for low-income children and families, aged persons, disabled persons, and persons seeking institutional care.
- 

**Medicaid Basics**

- Not all providers accept Medicaid.
  - Providers that choose to accept Medicaid, must accept Medicaid payment as payment in full. (This does not include copayments and coinsurance.)
  - Not all services are covered by Medicaid.
  - Medicaid has a set fee for each individual type of service.
  - Providers cannot bill the client for any amount in excess of Medicaid payment, other than Medicaid copays and coinsurance.
  - Medicaid payments are made directly to the provider, not to the recipient.
-

### AHCA: MAP OF AREA OFFICES



See the next page for the addresses and telephone numbers for each Area Medicaid Office.

**AHCA: AREA MEDICAID OFFICES**

<b>Areas—Counties Covered</b>	<b>Address</b>	<b>Phone</b>
<b>Area 1</b> Escambia, Okaloosa, Santa Rosa, and Walton	160 Governmental Center, Room 510 Pensacola, Florida 32502	Escambia and Santa Rosa— (850) 595-5700 Okaloosa and Walton— (800) 303-2422; SC 690-5840
<b>Area 2A</b> Bay, Gulf, Franklin, Holmes, Jackson, and Washington	651-K West 14 Street Panama City, Florida 32401	(850) 872-7690 (800) 226-7690 SC 777-7690
<b>Area 2B</b> Calhoun, Gadsden, Jefferson, Liberty, Leon, Madison, Taylor, and Wakulla	2002 Old St. Augustine Road Building D, Room 194 Tallahassee, Florida 32301	(850) 921-8474 (800) 248-2243 SC 291-8474
<b>Area 3A</b> Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union	14101 N.W. Hwy. 441, Suite 600 Alachua, Florida 32615-5669	(386) 418-5350 (800) NONE SC NONE
<b>Area 3B</b> Citrus, Hernando, Lake, Marion, and Sumter	2441 W. Silver Springs Boulevard Ocala, Florida 34475	(352) 732-1349 (800) NONE SC 667-1349
<b>Area 4</b> Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia	Duval Regional Service Center 921 North Davis Street Building A, Suite 160 Jacksonville, Florida 32209-6806	(904) 353-2100 (800) 273-5880 SC 826-2100
<b>Area 5</b> Pasco and Pinellas	525 Mirror Lake Drive North Suite 510 St. Petersburg, Florida 33701	(727) 552-1191 (800) 299-4844 SC 513-2659
<b>Area 6</b> Hardee, Highlands, Hillsborough, Manatee, and Polk	6800 North Dale Mabry Hwy. Suite 220 Tampa, Florida 33614	(813) 871-7600 (800) 226-2316 SC 512-8290
<b>Area 7</b> Brevard, Orange, Osceola, and Seminole	400 West Robinson Street Suite 309 – South Tower Orlando, Florida 32801	(407) 317-7851 (877) 254-1055 SC 344-7851
<b>Area 8</b> Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota	2295 Victoria Avenue, Room 309 Ft. Myers, Florida 33901 All mail should be addressed to: P. O. Box 60127 Ft. Myers, Florida 33906	(239) 338-2620 (800) 226-6735 SC 748-2620
<b>Area 9</b> Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie	1710 East Tiffany Drive, Suite 200 West Palm Beach, Florida 33407	(561) 881-5080 (800) 226-5082 SC 264-5080
<b>Area 10</b> Broward	1400 West Commercial Boulevard Suite 110 Ft. Lauderdale, Florida 33309	(954) 202-3200 (800) NONE SC 423-3200
<b>Area 11</b> Dade and Monroe	Doral Center Manchester Building 8355 NW 53 Street, 2 <sup>nd</sup> Floor Miami, Florida 33166	(305) 499-2000 (Dade only) (800) 953-0555 (Monroe only) SC 429-2000

**AHCA: HEADQUARTERS MEDICAID OFFICES**

<b>Title</b>	<b>Address</b>	<b>Phone</b>	<b>Fax</b>
Deputy Secretary for Medicaid Assistant Deputy Secretary for Medicaid Operations Assistant Deputy Secretary for Medicaid Finance	2727 Mahan Dr., Mail Stop 8 Tallahassee, Florida 32308	(850) 488-3560 SC 278-3560	(850) 488-2520 SC 278-2520
Medicaid Services	2727 Mahan Dr, Mail Stop 20 Tallahassee, Florida 32308	(850) 488-9347 SC 278-9347	(850) 922-7303 SC 292-7303
Medicaid Program Analysis	2727 Mahan Dr, Mail Stop 21 Tallahassee, Florida 32308	(850) 414-2756 SC 994-2756	(850) 414-2767 SC 994-2767
Medicaid Research	2727 Mahan Dr., Mail Stop 48 Tallahassee, Florida 32308	(850) 413-8059 SC 293-8059	(850) 922-7303 SC 292-7303
Medicaid Contract Management/ Provider Enrollment	2308 Killearn Center Blvd. Suite 200, Mail Stop 22 Tallahassee, Florida 32309	(850) 922-2726 SC 292-2726	(850) 410-1430 SC 210-1430
Medicaid Pharmacy Services	2727 Mahan Dr, Mail Stop 38 Tallahassee, Florida 32308	(850) 487-4441 SC 277-4441	(850) 414-6236 SC 994-6236
Medicaid Health Systems Development	2727 Mahan Dr, Mail Stop 50 Tallahassee, Florida 32308	(850) 487-2355 SC 277-2355	(850) 413-8809 SC 293-8809
Medicaid Program Integrity	2727 Mahan Dr, Mail Stop 6 Tallahassee, Florida 32308	(850) 921-1802 SC 291-1802	(850) 922-3806 SC 292-3806

**FEDERAL PROGRAMS**

<b>SOCIAL SECURITY ADMINISTRATION:</b>	<b>1-800-772-1213</b>
<b>MEDICARE: (1-800-MEDICARE)</b>	<b>1-800-633-4227</b>

**DCF: DISTRICT OFFICES****CLIENT RELATIONS toll-free: 1-800-342-0825**

<b>Districts/ Counties</b>	<b>Address</b>	<b>Phone</b>
<b>District 1</b> Escambia, Okaloosa, Santa Rosa, Walton	8190 Pensacola Boulevard Pensacola, Florida 32501	(850) 494-5800 SC 695-5800
<b>District 2</b> Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington	2639 North Monroe Street Building A, Suite 100 Tallahassee, Florida 32399-2949	(850) 487-1756 SC 277-1756
<b>District 3</b> Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union	P. O. Box 390 (IO 8) Gainesville, Florida 32602	(352) 955-5293 SC 625-5293
<b>District 4</b> Baker, Clay, Duval, Nassau, St. Johns	Roberts Building, Room 136 5920 Arlington Expressway Jacksonville, FL 32211	(904) 727-3700 SC 841-3700
<b>Suncoast Region</b> DeSoto, Hillsborough, Manatee, Pasco, Pinellas, Sarasota	9393 North Florida Avenue Suite 700 Tampa, Florida 33612-7236	(813) 558-5670 SC 514-5670
<b>District 7</b> Orange, Brevard, Osceola, and Seminole	400 W. Robinson Street—1009 Orlando, Florida 32801-1782	(407) 245-0450 SC 344-0450
<b>District 8</b> Charlotte, Collier, Glades, Hendry, Lee	2295 Victoria Avenue Fort Myers, Florida 33906	(239) 338-1377 SC 722-1377
<b>District 9</b> Palm Beach	111 S. Sapodilla Avenue West Palm Beach, Florida 33401	(561) 837-5574 SC 252-5247
<b>District 10</b> Broward	201 West Broward Boulevard Suite 510 Fort Lauderdale, Florida 33301	(954) 467-4373 SC 453-4373
<b>District 11</b> Dade, Monroe	401 NW 2 Avenue, Room S-1007 Miami, Florida 33128	(305) 377-7154 SC 452-7154
<b>District 12</b> Flagler, Volusia	210 North Palmetto Avenue Daytona Beach, Florida 32114- 3284	(386) 238-4910 SC 380-4401
<b>District 13</b> Citrus, Hernando, Lake, Marion, Sumter	1601 West Gulf Atlantic Highway Wildwood, Florida 34785	(352) 330-2177 Ext. 6230 SC 895-6273
<b>District 14</b> Hardee, Highlands, and Polk	4720 Old Highway 37 Lakeland, Florida 33813	(863) 619-4192 SC 561-4192
<b>District 15</b> Indian River, Martin, Okeechobee, St. Lucie	Ft. Pierce Regional Service Center 337 North 4th Street, Suite 320 Ft. Pierce, Florida 34950-4206	(561) 595-1306 SC 240-1306

**MEDICAID FISCAL AGENT: ACS STATE HEALTHCARE**

Title	Phone	Address
Provider Inquiry	1-800-289-7799 (inside Florida) 1-800-955-7799 (outside Florida)	ACS State Healthcare P.O. Box 7070 Tallahassee, Florida 32314-7070
Provider Enrollment Questions	1-800-377-8216	
Electronic Claims Submission Services	1-800-829-0218	

**RESOURCES ON THE INTERNET**

<b>ALL FLORIDA GOVERNMENT &amp; AGENCIES</b>	<a href="http://www.myflorida.com">www.myflorida.com</a>
Agency for Health Care Administration (AHCA)	<a href="http://www.fdhc.state.fl.us">www.fdhc.state.fl.us</a> <a href="http://www.Floridahealthstat.com">www.Floridahealthstat.com</a>
Department of Children and Families (DCF)	<a href="http://www.state.fl.us/cf_web/">http://www.state.fl.us/cf_web/</a>
<ul style="list-style-type: none"> <li>Public Assistance Policy Manual</li> </ul>	Go to menu at bottom: Economic Services, then under Quick Links (scroll down)-
Department of Health (DOH)	<a href="http://www.doh.state.fl.us">www.doh.state.fl.us</a>
Department of Elder Affairs (DOEA)	<a href="http://elderaffairs.state.fl.us">http://elderaffairs.state.fl.us</a>
Florida Statutes	<a href="http://www.leg.state.fl.us">www.leg.state.fl.us</a>
Florida Administrative Code	<a href="http://fac.dos.state.fl.us">http://fac.dos.state.fl.us</a>
Florida KidCare	<a href="http://www.floridakidcare.org">www.floridakidcare.org</a> <a href="http://www.cms-kids.com">www.cms-kids.com</a>
<b>MEDICAID FISCAL AGENT— ACS State Healthcare</b>	<a href="http://floridamedicaid.acs-inc.com">http://floridamedicaid.acs-inc.com</a>
Provider Handbooks	Go to Provider Support, then Handbooks
Fee Schedules	Go to Provider Support, then Fees
<b>FEDERAL GOVERNMENT</b>	
Code of Federal Regulations	<a href="http://www.access.gpo.gov/nara/cfr">www.access.gpo.gov/nara/cfr</a>
Department of Health and Human Services	<a href="http://www.hhs.gov">www.hhs.gov</a>
<ul style="list-style-type: none"> <li>CMS (Centers for Medicare and Medicaid Services)</li> </ul>	<a href="http://www.cms.gov">www.cms.gov</a>
U.S. Government Official Web Portal	<a href="http://www.firstgov.gov">www.firstgov.gov</a>
Centers for Medicare and Medicaid Services	<a href="http://cms.hhs.gov">http://cms.hhs.gov</a>
Social Security Administration	<a href="http://www.ssa.gov">www.ssa.gov</a>
Medicare	<a href="http://www.medicare.gov">www.medicare.gov</a>

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**SECTION II— RECIPIENT ELIGIBILITY  
FOR MEDICAID SERVICES**

**Introduction**

The Social Security Administration determines eligibility for the Supplemental Security Income program (SSI).

The Florida Department of Children and Families determines all other Medicaid eligibility including programs for children and families; aged, blind and disabled; and institutional care.

**Who is Eligible**

Three basic groups are eligible for Medicaid:

- SSI recipients
- Children and families, and
- Aged, blind and disabled people, including people needing institutional care. (These programs are also referred to as “SSI-related” Medicaid.)

An individual must meet specific eligibility requirements in order to get Medicaid. Each program has specific income and asset limits that must be met.

Persons may be eligible for full or limited benefits, depending on the program. Specific programs are listed below.

***SSI (SUPPLEMENTAL SECURITY INCOME)***

**Full Benefits**

All SSI recipients residing in Florida are automatically entitled to Florida Medicaid with full benefits.

To be eligible for an SSI check, an individual must be age 65 or older or if under age 65, be totally and permanently disabled, and meet the SSI income and asset limits.

***CHILDREN AND FAMILIES***

**Full Benefits**

Medicaid programs with FULL benefits for children and families include:

- **Low Income Families** include single-parent families and families with a disabled or unemployed parent. (This is sometimes referred to as the “TANF-related “group.”)
- **MEDS** (Medicaid Expansion Designated by SOBRA) includes children up to age 19 and pregnant women.

**CHILDREN AND FAMILIES**, continued**Full Benefits,**  
continued

- **Foster Care, Adoption Subsidy and Emergency Shelter** include dependent children in the care and control of the state and children with special medical needs whose adoption was supported by the state or a private adoption agency.
- **Public Medical Assistance (PMA)** includes children in intact families and children born after September 30, 1983, not living with relatives.
- **Mary Brogan Breast and Cervical Cancer Program** includes women who are screened and diagnosed with breast or cervical cancer through the Florida Breast and Cervical Cancer Early Detection Program administered by the Department of Health. Women entitled through this program must have income at or below 200% of the federal poverty level and will receive all Medicaid benefits.

**Limited Benefits**

Medicaid programs with LIMITED benefits for children and families include:

- **EMA (Emergency Medicaid for Aliens)** Aliens who do not meet citizenship or permanent residency requirements are eligible only for emergency services.  
Medicaid benefit: Coverage for emergency services only.
- **Medically Needy** includes individuals whose income is too high to qualify for other Medicaid programs but who have large monthly medical bills.  
On a month-by-month basis, the individual's medical expenses are subtracted from his or her income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the full or partial month, depending on the date the medical expenses were incurred. The amount of expenses that must be deducted from the individual's income to make him or her eligible for Medicaid is called a "share of cost."  
Medically Needy recipients are not eligible for long term care services, such as nursing facility, state mental hospital and intermediate care facility for the developmentally disabled (ICF/DD), community based waiver services and the payment of Medicare premiums by Medicaid.  
Medicaid benefit: Coverage only for month or partial month when share of cost is met.
- **Presumptively Eligible Pregnant Women (PEPW)** is temporary presumptive eligibility established by County Health Departments, Regional Perinatal Intensive Care Centers, and other qualified medical facilities for low-income pregnant women. This presumptive determination allows these women access to prenatal care while DCF makes regular determinations of eligibility.  
Medicaid benefit: only outpatient and office services.
- **Family Planning Waiver** extends eligibility for family planning services for 24 months to women who have had a Medicaid-financed delivery or other pregnancy-related service within two years before losing Medicaid eligibility.  
Medicaid benefit: family planning services, family-planning-related pharmacy and laboratory services, antibiotics and antifungals to treat sexually-transmitted diseases, sterilization, colposcopy, and transportation to family planning services.

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**AGED, BLIND and DISABLED PERSONS**


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**Full Benefits**

Medicaid programs with FULL benefits for aged and disabled persons who are not otherwise eligible for SSI include:

- **MEDS-AD (Medicaid for the Aged and Disabled)** covers individuals who are age 65 or older or totally and permanently disabled, have income less than 88 percent of the Federal Poverty Level, and meet the asset limit.
- **The Refugee Program** covers aliens who are eligible under a special general assistance program.
- **ICP (Institutional Care Program)** covers individuals requiring long-term institutional care (nursing facilities or ICFDDs) or hospice. Individuals who are not eligible for the institutional care program because they transferred assets may be eligible for other Medicaid services.
- **Hospice**
- **HCBS (Home and Community Based Services)** Federal requirements are waived for some special programs, which allow Medicaid to provide home and community-based services to individuals who would require institutionalization without these services.

Florida has eleven home and community-based waiver programs:

- Adult Cystic Fibrosis Waiver
- Aged/Disabled Adult Waiver
- Assisted Living for the Elderly Waiver
- Brain and Spinal Cord Injury Waiver
- Channeling Waiver
- Consumer-Directed Care Research and Demonstration Waiver
- Developmental Disabilities Waiver
- Model Waiver
- Nursing Home Diversion Waiver
- Project AIDS Care Waiver
- Supported Living Waiver

Note: Home and community-based services cannot be provided to recipients who reside in a hospital, nursing facility or intermediate care facilities for the developmentally disabled (ICF/DD).

**Limited Benefits**

Medicaid programs with LIMITED benefits for aged and disabled persons include:

- **EMA (Emergency Medicaid for Aliens)** Aliens who do not meet citizenship or permanent residency requirements are eligible only for emergency services.

Medicaid benefit: Coverage for emergency services only.

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**AGED and DISABLED PERSONS**, continued**Limited Benefits**, continued

- **Medically Needy** includes aged, blind, and disabled individuals whose income is too high to qualify for other Medicaid programs but who have large monthly medical bills. On a month-by-month basis, the individual's medical expenses are subtracted from his or her income. If the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the full or partial month, depending on the date the medical expenses were incurred. The amount of expenses that must be deducted from the individual's income to make him or her eligible for Medicaid is called a "share of cost."

Medically Needy recipients are not eligible for long term care services, such as nursing facility, state mental hospital and intermediate care facility for the developmentally disabled (ICF/DD), community based waiver services and the payment of Medicare premiums by Medicaid.

Medicaid benefit: Coverage only for month or partial month when share of cost is met.

All Medicaid programs RELATED TO MEDICARE have LIMITED benefits. Programs include:

- **QMB (Qualified Medicare Beneficiaries):**  
Individuals with income not exceeding 100% of the Federal Poverty Level, who are entitled to Medicare Part A and who are not otherwise eligible for Medicaid.

Medicaid Benefit: payment of their Medicare premiums, deductibles, and coinsurances. Also eligible for the Silver Saver Program if over age 65.
- **SLMB (Special or Specified Low-Income Medicare Beneficiaries):**  
Individuals with income above 100% but less than 120% of the Federal Poverty Level, who are entitled to Medicare Part A and who are not otherwise eligible for Medicaid.

Medicaid Benefit: payment of the Medicare Part B premium and Silver Saver Benefit if over age 65.
- **QI 1 (Qualifying Individuals I--formerly PBMO, Part B Medicare Only):**  
Individuals with income of at least 120% but less than 135% of the Federal Poverty Level, who are entitled to Medicare Part A and who are not otherwise eligible for Medicaid.

Medicaid benefit: payment of the Medicare Part B premium.

Note: Entitlement is limited by the availability of the capped federal funding allocated to the state.
- **Silver Saver Prescription Program**  
The Ron Silver Senior Drug Program, also known as Silver Saver, provides up to \$160 a month in prescription benefits to low-income seniors. Recipients must be aged 65 or older, eligible for Medicare Part A, and have income between 88% and 120% of the federal poverty level. There is a co-pay depending upon the prescription received: \$2 for generic, \$5 for a brand name preferred drug or \$15 for a non-preferred drug. QMB only and SLMB only recipients over age 65 are also eligible for this program.

Medicaid Benefit: Medicaid services are limited to pharmacy only with a monthly cap of \$160.

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**ASSESSMENT FOR MEDICAID SERVICES**


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**Introduction**

Certain programs require that applicants have a special assessment before they can receive Medicaid services. Two such assessments are listed below.

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**Long Term  
Care Services  
-CARES**

Comprehensive Assessment and Review for Long-Term Care Services (CARES) is the program that provides on-site assessments of applicants by a registered nurse and/or a social worker. The assessment evaluates the emotional, cognitive, medical, psychosocial and the activities of daily living of the individual. The goal of CARES is to place the applicant in the least restrictive, most appropriate setting with emphasis on community placement. After the assessment, an interdisciplinary team including a physician determine the placement and appropriate level of care (LOC) that is needed. The program is administered by the Department of Elder Affairs.

All individuals age 21 and older applying for nursing facility services and certain HCBS waivers must receive a CARES assessment. All applicants for the Project AIDS Care (PAC) waiver, regardless of age, must receive a hospital LOC from CARES.

CARES periodically assesses Medicaid nursing facility residents to ascertain continued LOC and the potential for returning to the community.

Private Pay nursing facility individuals may be assessed at their request at no charge.

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**Medically  
Complex  
Children  
-CMAT**

Children's Multidisciplinary Assessment Team (CMAT) is composed of family and representatives from multiple disciplines, programs, and agencies who provide assessments, recommendations, and decisions for services based on medical necessity for medically-complex children. The team is headed by staff from Children's Medical Services (CMS) in the Department of Health.

A recommendation from CMAT is required for children to receive the following:

- Medical Foster Care
- Model Waiver
- Nursing facility placement
- Prescribed pediatric extended care (PPEC) services
- Private duty nursing in excess of 16 hours per day
- Wheelchairs that cost more than \$12,000

CMAT assessments are available to all medically-complex children under the age of 21. Children do not have to be Medicaid eligible to have an assessment. The program is administered by the Department of Health, Children's Medical Services.

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**OTHER PROGRAMS RELATED TO MEDICAID**


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**Medicare**

Medicare is a federal health insurance program for people who are age 65 or older or disabled. Medicare is different from Medicaid. Eligibility for Medicare is not based on the person's income or assets. A person with Medicare will have a wallet-sized red, white, and blue ID card.

It is administered by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

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**Florida Kidcare Program**

Florida Kidcare is a program enacted by the 1998 Florida Legislature to provide comprehensive health coverage for previously uninsured children.

Florida Kidcare comprises four distinct components:

- Medicaid —entitlement program for children under 21 whose family income qualifies them for services
- MediKids —insurance for children ages 1 to 5 years.
- Florida Healthy Kids —insurance for children ages 5 to 19 years.
- Children's Medical Services Network —for children ages 1 to 19 years with special health care needs.

Note:

- Except for Medicaid, the monthly premium for children enrolled in KidCare is \$20. For children who do not qualify for the Title XXI KidCare subsidy, the premium may be more.
  - Healthy Kids enrollees must also pay copayments for services.
- 

**MediKids**

MediKids is an insurance program for children aged 1 to 5 that is administered by the Agency for Health Care Administration and that uses the Medicaid system for claims processing. MediKids enrollees:

- Receive most Medicaid services, including immunizations, dental, and transportation.
- Receive services from Medicaid participating providers or providers participating in a Medicaid HMO network.

Only health care providers or HMOs that are Medicaid providers may serve MediKids enrollees. Families must choose either a MediPass provider or a Medicaid-participating HMO before a child's MediKids coverage begins. Section 409.8132(7), Florida Statutes, lists the options that are available to a family:

- If a child lives in a county that has two or more Medicaid-participating HMOs, the family must choose only an HMO.
  - If a child lives in a county that has one Medicaid-participating HMO, the family may choose that HMO or a MediPass provider.
  - If a child lives in a county with no Medicaid-participating HMOs, the family may choose a MediPass provider.
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## SECTION III— MEDICAID MANAGED CARE PROGRAMS

### Introduction

Most Medicaid recipients are required to obtain services through managed care. Recipients who aren't required to get managed care obtain care through the providers of their choice on a "fee for service" basis.

Once approved for Medicaid, the recipient is sent information on managed care providers in their area and how to contact Medicaid Options.

### Medicaid Options

Medicaid contracts with a private company, Medicaid Options, to counsel recipients on their options for managed care programs. Medicaid Options can help recipients enroll or disenroll for Medicaid Managed Care programs:

- MediPass (Medicaid Provider Access System),
- HMOs (Medicaid Health Maintenance Organizations),
- PSNs (Provider Service Networks), and
- CMS (Children's Medical Services), the network for children with special health care needs.

Recipients who wish to receive information regarding their managed care options may call the Medicaid Options toll-free help line at **1-888-367-6554**.

### Managed Care Mandatory Assignment

Florida law mandates that Medicaid recipients must enroll with a managed care provider unless they have Medicare or are in a nursing facility.

Eligible recipients are given 30 days from the date that Medicaid eligibility begins to select a managed care option. If recipients do not select an option within 30 days, they are automatically assigned.

### 12 Month Enrollment Period

Recipients who enroll with a managed care plan begin a 12-month enrollment period. They have 90 days to try the plan and request a change. After the initial 90 days, they must remain with their plan for the next nine months.

Only plan changes for "good cause" will be allowed during these nine months. Each 12 months thereafter, recipients will receive notification of their open enrollment period when they may change plans for the following year.

Recipients may change primary care providers within their current plans. To change their primary care provider, recipients should contact the program in which they are enrolled (the MediPass Area Medicaid Office, the HMO's member services office, or the PSN's enrollee services office, respectively).

**Managed Care**, continued**Exceptions to 12 Month Enrollment Period**

Certain recipients are not bound to the 12 month enrollment period and are allowed to change their managed care plans at any time. These include:

- SSI recipients under age 19,
- Foster care children,
- Children in subsidized adoption arrangements,
- Children enrolled with Children's Medical Services,
- Dually eligible individuals (that is, eligible for both Medicare and Medicaid) and
- American Indians.

**MEDIPASS (Medicaid Provider Access System)****Description**

MediPass is a Medicaid primary care case management program that is available statewide.

MediPass primary care providers are responsible for providing or arranging for the recipient's primary care and for referring the recipient for other necessary medical services on a 24-hour basis. Recipients select the primary care provider of their choice from those participating in MediPass.

**Covered Services**

Enrolled recipients must receive all of the following services either through the MediPass provider or by referral from the MediPass provider to another Medicaid provider. If a recipient receives any of these services without a referral from the MediPass provider, Medicaid will not reimburse the service, and the recipient may be liable for the charges.

- Advanced registered nurse practitioner services
- Ambulatory surgical center services
- Birth center services
- Child Health Check-Up
- Chiropractic services (first ten visits per calendar year do not need MediPass authorization)
- County health department services
- Durable medical equipment and medical supply services
- Federally qualified health center services
- Home health services
- Hospital inpatient services
- Hospital outpatient services
- Laboratory services (Independent Laboratories do not need MediPass authorization.)
- Licensed midwife services
- Physician services

**MEDIPASS**, continued

**Covered Services,**  
continued

- Physician assistant services
- Podiatric services (first four visits per calendar year do not need MediPass authorization)
- Prescribed drug services
- Rural health clinic services
- Therapy services
- X-ray services including portable x-rays

**MediPass Limitations**

Up to 1,500 recipients may be under the care of each full-time equivalent physician. An additional 750 recipients are allowed for each full-time equivalent advanced registered nurse practitioner and physician assistant who works for the physician.

Independent advanced registered nurse practitioners and physician assistants may enroll as MediPass providers. They can only be assigned recipients who enroll voluntarily. Regardless of whether a nurse practitioner or physician assistant enrolls independently or with a physician, he or she cannot receive more than 750 recipients.

**MediPass Exceptions**

Prior authorization or a referral from the MediPass provider is not required for vision, hearing, dental, mental health (except in Medicaid Areas 1 and 6), family planning, early intervention, or dialysis services.

Prior authorization is not required for emergency services and care provided to a recipient experiencing an emergency medical condition. The MediPass provider must be notified that care has been provided, and medical records should be forwarded to the MediPass provider to be retained in the patient's comprehensive medical record.

**MediPass Reimbursement**

MediPass providers are paid a \$3 monthly patient management fee for each eligible person who selects them, plus Medicaid reimbursement for services that are rendered.

**MEDIPASS**, continued

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**MediPass  
Disease  
Management  
Program**

The Disease Management Program is a statewide endeavor aimed at improving health outcomes and quality of life for MediPass members who have certain chronic diseases. All MediPass recipients with applicable diagnoses are eligible to participate in this initiative. Exceptions are children who are enrolled in the Children's Medical Services Network, attend prescribed pediatric extended care centers, or reside in institutional settings.

MediPass recipients can be enrolled in only one Disease Management Organization (DMO). If the recipient has more than one of the covered diseases, he or she will be enrolled in the DMO responsible for the more life threatening disease condition.

The main focus of the disease management program is nursing care management. DMO nurse care managers work with the primary care physician, the MediPass recipient and the recipient's family, as well as specialists and case management agencies. Care managers provide disease-specific education to the recipient and family and monitor compliance with the physician's treatment plan. They also provide feedback to the primary care physician/specialist on a regular basis. Care managers become an extension of the physician's services by helping the recipient better understand his or her disease and make necessary life style and behavioral changes with the goal of self-management.

All services provided by DMOs are offered free of charge to MediPass physicians and their recipients.

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**HMOs (Health Maintenance Organizations)**

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**Description**

The Florida Medicaid Program supports the development of managed health care systems by entering into contracts with Health Maintenance Organizations (HMOs) to provide prepaid Medicaid services to a defined population of enrolled Medicaid recipients. About 670,000 Medicaid recipients are enrolled in 12 plans throughout the state. Most counties have at least two plans from which recipients can choose; however, some counties have no HMOs.

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**HMO Services**

The services provided under contract are negotiated with each contractor. However, contractors must provide the following services:

- Child Health Check-Up
- Community Mental Health services (AHCA Areas 1 & 6 only)
- Dialysis services in a freestanding center
- Durable medical equipment and medical supplies
- Family planning services
- Hearing services
- Home health services
- Hospital services (inpatient, outpatient and emergency services)
- Laboratory services, including independent laboratory services
- Mental Health Targeted Case Management services (AHCA Areas 1 & 6 only)
- Prescribed drug services
- Physician services (as described below)
- Therapy services
- Vision services
- X-ray services

Physician services include services rendered by a licensed physician, psychiatrist, advanced registered nurse practitioner, physician assistant, podiatrist, chiropractor, ambulatory surgical center, rural health clinic, federally qualified health center, birthing center, and county health department clinic.

In addition, HMO plans are required to provide the following quality and benefit enhancements:

- **Smoking Cessation:** Regularly scheduled smoking-cessation programs must be conducted by the plan as an option for all plan members. Members must also have access to smoking-cessation counseling. The plan must provide primary care physicians with the Quick Reference Guide for Smoking Cessation Specialists, published by the U.S. Department of Health and Human Services. The guide assists in identifying tobacco users and supporting and delivering effective smoking-cessation interventions.
- **Substance Abuse:** The plan must have primary care physicians screen enrollees for signs of substance abuse as part of prevention evaluation. Targeted enrollees must be asked to attend community or plan-sponsored substance abuse programs. The plan must provide substance-abuse screening training to its providers on a regular basis.

**HMOs**, continued**HMO Services**,  
continued

- Domestic Violence: The plan must have primary care physicians screen enrollees for signs of domestic violence and must provide referral services to applicable, domestic-violence prevention community agencies. The plan must provide domestic-violence screening training to its providers on a regular basis.
- Pregnancy Prevention: Regularly scheduled pregnancy-prevention programs must be conducted by the plan or the plan must make a good faith effort to involve members in existing community pregnancy-prevention programs. The workshops must be targeted toward teen members, but must be open to all enrollees.
- Prenatal/Postpartum Pregnancy Programs: The plan must provide regular home visits conducted by a home health nurse or aide, counseling and educational materials to pregnant members and postpartum members who are not in compliance with the plan's prenatal and postpartum programs. Plans must coordinate with Healthy Start Care Coordinators to prevent duplication of services.
- Children's Programs: The plan must provide regular general wellness programs targeted specifically toward plan members from birth to the age of five or the plan must make a good faith effort to involve members in existing community children's programs. Programs must promote increased utilization of prevention and early intervention services for at-risk families with children in the target population. The plan must provide training for providers that promote immunizations, Child Health Check-Ups (wellness and prevention), and early intervention services.

Plans are responsible for paying for family planning services for their members, regardless of whether the service provider is a plan subcontractor.

Other services that plans may provide include dental, transportation, nursing facility and home and community-based services. Plans may also provide services under the contract that Medicaid does not cover, such as over-the-counter drugs.

**HMO Limitations**

All services must be prior authorized by the HMO plan except for the following:

- Emergency services;
- Family planning services regardless of whether the provider is a plan provider;
- The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments;
- OB/GYN services for one annual visit and the medically-necessary follow up care for a condition(s) detected at that visit (the recipient must use a plan provider for these services);
- Chiropractic, podiatry, and some dermatology services (the recipient must use a plan provider for these services); and
- Immunizations by county health departments.

*HMOs*, continued

**HMO Eligibility**

Enrollment in any particular plan is specific to certain eligibility categories, counties, and zip codes within counties.

The following Medicaid recipients are NOT eligible to enroll in Medicaid HMOs:

- Recipients who reside in an intermediate care facility for the developmentally disabled (ICF/DD), nursing facility, state mental hospital, or state-operated residential program;
- Recipients who are under the age of 21 and are enrolled in Children’s Medical Services or attend a prescribed pediatric extended care center;
- Recipients who receive hospice or Home and Community-Based Waiver services;
- Recipients who are enrolled in a Medicare or private HMO or other major medical insurance such TRICARE (formerly known as CHAMPUS); and
- Recipients who are only eligible for limited Medicaid under such programs as the Family Planning waiver, Medically Needy or Qualified Medicare Beneficiary (QMB) coverage groups.

**HMO Reimbursement**

Contractors are prepaid a fixed monthly rate per member in each of the various eligibility categories, by age group, to provide all the covered services required by each member during the month. This is known as a capitation rate. The rate is based on actual fee-for-service Medicaid claims experience for each eligibility category in the plan’s operating area.

**Special Project: Prepaid Mental Health Plan: Area 1 and 6**

Recipients in AHCA Areas 1 and 6 have the option of enrolling with MediPass and a prepaid mental health plan, a PSN and a prepaid mental health plan, or in an HMO that will provide medical and mental health care services. All the options cover inpatient and outpatient hospital services, psychiatric and physician services, community mental health services, and targeted case management services. Medicaid contracts with Access Behavioral Health, Inc., (ABH) in Area 1 and Florida Health Partners, Inc. (FHP) in Area 6 for mental health services provided to recipients who enroll in MediPass or a PSN. These recipients receive physical health care services from an assigned MediPass or PSN primary care provider and mental health care services from the prepaid mental health plan contractor. MediPass or PSN primary care providers and the prepaid mental health plan contractor providers coordinate the recipient’s health care needs to assure that medical and psychiatric services are provided collaboratively for continuity of care.

Recipients who are enrolled in a Medicaid HMO in Areas 1 and 6 receive both physical health care and mental health care services from HMO providers. Services provided under all plans are approved by the contract provider (the prepaid mental health contractor or the Medicaid HMO).

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**PSNs (Provider Service Networks)**

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**Description**

A Provider Service Network (PSN) is an integrated health care delivery system owned and operated by Florida hospitals and physician groups. The PSN is a Medicaid managed care option for Medicaid recipients in Miami-Dade and Broward Counties, along with HMOs, MediPass, and the CMS Network. The South Florida Community Care Network (SFCCN) PSN is composed of the Public Health Trust of Miami-Dade County (PHT), the Memorial Healthcare System (MHS), and the North Broward Hospital District (NBHD).

SFCCN enrollees receive the majority of their health care through the PSN. Out of network care provided to PSN enrollees (for PSN-managed services) must be authorized by and claims must be submitted to the PSN in order for the claims to be paid by the Medicaid fiscal agent. All Medicaid covered services are available to PSN enrollees. However, the SFCCN does not manage community mental health, targeted case management, hospice, nursing facility, dental, transportation, early intervention, medical foster care, prescribed pediatric extended care, school based, or waiver services. Claims for non-PSN managed services may be submitted directly to the Medicaid fiscal agent for processing.

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**PSN Services**

The following services are managed by the PSN:

- Advanced registered nurse practitioner services
- Ambulatory surgical center services
- Birth center services
- Child Health Check-Up
- Chiropractic services
- County health department services
- Dermatology services
- Durable medical equipment and medical supply services
- Family planning
- Federally qualified health center services
- Home health services
- Hospital inpatient services
- Hospital outpatient services
- Laboratory services
- Licensed midwife services
- Optometric services
- Physician services
- Physician assistant services
- Podiatric services
- Rural health clinic services

**PSNs**, continued**PSN Services**, continued

- Therapy services
- Visual services
- X-ray services including portable x-rays

Claims for PSN-managed services must be submitted to the PSN. Although PSN enrollees may self-refer for family planning, FQHC, chiropractic (10 visits per calendar year), podiatric (5 visits per calendar year), and school based services, claims for these services must be submitted through the PSN. The enrollee must use a PSN provider for chiropractic, podiatric, and dermatology services.

**PSN Limitations**

Although the PSN services cannot be more restrictive than those provided under Medicaid fee-for-service, the following services require PSN prior authorization:

- PSN managed services from out-of-network providers
- Chemotherapy
- Outpatient consultations
- Out-of-network referrals
- Specialist to specialist referrals
- Dialysis (peritoneal/hemodialysis)
- Elective surgery (inpatient/outpatient)
- Emergency visits (payment only, not service approval)
- Endoscopy
- Growth evaluation and treatment
- Hearing aids
- Home health care
- DME
- Oxygen related equipment and services
- Hyperbaric oxygen therapy
- Inpatient admissions
- Magnetic Resonance Imaging (MRI)
- Nerve conduction studies/ electromyogram (EMG)
- Observational stays
- Obstetrical care (block authorization)
- Oral surgery
- Orthotics/prosthetics/prosthetics and braces
- Outpatient procedures with a facility fee
- Pharmacological stress tests (Thallium, Cardiolyte, etc.)

**PSNs**, continued**PSN Limitations**, continued

- Plastic surgery and related care
- Stress echo
- Physical therapy
- Occupational therapy
- Speech therapy
- Transplants and related care
- Vestibular testing

Any service authorization/pending cases prescribed or authorized before the enrollee's effective date with the PSN.

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**PSN Eligibility**

The following categories of recipients are eligible to enroll in a PSN:

- Low Income Families and Children
  - Sixth Omnibus Budget Reconciliation Act (SOBRA) children
  - Children in Foster Care
  - Children in Subsidized Adoptions
  - Supplemental Security Income (SSI) recipients who do not receive Medicare
- 

**PSN Reimbursement**

The PSN is paid a monthly administrative allocation payment for the management of its enrollees. PSN primary care providers are paid a monthly case management fee of \$3. Providers rendering services to PSN enrollees are reimbursed on a fee-for-service basis.

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***CMS (Children's Medical Services)*****Description**

The CMS (Children's Medical Services) program provides a family centered, managed system of care for children with special health care needs.

Children with special health care needs are those children under age 21 whose serious or chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children.

CMS offers a full range of care which includes prevention and early intervention services; primary and specialty care; as well as long term care for medically complex, fragile children.

Most services are provided at or coordinated through CMS offices in local communities throughout the state. When necessary, children are referred to CMS affiliated medical centers. These centers provide many specialty programs with follow-up care provided at local CMS offices.

CMS is administered by the Department of Health. For more information, see its web site at: <http://www.cms-kids.com/>

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## SECTION IV— SPECIAL MEDICAID REQUIREMENTS AND POLICIES

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### **COPAYMENTS AND COINSURANCES**

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#### **Definitions**

Medicaid recipients are required to pay a copayment or coinsurance for certain services unless they meet one of the exceptions listed below.

A copayment is a set fee. A coinsurance is a percentage of the cost of the service. A provider cannot deny services solely because a recipient is unable to pay at the time of service. In these cases, the recipient remains liable for the copayment charge and can be billed for later payment.

The Medicaid claims processing system automatically deducts the amount of the co-payment from the provider's reimbursement regardless of whether the provider bills or collects the copayment. The system is programmed to systematically exempt those recipients who are under age 21, in an HMO, or in an institution.

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#### **Exceptions**

The following recipients are NOT required to pay a **copayment**:

- Recipients under 21 years of age
- Recipients who are pregnant
- Recipients participating in a hospice program
- Recipients receiving family planning services
- Recipients residing in a nursing facility or ICF/DD
- Recipients being treated for an emergency in an emergency facility
- Recipients currently enrolled in a Medicaid HMO/Prepaid Health Plan

The following recipients are NOT required to pay a **coinsurance**:

- Recipients under 21 years of age.
  - Recipients currently enrolled in a Medicaid HMO/Prepaid Health Plan.
  - Recipients living in nursing facilities, ICF/DDs or state mental hospitals.
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**COPAYMENTS AND COINSURANCES**, continued**Required Copayments**

Chiropractor	\$1.00 per day per provider per recipient
Community Mental Health	\$2.00 per day per provider per recipient
FQHC	\$3.00 per day per provider per recipient
Home Health Agency	\$2.00 per day per provider per recipient
Hospital Inpatient	\$3.00 per admission
Hospital Outpatient	\$3.00 per visit
Independent Laboratory	\$1.00 per day per provider per recipient
Nurse Practitioner	\$2.00 per day per provider per recipient
Optometrist	\$2.00 per day per provider per recipient
Physician	\$2.00 per day per provider per recipient
Physician Assistant	\$2.00 per day per provider per recipient
Podiatrist	\$2.00 per day per provider per recipient
Portable X-Ray Company	\$1.00 per day per provider per recipient
Rural Health Clinic	\$3.00 per day per provider per recipient
Transportation all types	\$1.00 per trip

**MEDICARE PREMIUMS, DEDUCTIBLES AND COINSURANCES****Definitions**

Medicare Hospital Insurance, referred to as Part A, provides coverage for inpatient hospital care, limited skilled nursing care, some home health services, some outpatient hospital services, and other services.

Medicare Supplemental Medical Insurance, referred to as Part B, provides basic health care coverage for the services provided by doctors, suppliers, therapists, and other licensed health care practitioners.

Medicare imposes cost sharing expenses for Part A and Part B by requiring a deductible and coinsurance amount. These expenses are usually paid by the Medicare beneficiary or a supplemental insurance policy. However, for individuals who are eligible for both Medicare and Medicaid, Medicaid pays the following deductibles and coinsurances:

- Medicare Part A hospital inpatient deductible up to Medicaid's rate and skilled nursing home facility coinsurance amounts,
- Medicare Part B deductibles and coinsurance amounts up to Medicaid's rate, and
- Medicare deductibles for blood supplied under Part A and Part B.

**What Medicaid Pays**

Medicaid pays Medicare premiums for all Medicaid eligible recipients who are entitled to receive Medicare. (An exception is Medically Needy recipients unless they are also eligible as Part B Medicare Only, Qualified Medicare Beneficiaries or Special (Specified) Low-Income Medicare Beneficiaries.)

**MEDICARE PREMIUMS, DEDUCTIBLES AND COINSURANCES**, continued**Part A Crossover Claims**

Medicaid reimburses the following amounts for Medicare premiums, deductibles and coinsurances:

- For inpatient hospitals, Medicaid reimburses 100 percent of the deductible and the first three pints of blood up to \$25 per pint during each “benefit period.” A new benefit period begins each time a recipient is admitted to a hospital if there has been a 60-day break between hospitalizations.
- For skilled nursing facilities, Medicaid reimburses either the Part A skilled nursing facility coinsurance rate or the Medicaid per diem rate for the facility, whichever is less.

**Part B Crossover Claims**

Medicaid reimburses the following amounts for Medicare premiums, deductibles and coinsurances:

- For emergency transportation providers, Medicaid pays 100 percent of both the deductible and coinsurance.
- For rural health centers, federally qualified health centers, and county health departments, Medicaid reimburses the deductible and coinsurance up to the difference between Medicare’s payment and the facility’s Medicaid rate.
- For outpatient hospitals Medicaid reimburses 100 percent of the deductible and 100 percent of the coinsurance, based on the Medicare allowable amount, in addition to the first three pints of blood up to \$25 per pint. Medicaid will pay no portion of the Medicare deductible and coinsurance when the payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payer. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payer.
- For dialysis centers, Medicaid reimburses 100 percent of the deductible and 100 percent of the coinsurance, based on the Medicaid rate.
- For all other Part B suppliers/providers such as physicians, chiropractors, podiatrists, durable medical equipment, ambulatory surgery centers, and optometrists, Medicaid reimburses 100 percent of the deductible and coinsurance up to the Medicaid allowable for the procedure code. The combined amounts received from Medicare, any other third party, and Medicaid cannot exceed the Medicaid fee for the procedure.

**What Medicaid Does NOT Pay**

Medicaid does not pay crossover claims for services that are not covered by Medicaid.

Medicaid does not pay copayments or deductibles for Medicare Health Maintenance Organizations (HMOs).

Medicaid does not pay the deductible and coinsurance for medical supplies and durable medical equipment that are covered by nursing facility services and included in the nursing facility’s per diem payment.

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**Prior Authorization of Medicaid Services**


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**Services Requiring Prior Authorization**

Some services require that providers obtain prior authorization (or post authorization in an emergency) before the services are performed in order to be reimbursed by Medicaid. Some services have limitations on the number of times Medicaid will reimburse for them. Exceptions to some limitations can be obtained through the prior authorization process.

The following services have specific procedure codes that require prior authorization or require prior authorization for services that exceed the service limitations:

- Chiropractic
- Community mental health services
- Dental
- Durable medical equipment and medical supplies
- Hearing
- Home Health
- Hospital
- Optometric
- Prescribed drug services
- Physician
- Podiatry
- Transportation
- Visual

If the service is covered under MediPass, the provider must obtain a MediPass referral in addition to prior authorization. Medicare crossover claims do not require prior authorization.

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**Service Authorization of Medicaid Services**


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**Services Requiring Authorization**

Service authorization by the Medicaid area office, service-authorization nurse is required before providing certain services to recipients under 21 years of age. Medicaid will not reimburse for these services without service authorization when it is required.

The following services require service authorization:

- Medical foster care
  - Personal care through the home health services program
  - Prescribed pediatric extended care (PPEC)
  - Private duty nursing through the home health services program
  - Custom wheelchairs
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**Utilization Review of Medicaid Services**

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**Utilization Review**

Some services are subject to utilization review by a Peer Review Organization (PRO) under contract with AHCA. Those services selected for review by the PRO are based on a sample selection of specified providers. The purpose of the utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to Medicaid recipients. Medical records are reviewed for medical necessity of billed services, quality of care, appropriateness of place of service and length of stay (inpatient hospital).

The PRO develops quality improvement initiatives that are designed to improve quality and/or reduce the cost of care for Medicaid recipients and conducts annual provider seminars on new and updated policies and recommendations that will improve the provider's performance on utilization review.

Utilization review staff also approve requests for supplemental payments from nursing facilities for Medicaid patients with AIDS.

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**Who is Subject to Review**

The following provider types are subject to review by the PRO:

- Community mental health centers
  - Hospitals (inpatient only)
  - Home and community-based waiver services for the developmentally disabled
  - Home health
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**SECTION V—MEDICAID COVERED SERVICES**

**ADVANCED REGISTERED NURSE  
PRACTITIONER SERVICES**

<b>Description</b>	<p>Medicaid reimburses for services rendered by licensed, Medicaid-participating advanced registered nurse practitioners (ARNPs). The services must be rendered in collaboration with a physician. Reimbursement for anesthesia, obstetrical and psychiatric services is limited to ARNPs who have completed the educational program in the appropriate specialty and are authorized to provide these services by Chapter 464, Florida Statutes, and protocols filed with the Board of Medicine.</p> <p>Medicaid reimburses ARNPs who are Medicaid-participating independent providers with formal relationships with Florida licensed physicians.</p>
<b>Limitations</b>	<p>Medicaid reimbursement for ARNP services is limited to:</p> <ul style="list-style-type: none"> <li>• One ARNP-recipient contact per day (except for emergencies);</li> <li>• One long-term-care facility service, per ARNP, per month, per recipient (except for emergencies);</li> <li>• Ten low-risk prenatal and two postpartum visits per pregnancy; and</li> <li>• One new patient evaluation and management service, per ARNP, per recipient, every three years, if no services were rendered by the ARNP to the recipient during the three years. Subsequent encounters must be reimbursed as established patient evaluation and management services.</li> </ul>
<b>Exceptions</b>	<p>The ARNP may request authorization for reimbursement for services in excess of the service limitations.</p>
<b>Eligibility</b>	<p>Medicaid reimburses for ARNP services for all Medicaid recipients based on medical necessity.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for ARNP services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. ARNPs are reimbursed at 80 percent of the physician's rate for services that are approved by the Centers for Medicare and Medicaid Services (CMS). If an ARNP is salaried by a hospital or other facility that is reimbursed on a cost-related basis, the ARNP cannot be paid on a fee-for-service basis if the costs for the ARNP's salary are included in the facility's cost report.</p>
<b>Copay</b>	<p>There is a \$2 recipient copayment for ARNP services, per provider, per day, unless the recipient is exempt.</p>

## AMBULATORY SURGICAL CENTERS

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<b>Description</b>	<p>Ambulatory Surgical Centers (ASCs) provide scheduled, elective, medically necessary surgical care to patients who do not require hospitalization.</p> <p>Medicaid reimburses surgical procedures that have been approved by the federal Centers for Medicare and Medicaid Services (CMS), that are provided in a licensed, Medicare-approved, Medicaid-participating ASC entity that is separate and distinguishable from any other entity or type of facility, and is not part of a hospital. The reimbursed facility fee is all-inclusive of the following:</p> <ul style="list-style-type: none"> <li>• Nursing, technical and related services;</li> <li>• Use of ASC facilities;</li> <li>• Drugs, biologicals, intraocular lens, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to providing surgical procedures;</li> <li>• Diagnostic or therapeutic services or items directly related to providing surgical procedures;</li> <li>• Blood, blood plasma and components;</li> <li>• Administrative, record keeping, and housekeeping items and services; and</li> <li>• Materials for anesthesia.</li> </ul>
<b>Limitations</b>	<p>Reimbursable surgical procedures are limited to services that:</p> <ul style="list-style-type: none"> <li>• Require a dedicated operating room;</li> <li>• Do not exceed a total of 90 minutes operating time;</li> <li>• Do not exceed a total of four hours recovery or convalescent time;</li> <li>• Do not usually result in heavy loss of blood;</li> <li>• Are normally not emergency or life threatening in nature; and</li> <li>• Do not require major invasion of body cavities or directly involve major blood vessels.</li> </ul> <p>Anesthesia is limited to local, regional or general anesthesia that lasts 90 minutes or less.</p> <p>Medicaid cannot reimburse ASC surgical procedures that are commonly performed or can be safely performed in a physician's office.</p>
<b>Exceptions</b>	None
<b>Eligibility</b>	Medicaid reimburses for ASC services for all Medicaid recipients.
<b>Reimbursement</b>	Medicaid reimbursement is the amount billed or the Medicare established allowable amount for the facility, whichever is lower.
<b>Copay</b>	None

## **ASSISTIVE CARE SERVICES**

<b>Description</b>	<p>Assistive Care Services provide care to eligible recipients living in congregate living facilities and requiring integrated services on a 24-hour per day basis.</p> <p>This includes residents of licensed Assisted Living Facilities (ALFs), adult family care homes (AFCHs) and residential treatment facilities (RTFs).</p> <p>Assistive Care Service recipients must have functional deterioration that makes it medically necessary for them to live in congregate living facilities and receive integrated assistive care services on a 24-hour scheduled and unscheduled basis.</p> <p>There are four components to Assistive Care Services:</p> <ul style="list-style-type: none"> <li>• Assistance with activities of daily living (eating, bathing, walking, etc.)</li> <li>• Assistance with instrumental activities of daily living (shopping, making phone calls, etc.)</li> <li>• Assistance with medications</li> <li>• Health support</li> </ul>
<b>Limitations</b>	Limited to residents of above facilities.
<b>Exceptions</b>	<p>The following Medicaid recipients are not eligible for ACS:</p> <ul style="list-style-type: none"> <li>• Those residing in institutions such as nursing facilities, state mental hospitals, institutions for mental disease, or intermediate facilities for the developmentally disabled and</li> <li>• Those enrolled in any Medicaid managed care program such as Medicaid HMOs, or the Nursing Home Diversion Waiver where the capitated payment is designed to cover all Medicaid services.</li> </ul>
<b>Eligibility</b>	<p>To receive assistive care services, recipients in this program must be at least 18 years of age or older and meet the following requirements:</p> <ol style="list-style-type: none"> <li>1. Be Medicaid eligible;</li> <li>2. Have a health assessment completed by a physician or other licensed practitioner of the healing arts acting within the scope of their practice under state law which indicates the medical necessity of assistive care services;</li> <li>3. Be determined to need at least two service components of the assistive care service; and</li> <li>4. Reside in a Medicaid enrolled ALF, RTF, or AFCH.</li> </ol>
<b>Reimbursement</b>	Assistive care service components are reimbursed at a single per diem rate.
<b>Copay</b>	None

## BIRTH CENTER SERVICES

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<b>Description</b>	<p>Birth Centers are licensed facilities that provide obstetrical, gynecological and family planning services.</p> <p>Medicaid reimburses for services rendered by licensed, Medicaid-participating birth centers. Medicaid reimbursable services include:</p> <ul style="list-style-type: none"> <li>• Initial comprehensive and prenatal examinations</li> <li>• Labor management for recipients who transfer to a hospital</li> <li>• Post delivery examinations</li> <li>• Vaginal delivery</li> <li>• Post delivery recovery</li> <li>• Newborn assessment</li> <li>• Related pregnancy services</li> <li>• Family planning services</li> <li>• Gynecological services</li> </ul>
<b>Limitations</b>	<p>Medicaid reimbursement for birth center services is limited to:</p> <ul style="list-style-type: none"> <li>• One family planning comprehensive visit, per year, per recipient;</li> <li>• One family planning supply visit, per 75 days, per recipient;</li> <li>• One ultrasound per pregnancy;</li> <li>• Ten low-risk prenatal visits;</li> <li>• Two postpartum visits, which include an examination of both mother and baby; and</li> <li>• One newborn assessment.</li> </ul> <p>Post delivery recovery at the birth center is limited to 24 hours.</p>
<b>Exceptions</b>	None.
<b>Eligibility</b>	<p>Medicaid reimburses for birth center services for all Medicaid recipients whose pregnancies are determined to be low risk. Recipients whose eligibility is determined through the Presumptively Eligible Pregnant Women program are not eligible for services associated with labor, delivery, postpartum, and inpatient hospitalization. The Department of Children and Families must complete an eligibility determination and find the recipient eligible under another coverage group before the recipient is eligible for these services.</p>
<b>Reimbursement</b>	Birth centers are reimbursed on a fee-for-service basis. Medicaid reimbursement for birth center services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.
<b>Copay</b>	There is a \$2 recipient copayment for gynecological services, per provider, per day, unless the recipient is exempt.

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## CHILD HEALTH CHECK-UP

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**Description**

Child Health Check-Up consists of a comprehensive, preventive health screening that is performed on a periodic basis on children under the age of 21.

A Child Health Check-Up includes:

- (1) A comprehensive Health and developmental history; an assessment of past medical history, developmental history and behavioral health status; unclothed physical exam; nutritional assessment; developmental assessment; updating of routine immunizations; laboratory tests (including blood lead screening); vision, hearing, and dental screening (including dental referral); and health education/anticipatory guidance.
- (2) Referral and follow-up for further diagnosis and treatment as indicated as a result of the screening process.

Medicaid reimburses county health departments, Children's Medical Services clinics, physicians, community health centers (rural health clinics and federally qualified health centers), physician assistants and advanced registered nurse practitioners for Child Health Check-Ups. Birth centers and licensed midwives may be reimbursed only for the initial Child Health Check-Up newborn evaluation.

The Child Health Check-Up schedule is as follows:

- Birth
- Two to four days if newborn is discharged in less than 48 hours
- By one month
- Two months
- Four months
- Six months
- Nine months
- Twelve months
- Fifteen months
- Eighteen months
- Once per year from age two through 20.\*

\* Note: Florida Medicaid recommends check-ups at 7 and 9 years of age for those children at risk. Additional screening examinations may be provided on referral, if medically necessary, from a health care, developmental, or education professional or on request of a parent, guardian or the recipient.

A dental referral is provided for recipients beginning at age three, or earlier if indicated. Subsequent examinations by a dentist are recommended every six months or as prescribed by a dentist or other authorized provider. Vision and hearing screenings are provided according to an established periodicity schedule.

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**Child Health Check-Up**, continued

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<b>Limitations</b>	Birth centers and licensed midwives may be reimbursed only for the initial Child Health Check-Up newborn evaluation.
<b>Exceptions</b>	Additional screening examinations may be provided on referral, if medically necessary, from a health care, developmental, or education professional or on request of a parent, guardian or the recipient.
<b>Eligibility</b>	Medicaid reimburses for Child Health Check-Ups for Medicaid recipients under the age of 21 and children from 1 year of age through age 4 who are enrolled in the MediKids program.
<b>Reimbursement</b>	Medicaid reimburses an all-inclusive fee for a Child Health Check-Up. Immunizations and laboratory tests are reimbursed separately. (Some provider types are not reimbursed for laboratory tests in addition to their Child Health Check-Up fee.)
<b>Copay</b>	None

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**CHILD HEALTH SERVICES TARGETED CASE MANAGEMENT**

<b>Description</b>	<p>Targeted case management provides case-management services to the Department of Health, Children’s Medical Services (CMS) clients. Case management is defined as activities associated with ensuring access to necessary medical, social, educational, and other services as required by the individual.</p> <p>Medicaid reimburses Department of Health, Children’s Medical Services (CMS) clinic staff for case management activities.</p>
<b>Limitations</b>	<p>Medicaid reimbursement for individual mental health case-management services is limited to 86 hours, per individual case manager, per month, per recipient. Reimbursement for intensive, team case management services is limited to 12 hours per day, per recipient. Only one claim for all cumulative units that occurred during the day is reimbursed per individual case manager, per recipient.</p>
<b>Exceptions</b>	<p>None</p>
<b>Eligibility</b>	<p>To receive case-management services, a recipient must meet the individual eligibility criteria for Children’s Medical Services.</p>
<b>Reimbursement</b>	<p>Medicaid reimburses the provider an established fee based on a unit of service for each allowable case management service. A unit is from one to 15 minutes.</p> <p>Case management services provided by CMS must be adjusted annually to their actual cost.</p>
<b>Copay</b>	<p>None</p>

## CHIROPRACTIC SERVICES

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<b>Description</b>	<p>Chiropractic services include a new patient visit, manipulation of the spine, and spinal x-rays. The new patient visit consists of a screening and any required manipulation of the spine.</p> <p>Medicaid reimburses for chiropractic services rendered by licensed, Medicaid-participating chiropractors.</p>
<b>Limitations</b>	<p>Medicaid reimbursement for chiropractic services is limited to one visit per provider, per recipient, per day.</p> <p>A new patient visit is limited to one per provider, per recipient. A new patient is one who has not received any professional services from the provider or provider group within the past three years.</p> <p>Visits are limited to a total of 24 during a calendar year.</p> <p>Medicaid does not reimburse massage or heat treatments.</p>
<b>Exceptions</b>	<p>The provider may request authorization for reimbursement for services in excess of the service limitations for recipients under the age of 21.</p>
<b>Eligibility</b>	<p>Medicaid reimburses for chiropractic services for all Medicaid recipients.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for chiropractic services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.</p>
<b>Copay</b>	<p>There is a \$1 recipient copayment for chiropractic services, per provider, per day, unless the recipient is exempt.</p>

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## COMMUNITY MENTAL HEALTH SERVICES

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<b>Description</b>	Community mental health services include mental health and substance abuse services and are provided for the maximum reduction of the recipient's mental health or substance abuse disability and restoration to the best possible functional level. Services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.
<b>Limitations</b>	Services are limited to those, which are medically necessary and are recommended by a licensed practitioner of the healing arts, psychiatrist, or other physician and included in the recipient's treatment plan.
<b>Exceptions</b>	None
<b>Eligibility</b>	Medicaid reimburses for community mental health services for all Medicaid recipients who meet the service criteria.
<b>Reimbursement</b>	Medicaid reimbursement for community mental health services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.
<b>Copay</b>	There is a \$2 recipient copayment for community mental health services, per provider, per day, unless the recipient is exempt.

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## COUNTY HEALTH DEPARTMENT CLINIC SERVICES

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<b>Description</b>	<p>Medicaid reimburses for clinic services rendered by county health departments. County health departments provide primary and preventive health care to diagnose, treat and refer patients who need more extensive care.</p> <p>County health department clinic services are rendered by licensed health professional staff at the clinics, including physicians, dentists, registered nurses, advanced registered nurse practitioners and physician assistants.</p> <p>Medicaid reimbursement to county health departments includes:</p> <ul style="list-style-type: none"> <li>• Adult health screening services</li> <li>• Child Health Check-Ups</li> <li>• Dental services</li> <li>• Family planning services</li> <li>• Medical primary care services</li> <li>• Nursing protocol services</li> </ul> <p>County health departments participate in the Vaccines for Children Program.</p>
<b>Limitations</b>	Medicaid reimbursement is limited to one county health department encounter, per day, per recipient.
<b>Exceptions</b>	None
<b>Eligibility</b>	Medicaid reimburses for county health department clinic services for all Medicaid recipients.
<b>Reimbursement</b>	County health department clinics are reimbursed at an encounter rate, as determined by cost-based reporting.
<b>Copay</b>	None

## DENTAL SERVICES—CHILDREN

<b>Description</b>	<p>Medicaid reimburses for children’s dental services rendered by licensed, Medicaid-participating dentists. Medicaid reimbursable children’s dental services include:</p> <ul style="list-style-type: none"> <li>• Diagnostic examinations</li> <li>• Radiographs necessary to make a diagnosis</li> <li>• Preventive services</li> <li>• Restorations</li> <li>• Endodontics/Periodontal treatment</li> <li>• Dentures, complete and partial</li> <li>• Oral surgery</li> <li>• Orthodontic treatment</li> </ul>
<b>Limitations</b>	<p>Medicaid does not reimburse for the following services:</p> <ul style="list-style-type: none"> <li>• Fixed bridge work, or</li> <li>• Sealants applied to deciduous (baby) teeth.</li> </ul> <p>Medicaid reimburses for the application of sealants on permanent first and second molars once per three years, per tooth.</p> <p>For orthodontics, Medicaid services are limited to treatment of severely handicapping malocclusions or correction of a dental condition deterring physical development. Prior authorization is required for all orthodontic services except the initial evaluation.</p>
<b>Exceptions</b>	<p>The provider may request prior authorization for reimbursement for services in excess of the service limitations.</p>
<b>Eligibility</b>	<p>Medicaid reimburses for children’s dental services for all Medicaid recipients under the age of 21.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for children’s dental services is the maximum Medicaid fee or the provider’s customary fee, whichever is lower.</p> <p>For orthodontic treatment, an initial payment is made at the start of treatment, but regardless of the severity or duration of treatment, total payment may not exceed the fee for banding and 24 monthly adjustment visits.</p>
<b>Copay</b>	<p>None</p>

## **DENTAL SERVICES—ADULTS**

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<b>Description</b>	<p>Medicaid reimburses for acute adult emergency dental services rendered by licensed, Medicaid-participating dentists. Medicaid reimbursable acute adult emergency dental services are provided to recipients age 21 and older to alleviate pain or infection. Services include:</p> <ul style="list-style-type: none"> <li>• Problem-focused oral examination;</li> <li>• Necessary radiographs to make a diagnosis;</li> <li>• Extractions; and</li> <li>• Incision and drainage of an abscess.</li> </ul>
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<b>Limitations</b>	<p>Recipients who reside in a nursing facility, intermediate care facility for the developmental disabled or state mental hospital must have the oral examination requested by their attending physician or the Director of Nurses.</p>
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<b>Exceptions</b>	<p>The provider may request authorization for reimbursement for services in excess of the service limitations.</p>
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<b>Eligibility</b>	<p>Medicaid reimburses for adult emergency dental services for all Medicaid recipients 21 years of age and older.</p>
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<b>Reimbursement</b>	<p>Medicaid reimbursement for adult emergency dental services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.</p>
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<b>Copay</b>	<p>None</p>

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## **DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES**

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**Description**

Durable medical equipment (DME) is equipment that can be used repeatedly, serves a medical purpose, and is appropriate for use in the patient's home.

Medical supplies are medical or surgical items that are consumable, expendable, disposable or non-durable, and are appropriate for use in the patient's home.

Medicaid reimburses for DME and medical supplies provided by Medicaid-participating providers.

DME may be rented or purchased. Examples of reimbursable equipment include, but are not limited to:

- Ambulatory equipment (canes, crutches, walkers)
- Augmentative and assistive communication devices
- Commodes
- Hospital type beds and accessories
- Orthotics and prosthetics
- Oxygen and oxygen-related equipment
- Suction pumps
- Wheelchairs

Examples of reimbursable medical supplies include, but are not limited to, ostomy and urological supplies.

Medical necessity for DME or supplies must be documented by a prescription, a statement of medical necessity, a plan of care, or a hospital discharge plan. The documentation must be signed and dated by the attending physician and include specific information on the item needed, the duration of need, and the recipient's diagnosis.

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**Limitations**

Medicaid reimbursement for DME and medical supplies includes some of the following limitations:

- Most medical supplies are limited to one per day, per recipient.
  - DME and supplies are not covered for recipients in a hospital, nursing facility or intermediate care facility for the developmentally disabled (ICF/DD).
  - Some DME services and medical supplies are reimbursable only for recipients under 21 years of age.
  - Wheelchairs for children under age 21 that cost more than \$12,000 must be recommended by the Children's Multidisciplinary Assessment Team (CMAT).
  - Custom wheelchairs must be prior-authorized by the Area Medicaid Office service authorization nurse.
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**Durable Medical Equipment**, continued

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**Exceptions**

The following services may be reimbursed for recipients under the age of 21 in nursing facilities or intermediate care facilities for the developmentally disabled (ICF/DD):

- Some customized orthotics and prosthetics
  - Customized wheelchairs
  - Augmentative and assistive communication devices for children under age 21
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**Eligibility**

Medicaid reimburses for DME and medical supplies for all Medicaid recipients.

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**Reimbursement**

Medicaid reimbursement for services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

The total amount reimbursed for rental payments for DME cannot exceed the established maximum allowed purchase fee.

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**Copay**

None

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## EARLY INTERVENTION SERVICES

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<b>Description</b>	<p>Early intervention services are medical and remedial services designed to enhance the capacity of children with a developmental delay or conditions that cause a delay in normal development.</p> <p>Medicaid reimburses for early intervention services rendered by Medicaid-participating providers who are licensed health care professionals and paraprofessionals.</p> <p>Medicaid reimbursable early intervention services include screenings, evaluations, and early intervention sessions to provide medically-necessary services for identified delays in one or more of the areas of cognition: physical/motor, sensory, communication, social, emotional or adaptive development.</p>
<b>Limitations</b>	<p>Medicaid reimburses one initial psychosocial and developmental evaluation per lifetime, per recipient.</p> <p>Ongoing early intervention sessions are limited to one hour per type of session, per day.</p>
<b>Exceptions</b>	<p>The provider may request authorization for reimbursement for services in excess of the service limitations.</p>
<b>Eligibility</b>	<p>Medicaid reimburses for early intervention services for <b>all</b> Medicaid recipients under the age of 21 who meet the service criteria. Although the term “children” encompasses those up to 21 years of age for Medicaid purposes, the intent is to serve young children, birth to three years of age.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for services is the maximum Medicaid fee or the provider’s customary fee, whichever is lower.</p>
<b>Copay</b>	<p>None</p>

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## FEDERALLY QUALIFIED HEALTH CENTERS

<b>Description</b>	<p>A Federally Qualified Health Center (FQHC) is a clinic that is receiving a grant from the Public Health Service. FQHCs provide primary and preventive outpatient health care. FQHC services are performed by advanced registered nurse practitioners, chiropractors, clinical psychologists, clinical social workers, dentists, optometrists, physicians, physician assistants, and podiatrists.</p> <p>Medicaid reimbursement to FQHCs includes:</p> <ul style="list-style-type: none"> <li>• Adult health screening services</li> <li>• Child Health Check-Ups</li> <li>• Chiropractic services</li> <li>• Dental services</li> <li>• Family planning services</li> <li>• Medical primary care services</li> <li>• Mental health services</li> <li>• Optometric services</li> <li>• Podiatry services</li> </ul> <p>FQHCs participate in the Vaccines for Children program. Immunization services are reimbursed separately from the FQHC's cost-based reimbursement rate.</p>
<b>Limitations</b>	<p>Medicaid reimbursement for FQHC services is limited to one encounter, per day, per recipient.</p> <p>The service limitations that apply to the Medicaid program for a particular service, such as dental, apply to the services when rendered by an FQHC. FQHC mental health services are limited to 26 visits, per recipient, per calendar year.</p>
<b>Exceptions</b>	None
<b>Eligibility</b>	Medicaid reimburses for FQHC services for all Medicaid recipients.
<b>Reimbursement</b>	Medicaid reimburses the FQHC a clinic-specific, all-inclusive encounter rate for clinic services. Immunizations, emergency services, and services rendered away from the clinic are reimbursed on a fee-for-service basis.
<b>Copay</b>	There is a \$3 recipient copayment for FQHC services, per clinic, per day, unless the recipient is exempt.

**FREESTANDING DIALYSIS CENTER SERVICES**

<b>Description</b>	<p>Freestanding dialysis center services include in-center hemodialysis, in-center administration of the injectable medication Erythropoietin (Epogen or EPO), and home peritoneal dialysis. These services must be provided under the supervision of a physician licensed to practice medicine or osteopathic medicine in Florida.</p> <p>The dialysis treatment includes routine laboratory tests, dialysis-related supplies and ancillary and parenteral items.</p> <p>A freestanding dialysis center is one that is not supervised, managed or controlled by a hospital or hospital staff.</p>
<b>Limitations</b>	<p>Medicaid reimbursement for hemodialysis provided in a freestanding dialysis center is limited to the payment of one treatment per recipient, per day, up to three times per week. Medicaid reimbursement for home peritoneal dialysis is limited to one treatment per recipient, per day. Medicaid reimbursement for the medication Erythropoietin (Epogen or EPO) is limited to up to three times per week.</p>
<b>Exceptions</b>	<p>The weekly maximum number of treatments may be exceeded if additional treatments are determined to be medically necessary by the recipient's nephrologist or primary care physician.</p>
<b>Eligibility</b>	<p>Medicaid reimburses freestanding dialysis center services for all Medicaid recipients. When submitted with proper documentation of medical necessity, these services are considered an emergency and are reimbursable for alien recipients.</p>
<b>Exclusions</b>	<p>Medicaid does not cover any services other than in-center hemodialysis, in-center administration of the injectable medication Erythropoietin (Epogen or EPO), and home peritoneal dialysis supplies provided by a freestanding dialysis center.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for freestanding dialysis center services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. The fee includes payment for all routine laboratory tests, dialysis-related supplies, and ancillary and parenteral items used in the dialysis procedure.</p>
<b>Copay</b>	<p>None</p>

## HEARING SERVICES

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<b>Description</b>	<p>Medicaid reimburses for hearing services rendered by licensed, Medicaid-participating otolaryngologists, otologists, audiologists, and hearing aid specialists.</p> <p>Medicaid reimbursable hearing services include:</p> <ul style="list-style-type: none"> <li>• Cochlear implants services</li> <li>• Diagnostic testing</li> <li>• Hearing aids</li> <li>• Hearing aid evaluations</li> <li>• Hearing aid fitting and dispensing</li> <li>• Hearing aid repairs and accessories</li> <li>• Newborn hearing screening</li> </ul> <p><u>Note:</u> See Hearing Services – Newborn Screening section for more information on these services.</p>
<b>Limitations</b>	<p>Medicaid reimbursement for hearing services has the following limitations:</p> <ul style="list-style-type: none"> <li>• Limited to recipients younger than 21 years of age.</li> <li>• Medicaid reimbursement for evaluations and hearing devices is limited to one every three years from the date of the last evaluation.</li> <li>• Medicaid does not reimburse for routine maintenance; batteries, cord or wire replacement; or cleaning.</li> <li>• Medicaid does not reimburse for repairs until after the manufacturer's warranty has expired.</li> </ul>
<b>Exceptions</b>	<p>The provider may request authorization for reimbursement for services in excess of the service limitations.</p>
<b>Eligibility</b>	<p>Medicaid reimburses for hearing services for all Medicaid recipients, according to medical necessity and hearing loss criteria.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for hearing services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.</p>
<b>Coinsurance</b>	<p>None.</p>

## HEARING SERVICES—NEWBORN SCREENING

<b>Description</b>	<p>Newborn screening for hearing includes early hearing impairment screening, identification, and follow-up care for newborns in the hospital.</p> <p>Screening must include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the U. S. Food and Drug Administration.</p> <p>The goal is to screen all newborns for hearing impairment in order to alleviate the adverse effects of hearing loss on speech and language development, academic performance, and cognitive development.</p>
<b>Limitations</b>	<p>Newborn hearing screening must be performed in the hospital by a licensed audiologist, a physician licensed under Chapter 458 or Chapter 459, Florida Statutes, or an appropriately supervised individual who has completed documented training specifically for newborn hearing screening. The individual selected by the hospital to do the screening may be a current employee of the hospital or the screening services may be contracted out to an individual in the community who meets the same qualifications and who comes to the hospital to furnish the service.</p>
<b>Exceptions</b>	<p>If the parent or legal guardian of the newborn objects to the screening, it may not be performed. In such cases, the physician or other person attending the newborn must maintain a record that the screening was not performed and attach a written objection that must be signed by the parent or guardian. These documents must be placed in the newborn's medical chart.</p>
<b>Eligibility</b>	<p>Medicaid reimburses for all Medicaid recipients</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for hearing screening services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.</p>
<b>Copay</b>	<p>None</p>

## HOME HEALTH SERVICES

<b>Description</b>	<p>Home health services are provided in a recipient's home or other authorized setting to promote, maintain or restore health or to minimize the effects of illness and disability.</p> <p>Medicaid reimburses for home health services rendered by licensed, Medicaid-participating home health agencies. Medicaid reimbursable services include:</p> <ul style="list-style-type: none"> <li>• Home visit services provided by a registered nurse or a licensed practical nurse;</li> <li>• Home visits provided by a qualified home health aide;</li> <li>• Private duty nursing;</li> <li>• Personal care services;</li> <li>• Therapy (occupational and physical therapy and speech-language pathology) services; and</li> <li>• Medical supplies, appliances and durable medical equipment.</li> </ul>
<b>Limitations</b>	<p>Medicaid reimbursement for home health services has the following limitations:</p> <ul style="list-style-type: none"> <li>• Nursing and home health aide visit services are limited to: <ul style="list-style-type: none"> <li>- a total of four visits by nurses and/or aides per day, per recipient and</li> <li>- a total of 60 visits by nurses and/or aides per lifetime, per recipient.</li> </ul> </li> <li>• Private duty nursing, personal care and therapy services are limited to children under 21 who are medically complex. Private duty nursing and personal care services must be service authorized by the Area Medicaid Office, service-authorization nurse.</li> <li>• Private duty nursing and personal care services are limited to: <ul style="list-style-type: none"> <li>- Two to 24 hours of private duty nursing per day, per recipient, and</li> <li>- Two to 24 hours of personal care provided by home health aides per day, per recipient.</li> </ul> </li> <li>• Dually eligible Medicaid/Medicare recipients must receive Medicare reimbursable home health services from a Medicare-enrolled home health agency.</li> </ul>
<b>Exceptions</b>	<p>Exceptions to the 60-visit limit for children and adults must be requested through the Medicaid contracted peer review agency. Service authorization requests should be submitted before services are provided or billed.</p>
<b>Eligibility</b>	<p>Medicaid reimburses for home health services that are medically necessary and that can be safely, effectively and efficiently provided in the home when either leaving home is medically contraindicated or the Medicaid recipient is unable to leave home without the assistance of another person.</p>
<b>Reimbursement</b>	<p>Medicaid reimburses home health agencies the maximum allowable Medicaid fee or the provider's customary fee, whichever is lower.</p>
<b>Copay</b>	<p>There is a \$2 recipient copayment for home health services, per provider, per day, unless the recipient is exempt.</p>

## HOSPICE SERVICES

<b>Description</b>	<p>Hospice services are forms of palliative health care and supportive services for terminally ill patients and their families. The services are administered by a hospice agency and coordinated by the hospice nurse assigned to the patient.</p> <p>Hospice employs an interdisciplinary team to meet the special needs arising out of the physical, emotional, spiritual, and social stresses associated with the final stages of illness and during dying and bereavement.</p> <p>Medicaid reimburses Medicaid-participating hospice providers who are licensed by the Agency for Health Care Administration and meet the requirements to participate in Medicare. Medicaid reimbursement includes:</p> <ul style="list-style-type: none"> <li>• Hospice care provided by the designated hospice,</li> <li>• Direct care services of a hospice physician, and</li> <li>• Nursing facility room and board.</li> </ul>
<b>Limitations</b>	<p>Once a recipient elects to receive hospice care, Medicaid will not reimburse for other Medicaid services that treat the terminal condition. Medicaid will reimburse for services that are required for conditions that are unrelated to the terminal condition.</p>
<b>Exceptions</b>	<p>None</p>
<b>Eligibility</b>	<p>Medicaid reimburses for hospice services for all Medicaid recipients who meet the eligibility criteria. The recipient must be certified by a physician as being terminally ill and having a life expectancy of six months or less, if the disease runs its normal course; must elect a hospice; and must complete and sign an election statement to receive hospice services from the designated hospice.</p>
<b>Reimbursement</b>	<p>Medicaid reimburses for hospice services on an established daily rate based on the recipient's level of care.</p> <p>For eligible individuals who live in nursing facilities and elect hospice care, Medicaid may reimburse the hospice a per diem rate for room and board. This rate is in addition to the daily rate for hospice services.</p>
<b>Copay</b>	<p>None</p>

## **HOSPITAL SERVICES—INPATIENT**

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<b>Description</b>	<p>Medicaid reimburses licensed, Medicaid-participating hospitals for inpatient services. The services must be provided under the direction of a licensed physician or dentist.</p> <p>Medicaid reimbursement for inpatient hospital services includes: room and board, medical supplies, diagnostic and therapeutic services, use of hospital facilities, drugs and biologicals, nursing care, and all supplies and equipment necessary to provide the appropriate care and treatment of patients.</p> <p>To participate in Medicaid, the hospital must be maintained primarily for the care and treatment of patients with disorders other than mental diseases.</p>
<b>Limitations</b>	<p>Medicaid reimbursement for inpatient hospital care for adults age 21 and older is limited to 45 days per state fiscal year (July 1 through June 30). There is no limit on the number of days that Medicaid can reimburse for recipients under age 21.</p> <p>Inpatient admissions for Medicaid recipients must be prior authorized. Certain categories of recipients and circumstances are exempt from the prior authorization requirement. For example, some recipient exemptions are as follows:</p> <ul style="list-style-type: none"> <li>• Recipients enrolled in an HMO or Provider Service Network,</li> <li>• Dually eligible for Medicare and Medicaid recipients, and</li> <li>• Recipients enrolled in the Children's Medical Service Network.</li> </ul>
<b>Exceptions</b>	<p>Medicaid will reimburse inpatient hospital services to a non-Medicaid-participating hospital in an emergency, for the duration of the emergency, subject to the established limitations.</p>
<b>Eligibility</b>	<p>Medicaid reimburses for inpatient hospital services for all Medicaid recipients. An exception is recipients whose eligibility is determined through the Presumptively Eligible Pregnant Women program are not eligible for services associated with labor, delivery, postpartum, and inpatient hospitalization. The Department of Children and Families must complete an eligibility determination and find the recipient eligible under another coverage group before the recipient is eligible for these services.</p>
<b>Reimbursement</b>	<p>Medicaid reimburses for inpatient hospital services prospectively based on cost-reported, per diem rates that are subject to caps. Teaching, specialty, and community health education hospitals are exempted from the caps contingent upon counties contributing to the state's share of the cost of the exemption. Details of the reimbursement plan are explained in the Florida Medicaid (Title XIX) Inpatient Hospital Reimbursement Plan. The plan is available on the AHCA web site at <a href="http://www.fdhc.state.fl.us/Medicaid">www.fdhc.state.fl.us/Medicaid</a>. Additional payments are made to disproportionate share hospitals.</p> <p>Inpatient newborn hearing screening services are reimbursed using an established fee. These are the only inpatient services to which the per diem reimbursement does not apply. Medicaid does not pay for routine newborn circumcision.</p>
<b>Copay</b>	<p>There is a \$3 recipient copayment for each admission to a hospital, unless the recipient is exempt.</p>

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**HOSPITAL SERVICES—OUTPATIENT**

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<b>Description</b>	<p>Outpatient hospital services are preventive, diagnostic, therapeutic or palliative care and service items provided to an outpatient. The services must be provided under the direction of a licensed physician or dentist.</p> <p>Medicaid reimburses licensed, Medicaid-participating hospitals for outpatient services. Medicaid reimbursement includes medical supplies, nursing care, therapeutic services and drugs. Primary care services provided in an outpatient hospital setting, hospital-owned clinic or satellite facility are not considered outpatient hospital services and are not reimbursable under the outpatient hospital program.</p>
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<b>Limitations</b>	<p>Medicaid reimbursement for outpatient hospital services is limited to \$1,500 per recipient, per state fiscal year (July 1 through June 30) for recipients who are age 21 and older. There is no reimbursement limitation for children under the age of 21.</p>
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<b>Exceptions</b>	<p>Exceptions to the outpatient fiscal year limitation are made for the surgical procedures that are performed in an outpatient setting. Services include, but are not limited to, cataract surgery, myringotomy with insertion of tube, single mastoidectomy, ligation and stripping of varicose lower limb veins, inguinal hernia repair, tubal ligation, ligation of vas deferens, dilation and curettage, vaginal child delivery, and dialysis services.</p> <p>Medicaid will reimburse outpatient hospital services furnished by a non-Medicaid-participating hospital in an emergency, for the duration of the emergency.</p>
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<b>Eligibility</b>	<p>Medicaid reimburses for outpatient hospital services for all Medicaid recipients.</p>
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<b>Reimbursement</b>	<p>Outpatient reimbursement is made on the basis of a payment plan in the form of a prospective rate as detailed in the Florida Medicaid (Title XIX) Outpatient Hospital Reimbursement Plan. The plan is available on the AHCA web site at <a href="http://www.fdhc.state.fl.us/Medicaid">www.fdhc.state.fl.us/Medicaid</a>. An exception is diagnostic laboratory procedures, which are reimbursed the maximum Medicaid fee or the provider's customary fee, whichever is lower. Another exception to the outpatient prospective rate is newborn hearing screening. This service is reimbursed using an established fee.</p>
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<b>Copay</b>	<p>There is a \$3 recipient copayment for each hospital outpatient department or clinic visit and emergency room visit to receive non-emergency services, unless the recipient is exempt.</p>
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## INDEPENDENT LABORATORY SERVICES

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<b>Description</b>	<p>Independent laboratory services are clinical laboratory procedures performed in freestanding laboratory facilities. A doctor of medicine or osteopathy or other licensed health care practitioner authorized within the scope of practice to order clinical laboratory tests must authorize the services.</p> <p>Medicaid reimburses for services rendered by licensed, Clinical Laboratory Improvements Act (CLIA) certified, Medicaid-participating independent laboratories.</p> <p>Medicaid does not reimburse hospitals, ambulatory surgical centers, federally qualified health centers, rural health clinics, or practitioners for services performed in their offices for independent laboratory services.</p>
<b>Limitations</b>	<p>Medicaid reimbursement is limited to the specific procedures that an independent laboratory facility has been certified under CLIA to provide. The frequency of some tests is also limited.</p>
<b>Exceptions</b>	<p>If medically necessary, the provider may request reimbursement for services in excess of the established limits by billing with a modifier.</p>
<b>Eligibility</b>	<p>Medicaid reimburses independent laboratory services for all Medicaid recipients.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for independent laboratory services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.</p>
<b>Copay</b>	<p>There is a \$1 recipient copayment for independent laboratory services, per provider, per day, unless the recipient is exempt.</p>

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## INTERMEDIATE CARE FACILITY SERVICES FOR THE DEVELOPMENTALLY DISABLED

**Description** Medicaid reimburses for services rendered by state owned and operated intermediate care facilities for the developmentally disabled (ICF/DD).

Medicaid reimbursement for ICF/DD services includes:

- Room and board
- Food and food supplements
- Nursing services
- Rehabilitative care
- Therapy
- Basic wardrobe
- Training and help with daily living skills
- Medical supplies, durable medical equipment, eyeglasses, hearing aids
- Dental care
- Transportation

**Limitations** There is no Medicaid limitation on the length of stay in an ICF/DD. However, Medicaid reimbursement for a reserved bed is limited to:

- 15 days per hospital stay,
- 30 days per 12 months for infirmary stays, and
- 45 days per state fiscal year (July 1—June 30) for therapeutic leave.

**Exceptions** None

**Eligibility** Medicaid reimburses for ICF/DD services for all Medicaid recipients except for Medically Needy recipients. All admissions to ICF/DDs must be prior approved by the Department of Children and Families, Developmental Disabilities Program Office. The Developmental Disabilities Program Office is responsible for determining the medical necessity for ICF/DD services. Individuals admitted to ICF/DDs must have been determined to be eligible for, to require, and to have chosen ICF/DD placement prior to admission.

**Reimbursement** Medicaid reimbursement for an ICF/DD is made in accordance with the Florida Medicaid (Title XIX) ICF/DD Reimbursement Plan. Payment is an all-inclusive prospective per diem rate, based on cost reports and staff ratios for each level of care, and is subject to AHCA’s established annual inflation allowance for cost increases by level of care.

**Copay** None

## LICENSED MIDWIFE SERVICES

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<b>Description</b>	<p>Medicaid reimburses Medicaid-participating, licensed midwives for obstetrical care services rendered to women during the antepartum and postpartum phases of pregnancy and home deliveries.</p> <p>Medicaid reimbursable services include:</p> <ul style="list-style-type: none"><li>• Initial comprehensive and prenatal examinations</li><li>• Labor management for recipients who transfer to a hospital</li><li>• Post delivery examinations</li><li>• Vaginal delivery</li><li>• Post delivery recovery</li><li>• Newborn assessment</li><li>• Related pregnancy services</li></ul>
<b>Limitations</b>	<p>Medicaid reimbursement for licensed midwife services is limited to one visit, per day, per recipient. Visits are limited to a total of ten low-risk antepartum visits and two postpartum visits per pregnancy. Newborn assessments are limited to one per recipient.</p>
<b>Exceptions</b>	<p>None</p>
<b>Eligibility</b>	<p>Medicaid reimburses for licensed midwife services for Medicaid recipients whose pregnancy is determined to be low risk. Recipients whose eligibility is determined through the Presumptively Eligible Pregnant Women program are not eligible for services associated with labor, delivery, postpartum, and inpatient hospitalization. The Department of Children and Families must complete an eligibility determination and find the recipient eligible under another coverage group before the recipient is eligible for these services.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for licensed midwife services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. Licensed midwives are reimbursed at 80 percent of the physician's rate for services that are approved by the Centers for Medicare and Medicaid Services (CMS).</p>
<b>Copay</b>	<p>None</p>

## MEDICAL FOSTER CARE SERVICES

<b>Description</b>	<p>Medical foster care (MFC) services enable medically-complex children whose parents cannot care for them in their own homes to live and receive medical care in alternative-home settings rather than hospitals or other institutions. The Department of Health, Children’s Medical Services (CMS) administers the medical foster care program. The Department of Children and Families (DCF) reimburses the medical foster parent for the child’s room, board and other living expenses.</p> <p>Medicaid reimburses the medical foster parent for providing the child with medically necessary care needed in daily living activities. These activities include, but are not limited to, feeding, bathing, administering medications, changing dressings, and turning and positioning the medical foster child.</p>
<b>Limitations</b>	<p>Medicaid will reimburse only one medical foster care provider per day, per child.</p> <p>Medicaid does not reimburse for additional services to allow the medical foster care parent to obtain respite from caring for the child.</p> <p>Medical Foster Care providers must be supervised by the MFC staff.</p>
<b>Exceptions</b>	<p>None</p>
<b>Eligibility</b>	<p>Medicaid reimburses for medical foster care services for all Medicaid-eligible, medically-complex recipients under the age of 21 when the following criteria have been met:</p> <ul style="list-style-type: none"> <li>• MFC services are recommended by the Children’s Multidisciplinary Assessment Team (CMAT),</li> <li>• DCF and CMS have placed the child in a MFC home, and</li> <li>• The MFC services are authorized by the Area Medicaid Office service authorization nurse.</li> </ul>
<b>Reimbursement</b>	<p>Medicaid reimbursement for medical foster care services is based on the level of medical foster care required by the child.</p>
<b>Copay</b>	<p>None</p>

## MENTAL HEALTH TARGETED CASE MANAGEMENT

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<b>Description</b>	The purpose of mental health targeted case management is to assist recipients in gaining access to needed medical, social, educational, and other services.
<b>Limitations</b>	Medicaid will reimburse: <ul style="list-style-type: none"><li>• Up to 344 units of children's or adult mental health targeted case management per month, per recipient.</li><li>• Up to 48 units of intensive team services per recipient, per day, per case management team.</li></ul>
<b>Exceptions</b>	None
<b>Eligibility</b>	Mental health targeted case management is limited to recipients who are enrolled in a Department of Children and Families mental health target program.
<b>Reimbursement</b>	<p>Mental health targeted case management services are reimbursed in time increments. Fifteen minutes equal one unit of service.</p> <p>If multiple units are provided on the same day, the actual time spent must be totaled and rounded up to the nearest 15-minute increment. The provider may not round up each service episode to the nearest 15-minute increment prior to summing the total.</p>
<b>Copay</b>	None

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## NURSING FACILITY SERVICES

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<b>Description</b>	<p>Nursing facility services are 24-hour-a-day nursing and rehabilitation services provided in a facility that is licensed and certified by the Agency for Health Care Administration (AHCA) to participate in the Medicaid program. Nursing facility services include special care for AIDS patients and medically-fragile children; reimbursement for swing bed services provided in a rural acute care hospital; and skilled nursing services provided in a hospital-based, skilled-nursing unit.</p> <p>The recipient's care and services must be ordered by a doctor of medicine or osteopathy. There are three levels of nursing facility care: skilled and intermediate I and II. The Department of Elder Affairs, Comprehensive Assessment and Review for Long Term Care Services (CARES) unit recommends the level of care for recipients age 21 and older. The Department of Health, Children's Medical Services, Children's Multidisciplinary Assessment Team (CMAT) recommends the level of care for recipients under the age of 21.</p>
<b>Limitations</b>	<p>There is no limitation on the length of stay in a nursing facility. However, Medicaid reimbursement for a reserved bed (subject to specific criteria) is limited to:</p> <ul style="list-style-type: none"> <li>• Eight days per hospital stay, and</li> <li>• Sixteen days per state fiscal year (July 1 - June 30) for home visits.</li> </ul> <p>Swing bed services cannot exceed 60 days unless a longer stay has been prior authorized by CARES. Hospital-based skilled-nursing unit services cannot exceed 30 days, unless one 15-day extension has been prior authorized by CARES.</p>
<b>Exceptions</b>	None
<b>Eligibility</b>	<p>Medicaid reimburses for nursing facility services for Medicaid recipients who meet the Medicaid Institutional Care Program (ICP) eligibility requirements. The Department of Children and Families' Office of Economic Self Sufficiency determines if recipients meet the ICP financial eligibility requirements. The Department of Elder Affairs' CARES Program determines if recipients meet the level of care requirements .</p>
<b>Reimbursement</b>	<p>Reimbursement is made in accordance with the Florida Medicaid (Title XIX) Long-Term Care Reimbursement Plan. The plan is available on the AHCA web site at <a href="http://www.myflorida.com">www.myflorida.com</a>. A daily rate is determined for each nursing facility based on an audited cost report submitted by the nursing facility. There is no rate difference between the skilled and intermediate levels of care. Rural swing-bed providers receive the average statewide nursing-facility rate. Hospital-based skilled-nursing units receive the average nursing-facility rate for the county in which the hospital is located. Supplemental reimbursement is available for approved recipients who have AIDS or are medically-fragile children under the age of 21. Prior authorization is required for a supplemental reimbursement.</p>
<b>Copay</b>	<p>Based upon the recipient's income, each recipient will have a patient responsibility amount determined by DCF.</p>

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## OPTOMETRIC SERVICES

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<b>Description</b>	<p>Medicaid reimburses for services rendered by licensed, Medicaid-participating optometrists.</p> <p>Medicaid reimbursable services include:</p> <ul style="list-style-type: none"> <li>• Visual examinations when there is a reported vision problem, illness, disease or injury</li> <li>• Consultation and referral services</li> <li>• Custodial care facility services</li> <li>• Nursing facility services</li> <li>• Evaluation and management services</li> <li>• General and special ophthalmological services</li> <li>• Pathology and laboratory services</li> <li>• Surgical services within the optometrist's scope of practice, and</li> <li>• Post-operative management.</li> </ul>
<b>Limitations</b>	<p>Medicaid reimbursement for optometric services has the following limitations:</p> <ul style="list-style-type: none"> <li>• Visual examinations, refractions, eyeglasses and eyeglass repairs are limited to recipients younger than 21 years of age.</li> </ul> <p>Medicaid reimbursement for all post-operative, follow-up services must be ordered by the operating surgeon. A written referral signed by the surgeon must be filed in the recipient's medical record.</p>
<b>Exceptions</b>	None
<b>Eligibility</b>	Medicaid reimburses for optometric services for all Medicaid recipients.
<b>Reimbursement</b>	Medicaid reimbursement for optometric services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.
<b>Copay</b>	There is a \$2 recipient copayment for optometric services, per provider, per day, unless the recipient is exempt-

## PHYSICIAN SERVICES

**Description** Medicaid reimburses for services rendered by licensed, Medicaid-participating doctors of medicine or osteopathic medicine. The services can be rendered in the physician’s office, the patient’s home, a hospital, a nursing facility or other approved places of services as necessary to treat a particular injury, illness, or disease.

**Limitations** Medicaid reimbursement for physician services is limited to:

- One physician-recipient contact per provider specialty, per day (except for emergencies);
- One long-term care facility service per physician, per month, per recipient (except for emergencies);
- One physician consultation per 365 days, per physician of any specialty, per recipient (for non-hospitalized Medicaid recipients);
- Ten prenatal visits for low-risk pregnancy, fourteen visits for high-risk pregnancy, and two postpartum visits per pregnancy; and
- One new patient evaluation and management service per physician specialty, every three years, if no services were rendered by the physician to the recipient during the prior three years. Subsequent encounters must be reimbursed as established patient evaluation and management services.

Medicaid does not reimburse cosmetic surgery, experimental or investigational procedures.

Eye exams are reimbursable only if related to reported vision problems, illness, disease or injury.

Elective surgery performed within the inpatient hospital setting must be medically necessary and prior authorized, except for recipients under age 21 who have been screened in the Child Health Check-Up program within 12 months prior to the date of surgery.

Medicaid does not reimburse abortions except for one of the following reasons:

- The woman suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
- The pregnancy is the result of incest.
- The pregnancy is the result of rape.

**Exceptions** The provider may request authorization for reimbursement for services in excess of the service limitations.

**Physician Services**, continued

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<b>Eligibility</b>	Medicaid reimburses for physician services for all Medicaid recipients. Recipients whose eligibility is determined through the Presumptively Eligible Pregnant Women program are not eligible for services associated with labor, delivery, postpartum, and inpatient hospitalization. The Department of Children and Families must complete an eligibility determination and find the recipient eligible under another coverage group before the recipient is eligible for these services. Legal non-citizens are limited to emergency services only.
<b>Reimbursement</b>	Medicaid reimbursement for physician services is the maximum Medicaid fee or the provider's billed charge, whichever is lower.  An exception is certain obstetrical and neonatal services provided in Regional Perinatal Intensive Care Centers (RPICCs), whose payment is based on a Diagnosis Related Group (DRG). DRG payments are prospective and based on average patient lengths of stay in a hospital.
<b>Copay</b>	There is a \$2 recipient copayment for physician services, per provider, per day, unless the recipient is exempt.

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## PHYSICIAN ASSISTANT SERVICES

<b>Description</b>	<p>Medicaid reimburses for services provided by licensed, Medicaid-participating physician assistants. The services must be provided in collaboration with a practitioner licensed pursuant to Chapter 458 or 459, Florida Statutes.</p>
<b>Limitations</b>	<p>Medicaid reimbursement for physician assistant services is limited to:</p> <ul style="list-style-type: none"> <li>• One physician assistant-recipient contact per day (except for emergencies);</li> <li>• One long-term care facility visit per month, per recipient (except for emergencies); and</li> <li>• One new patient evaluation and management service per physician assistant, per recipient every three years, if no services were rendered by the physician assistant to the recipient during the three years. An additional new patient visit cannot be billed by the supervising physician for a patient already seen as a new patient by a physician assistant.</li> </ul> <p>Medicaid cannot reimburse a physician assistant and a physician for the same procedure, same recipient, and same date of service. Medicaid may reimburse a surgeon for a surgical service and a physician assistant for the assist-at-surgery service.</p>
<b>Exceptions</b>	<p>The provider may request authorization for reimbursement for services in excess of the service limitations.</p>
<b>Eligibility</b>	<p>Medicaid reimburses for physician assistant services for all Medicaid recipients.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for physician assistant services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. Physician assistants are reimbursed at 80 percent of the physician's rate for services that are approved by the Centers for Medicare and Medicaid Services (CMS). If a physician assistant is salaried by a hospital or other facility, such as a nursing facility, that is reimbursed on a cost-related basis, the physician assistant cannot be reimbursed on a fee-for-service basis if the costs for the physician assistant's salary are included in the facility's cost report.</p>
<b>Copay</b>	<p>There is a \$2 recipient copayment for physician assistant services, per provider, per day, unless the recipient is exempt.</p>

## PODIATRY SERVICES

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<b>Description</b>	Medicaid reimburses for podiatry services rendered by licensed, Medicaid-participating podiatrists. The services can be provided in the podiatrist's office, inpatient hospital, outpatient/emergency department of a hospital, ambulatory surgical center, nursing facility, intermediate care facility for the developmentally disabled (ICF/DD), boarding home, recipient's home, or other custodial facility.
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<b>Limitations</b>	<p>Podiatry services are limited to:</p> <ul style="list-style-type: none"> <li>• One podiatrist-recipient contact per day, not to exceed two per month (except for emergencies);</li> <li>• One long-term care facility service per month, per recipient (except for emergencies); and</li> <li>• One new patient evaluation and management service per recipient, every three years, if no services were rendered by the podiatrist to the recipient during the three years. Subsequent encounters must be reimbursed as established patient evaluation and management services.</li> </ul> <p>Medicaid reimburses for routine foot care if the recipient is under a physician's care for a metabolic disease, has conditions of circulatory impairment, or has conditions of desensitization of the legs or feet.</p> <p>Medicaid does not reimburse assistant fees for minor surgery, cosmetic surgery, and experimental or clinically unproven surgical procedures.</p> <p>All elective surgical procedures require prior authorization, except for recipients under 21 who have been screened in the Child Health Check-Up program within 12 months of the date of surgery.</p> <p>Recipients are able to receive up to four podiatry visits without authorization from their MediPass provider.</p>
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<b>Exceptions</b>	The provider may request authorization for reimbursement for services in excess of the service limitations.
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<b>Eligibility</b>	Medicaid reimburses for podiatry services for all Medicaid recipients.
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<b>Reimbursement</b>	Medicaid reimbursement for podiatry services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.
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<b>Copay</b>	There is a \$2 recipient copayment for podiatry services, per provider, per day, unless the recipient is exempt.
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## PORTABLE X-RAY SERVICES

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<b>Description</b>	<p>Portable x-ray services are interpretive and technical mobile x-ray services that are provided at the recipient's residence. A doctor of medicine or osteopathy or other licensed health care practitioner authorized within the scope of practice to order x-rays must authorize the services.</p> <p>Medicaid reimburses for services rendered by licensed, Medicaid-participating portable x-ray providers who are certified in accordance with Medicare standards.</p> <p>Medicaid does not reimburse hospitals, ambulatory surgical centers, federally qualified health centers, rural health clinics, or physicians for portable x-ray services rendered in their offices.</p> <p>In addition to the radiographs supplied by mobile x-ray equipment and their interpretation, Medicaid pays a fee for the transportation of the equipment and x-ray personnel to the place of service. The set up of the equipment is not a separately reimbursed service.</p>
<b>Limitations</b>	<p>Medicaid reimbursement for portable x-ray services is limited to one unit of service, per procedure, per recipient, per day.</p>
<b>Exceptions</b>	<p>None</p>
<b>Eligibility</b>	<p>Medicaid reimburses for portable x-ray services for all Medicaid recipients.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for portable x-ray services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.</p>
<b>Copay</b>	<p>There is a \$1 recipient copayment for portable x-ray services, per provider, per day, unless the recipient is exempt.</p>

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## PRESCRIBED DRUG SERVICES

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### Description

Medicaid reimburses licensed, Medicaid-participating pharmacies. Medicaid reimburses for most legend drugs used in outpatient settings, including injectable drugs, and specified non-legend drugs. Brand name prescriptions are limited to four per month with some exceptions. Generic drugs, insulin and diabetic supplies, contraceptives, mental health drugs, and antiviral drugs used to treat HIV are exempt from these limits. Based on the treatment needs of the Medicaid recipient, the agency may authorize exceptions to the four-brand-name drug restriction.

The non-legend drugs include:

- Insulin;
- Sodium chloride solution for inhalation;
- Urine ketone test strips for insulin dependent recipients under age 21;
- Disposable insulin syringe-needle combinations used to administer subcutaneous insulin;
- Blood glucose test strips and meters (limited to a contracted manufacturer unless an exception is approved. The current manufacturer is Lifescan.);
- Contraceptive devices and supplies;
- Aluminum and calcium products used as phosphate binders and multivitamin supplements for dialysis patients;
- Enteral nutritional supplements when prior authorized;
- Specified iron supplements;
- Aspirin when prescribed as an anti-inflammatory agent;
- Vaginal antifungal creams;
- Guaifenesin as a single entity expectorant, in either liquid or solid dosage form; and
- Specified smoking cessation products.

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Medicaid does not reimburse pharmacies for any over-the-counter products dispensed to institutionalized recipients that could be floor stock and included in the institution's per diem.

Medicaid does not reimburse pharmacies for the following products:

- DESI ineffective drugs as designated by the Centers for Medicare and Medicaid Services (CMS);
- Experimental drugs;
- Cough and cold combination medications for recipients age 21 and older;
- Anorectics (unless prescribed for an indication other than obesity);
- Prostheses, appliances and devices (except products for diabetics and products used as contraceptives);
- Hair growth restorers and other drugs for cosmetic use;
- Drugs for patients who are hospitalized or being treated in outpatient hospital facilities or ambulatory surgical centers;
- Drugs to treat the terminal condition of hospice recipients;

**Prescribed Drug Services**, continued

**Description**,  
continued

- Floor stock items required to be furnished by institutions;
- Vitamins (except prenatal vitamins for pregnant and lactating women and folic acid as a single entity; one vitamin or vitamin/mineral prescription monthly for dialysis patients, fluoridated pediatric vitamins for children under age 13); and prescribed ferrous sulfate, gluconate, or fumarate for non-institutionalized patients (ferrous sulfate, gluconate, or fumarate is available as floor stock to institutionalized patients);
- Immunizations for non-Child Health Check-Up recipients 21 years of age and older, except for influenza and pneumococcal vaccines for institutionalized recipients.
- Drugs used to treat infertility; and
- All other over-the-counter products not specified above.

Medicaid does not reimburse for drugs not included in a manufacturer's rebate agreement. Drugs must be prescribed for medically-accepted indications.

**Limitations**

Medicaid reimbursement for recipients age 21 and older is limited to four brand name prescriptions per month. Generic drugs, insulin and diabetic supplies, contraceptives, mental health drugs, and antiviral drugs used to treat HIV are exempt from these limits. There is no limitation on the number of prescriptions for recipients under the age of 21.

Prior authorization is required for albumin, Botox<sup>®</sup>, Cytogam<sup>®</sup>, immune globulins, food supplements, Neupogen<sup>®</sup>, Neutrexin<sup>®</sup>, Panretin<sup>®</sup>, Proleukin<sup>®</sup>, Provigil<sup>®</sup>, Procrit<sup>®</sup>, Targretin<sup>®</sup> gel and capsules, Regranex<sup>®</sup> in long term care facilities and adult human growth hormone for HIV/AIDS.

Prior authorization is required for all prescribed drugs that are not on the Preferred Drug List (PDL). Mental health drugs and anti-retrovirals for HIV are exempt from PDL restrictions.

Medicaid processes all prescription claims through Drug Utilization Review and will not reimburse for prescriptions that are refilled too often or too soon, that duplicate other prescriptions, or that result in excessively high dosages for the recipient.

**Exceptions**

The provider may request authorization for reimbursement for services in excess of the service limitations. The prescriber must request the exception to the four-brand-name limit and drugs not on the PDL.

**Eligibility**

Medicaid reimburses for prescribed drug services for all Medicaid recipients, except for those in limited programs, such as a Qualified Medicare Beneficiary (QMB) and aliens. Silver Saver recipients are limited to \$160 per month in prescribed drugs.

**Prescribed Drug Services**, continued

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<b>Reimbursement</b>	Medicaid reimbursement for prescribed drugs is the lowest of the Estimated Acquisition cost (EAC) calculated as: <ul style="list-style-type: none"><li>• Average wholesale price less 13.25% or</li><li>• Wholesaler Acquisition Cost plus 7% or</li><li>• Federal or state maximum-allowable cost plus, in each case, a dispensing fee of \$4.23; or</li><li>• The amount billed by the pharmacy, which cannot exceed the pharmacy's usual and customary charge for the prescription.</li></ul>
<b>Copay</b>	None

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## PRESCRIBED PEDIATRIC EXTENDED CARE SERVICES

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<b>Description</b>	<p>A prescribed pediatric extended care (PPEC) center is a non-residential health care center in which the needed continuum of care for children who are medically complex is provided. PPEC includes an array of services focused on meeting the medical, developmental, physical, nutritional and social needs of these children. The PPEC provides a less restrictive alternative to institutionalization and reduces the isolation that a homebound, medically complex child may experience. Medicaid reimbursement for PPEC services includes nursing care and personal care services that are ordered by the physician. PPECs that provide other Medicaid services, such as therapies and durable medical equipment, must be enrolled as Medicaid providers of those services.</p>
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<b>Limitations</b>	<p>Medicaid reimbursement for PPEC services is limited to one unit of service per recipient, per day.</p>
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<b>Exceptions</b>	<p>None</p>
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<b>Eligibility</b>	<p>Medicaid reimburses for PPEC services for Medicaid-eligible, medically-complex recipients under the age of 21 years who meet the following requirements:</p> <ul style="list-style-type: none"> <li>• The child must be medically complex or need acute medical care;</li> <li>• The services must be prescribed by the attending physician;</li> <li>• Services must be recommended by the Children’s Multidisciplinary Assessment Team (CMAT); and</li> <li>• The service must be authorized by an Area Medicaid Office service authorization nurse.</li> </ul>
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<b>Reimbursement</b>	<p>Medicaid reimbursement for PPEC services is an all-inclusive half-day or whole-day per diem rate for each child.</p>
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<b>Copay</b>	<p>None</p>
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## REGISTERED NURSE FIRST ASSISTANT SERVICES

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<b>Description</b>	Medicaid reimburses for services provided by licensed, Medicaid-participating registered nurse first assistants (RNFA). The services must be rendered in collaboration with a physician and in accordance with Chapter 464, Florida Statutes.
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<b>Limitations</b>	<p>Medicaid reimbursement for RNFA services is limited as follows:</p> <ul style="list-style-type: none"> <li>• One surgical assistant may be reimbursed per operative session.</li> <li>• Services provided by an RNFA must be within the specialty of the supervising physician.</li> </ul>
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Medicaid cannot reimburse a registered nurse first assistant and an assistant surgeon for the same recipient and same date of service.

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<b>Exceptions</b>	None
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<b>Eligibility</b>	Medicaid reimburses for RNFA services for all Medicaid recipients.
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<b>Reimbursement</b>	Medicaid reimbursement for RNFA services is the maximum Medicaid fee or the provider's billed charge, whichever is lower. RNFAs are reimbursed at 12.8 percent of the physician's rate for services that are approved by the Centers for Medicare and Medicaid Services (CMS).
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If an RNFA is salaried by a hospital or other facility that is reimbursed on a cost-related basis, the RNFA cannot be paid on a fee-for-service basis if the costs for the RNFA's salary are included in the facility cost report.

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<b>Copay</b>	There is a \$2 recipient copayment for RNFA services, per provider, per day, unless the recipient is exempt.
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## RURAL HEALTH CLINIC SERVICES

<b>Description</b>	<p>A Rural Health Clinic (RHC) is a clinic that is located in a rural area that has a health care provider shortage. RHCs provide primary and preventive health care and related diagnostic services. In addition, RHCs may provide optometric, podiatry, chiropractic and mental health services. RHC services are performed by advanced registered nurse practitioners, chiropractors, clinical psychologists, clinical social workers, optometrists, physicians, physician assistants, and podiatrists.</p> <p>Medicaid reimbursement to RHCs includes:</p> <ul style="list-style-type: none"> <li>• Adult health screening services</li> <li>• Child Health Check-Ups</li> <li>• Chiropractic services</li> <li>• Family planning services</li> <li>• Medical primary care services</li> <li>• Mental health services</li> <li>• Optometric services</li> <li>• Podiatry services</li> </ul> <p>RHCs participate in the Vaccines for Children program. Immunization services are reimbursed separately from the RHC's cost-based reimbursement rate.</p>
<b>Limitations</b>	<p>Medicaid reimbursement for RHC services is limited to one encounter, per day, per recipient.</p> <p>The service limitations that apply to the Medicaid program for a particular service, such as chiropractic, apply to the services when rendered by an RHC. RHC mental health services are limited to 26 visits, per recipient, per calendar year.</p>
<b>Exceptions</b>	<p>None</p>
<b>Eligibility</b>	<p>Medicaid reimburses for RHC services for all Medicaid recipients.</p>
<b>Reimbursement</b>	<p>Medicaid reimburses the RHC a clinic-specific, all-inclusive encounter rate for clinic services. Immunizations, emergency services, and services rendered at a hospital are reimbursed on a fee-for-service basis.</p>
<b>Copay</b>	<p>There is a \$3 recipient copayment for RHC services, per clinic, per day, unless the recipient is exempt.</p>

## **SCHOOL-BASED SERVICES PROGRAMS**

### **SCHOOL DISTRICT PROGRAM**

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<b>Description</b>	School districts may enroll as providers of a variety of Medicaid services. When the school district employs or contracts with staff who provide health care, the school district can enter into a provider agreement with Medicaid and receive the federal share of Medicaid payments for providing Medicaid-covered services to Medicaid-eligible children.
<b>Limitations</b>	Medicaid coverage limitations are based on the type of service(s) that the school district elects to have Medicaid reimburse.
<b>Exceptions</b>	None.
<b>Eligibility</b>	Medicaid reimburses school districts for certain services rendered to Medicaid-eligible students under the age of 21 who qualify as disabled under the "Individuals with Disabilities Education Act," Part B or C and who have the services referenced in their Individual Educational Plans or Family Support Plans.
<b>Reimbursement</b>	Medicaid reimbursement for services provided by a school is the federal share of the reasonable cost of service.
<b>Copay</b>	N/A

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**SCHOOL-BASED SERVICES PROGRAMS  
COUNTY HEALTH DEPARTMENT PROGRAM**

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<b>Description</b>	County Health Departments (CHDs) may enroll as providers of a variety of nursing services in public schools. When the CHD employs or contracts with nurses who provide nursing services, the CHD can enter into a provider agreement with Medicaid and receive the federal share of Medicaid payments for providing Medicaid-covered nursing services to Medicaid-eligible children.
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<b>Limitations</b>	Medicaid reimbursement is limited to nursing services (personally rendered), and medication administration by a registered nurse or licensed practical nurse.
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<b>Exceptions</b>	None
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<b>Eligibility</b>	Medicaid reimburses CHDs for services rendered to Medicaid-eligible students under the age of 21.
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<b>Reimbursement</b>	Medicaid reimbursement for services provided by a CHD is the federal share of the Medicaid maximum fee.
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<b>Copay</b>	None
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## STATE MENTAL HEALTH HOSPITAL SERVICES

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<b>Description</b>	State mental hospitals provide all-inclusive psychiatric inpatient hospital care. Medicaid reimbursement for services includes: room and board, professional services, rehabilitative nursing services, supplies, and equipment necessary to provide the appropriate care. Medicaid reimburses for state mental hospital services for all Medicaid recipients who are age 65 or older and require long-term mental health services.
<b>Limitations</b>	There is no limitation on the length of stay in a nursing facility. However, Medicaid reimbursement for a reserved bed (subject to specific criteria) is limited to: <ul style="list-style-type: none"><li>• Fifteen days per hospital stay, and</li><li>• Thirty days per state fiscal year (July 1 - June 30) for home visits if permitted by the recipient's plan of care.</li></ul>
<b>Exceptions</b>	None.
<b>Eligibility</b>	Medicaid reimburses for state mental health hospital services for Medicaid recipients who meet the Medicaid Institutional Care Program (ICP) eligibility requirements. The Department of Children and Families' Office of Economic Self Sufficiency determines if recipients meet the ICP financial eligibility requirements. The Department of Elder Affairs' CARES Program determines if recipients meet the level of care requirements.
<b>Reimbursement</b>	Inpatient reimbursement is made on the basis of a payment plan in the form of a prospective per diem cost rate as detailed in the Florida Medicaid (Title XIX) Inpatient Hospital Reimbursement Plan. The plan is available on the AHCA web site at <a href="http://www.myflorida.com">www.myflorida.com</a> .
<b>Copay</b>	Based upon the recipient's income, each recipient will have a patient responsibility amount determined by DCF.

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## **THERAPY SERVICES—OCCUPATIONAL**

<b>Description</b>	<p>Occupational therapy addresses the functional needs of an individual related to the performance of self-help skills; adaptive behavior; and sensory, motor, and postural development.</p> <p>Medicaid reimburses for occupational therapy services provided by licensed, Medicaid-participating occupational therapists and by supervised, occupational therapy assistants.</p> <p>Medicaid reimbursable services include evaluation and treatment to prevent or correct physical and emotional deficits or to minimize the disabling effect of these deficits. Typical activities are perceptual motor activity exercises to enhance functional performance, kinetic movement, guidance in the use of adaptive equipment, and other techniques related to improving motor development.</p> <p>Services are available in the home or other appropriate setting.</p>
<b>Limitations</b>	<p>Medicaid reimbursement is limited to:</p> <ul style="list-style-type: none"> <li>• One initial evaluation per recipient, per provider; and</li> <li>• One re-evaluation every six months per recipient, per provider.</li> </ul> <p>An occupational therapy treatment must have a minimum duration of 15 minutes of face-to-face contact between the therapist and the recipient with a maximum of 14 units-of-service per week. Daily treatment may not exceed 4 units-of-service.</p> <p>The recipient's primary care physician must prescribe therapy treatments.</p>
<b>Exceptions</b>	<p>None</p>
<b>Eligibility</b>	<p>Medicaid reimburses for medically necessary occupational therapy services for all Medicaid recipients under the age of 21.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for occupational therapy services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.</p>
<b>Copay</b>	<p>None</p>

## THERAPY SERVICES—PHYSICAL

<b>Description</b>	<p>Physical therapy addresses the development, improvement or restoration of neuromuscular or sensory motor function; relief of pain; or control of postural deviation to attain maximum performance.</p> <p>Medicaid reimburses for physical therapy services provided by licensed, Medicaid-participating physical therapists and by supervised, physical therapy assistants.</p> <p>Medicaid reimbursable services include the evaluation and treatment related to range-of-motion, muscle strength, functional abilities and the use of adaptive or therapeutic equipment. Activities include rehabilitation through exercises, massage, the use of equipment and rehabilitation through therapeutic activities.</p> <p>These services are available in the home or other appropriate setting.</p>
<b>Limitations</b>	<p>Medicaid reimbursement is limited to:</p> <ul style="list-style-type: none"> <li>• One initial evaluation per recipient, per provider; and</li> <li>• One re-evaluation every six months per recipient, per provider.</li> </ul> <p>A physical therapy treatment must have a minimum duration of 15 minutes of face-to-face contact between the therapist and the recipient with a maximum of 14 units-of-service per week. Daily treatment may not exceed 4 units-of-service.</p> <p>The recipient's primary care physician must prescribe therapy treatments.</p>
<b>Exceptions</b>	None.
<b>Eligibility</b>	<p>Medicaid reimburses for medically necessary physical therapy services for Medicaid recipients under the age of 21.</p> <p>Recipients age 21 and older can obtain physical therapy under the outpatient hospital services program. Services provided in the outpatient hospital are included in the hospital per diem and are subject to the \$1,500 outpatient cap.</p>
<b>Reimbursement</b>	Medicaid reimbursement for physical therapy services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.
<b>Copay</b>	None

## **THERAPY SERVICES—RESPIRATORY**

<b>Description</b>	<p>Respiratory therapy is the evaluation and treatment of pulmonary dysfunction. Medicaid reimbursable services include: ventilator support, therapeutic use of medical gases, respiratory rehabilitation, management of life support systems, bronchopulmonary drainage, breathing exercises, and chest physiotherapy.</p> <p>Medicaid reimburses for respiratory therapy services that are personally rendered by licensed registered respiratory therapists.</p> <p>These services are available in the home or other appropriate setting.</p>
<b>Limitations</b>	<p>Medicaid reimbursement is limited to:</p> <ul style="list-style-type: none"> <li>• One initial evaluation per recipient, per provider; and</li> <li>• One re-evaluation every six months per recipient, per provider.</li> </ul> <p>A respiratory therapy treatment must have a minimum duration of 15 minutes of face-to-face contact between the recipient and the therapist with a maximum of 14 units-of-service per week. Daily treatment may not exceed 4 units-of-service.</p> <p>The recipient’s primary care physician must prescribe therapy treatments.</p>
<b>Exceptions</b>	<p>None</p>
<b>Eligibility</b>	<p>Medicaid reimburses for medically necessary respiratory therapy services for Medicaid recipients under the age of 21.</p> <p>Recipients age 21 and older can obtain respiratory therapy under the outpatient hospital services program. Services provided in the outpatient hospital are included in the hospital per diem and are subject to the \$1,500 outpatient cap.</p>
<b>Reimbursement</b>	<p>Medicaid reimbursement for respiratory therapy services is the maximum Medicaid fee or the provider’s customary fee, whichever is lower.</p>
<b>Copay</b>	<p>None</p>

## THERAPY SERVICES—SPEECH-LANGUAGE PATHOLOGY

<b>Description</b>	<p>Speech-language pathology services involve the evaluation and treatment of speech-language disorders.</p> <p>Medicaid reimburses for speech-language pathology services provided by licensed, Medicaid-participating speech-language pathologists and by supervised, speech-language pathologist assistants.</p> <p>These services are available in the home or other appropriate setting. Speech-language pathology services may be rendered to a group of children.</p>
<b>Limitations</b>	<p>Medicaid reimbursement is limited to:</p> <ul style="list-style-type: none"> <li>• One initial evaluation per recipient, per provider; and</li> <li>• One re-evaluation every six months per recipient, per provider.</li> </ul> <p>An individual speech-language pathology treatment must have a minimum duration of 15 minutes of face-to-face contact between the therapist and the recipient with a maximum of 14 units-of-service per week. Daily treatment may not exceed 4 units-of-service.</p> <p>A group speech-language pathology treatment is limited to six children. The group must receive a minimum of 30-minutes of therapy.</p> <p>The recipient's primary care physician must prescribe therapy treatments.</p>
<b>Exceptions</b>	None
<b>Eligibility</b>	<p>Medicaid reimburses for medically necessary speech-language pathology services for Medicaid recipients under the age of 21.</p> <p>Medicaid reimburses speech-language pathology services for the provision of augmentative and communication systems for recipients regardless of age.</p>
<b>Reimbursement</b>	Medicaid reimbursement for speech-language pathology services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.
<b>Copay</b>	None

**TRANSPLANT SERVICES – ORGAN AND BONE MARROW**

**Description** Bone marrow transplantation is performed for the treatment of certain types of cancers and aplastic anemias; solid organ transplantation is performed for failure of the organ due to a variety of illnesses. Medicaid reimburses for organ and bone marrow transplantation services provided by specialized transplant physicians in designated transplant centers.

Determinations for medically accepted transplant procedures are established within the guidelines of the Agency for Health Care Administration (AHCA) Organ Transplant Advisory Council, the Bone Marrow Transplant Advisory Panel, and Medicaid medical consultants.

Acceptance as a candidate for covered transplant services is determined by the designated transplant hospital, not by Medicaid. Pre-transplant and post-transplant care, including immunosuppressive medications, is reimbursed even if the transplant is not a Medicaid-covered transplant.

**Limitations** Medicaid reimbursement for transplant services has the following limitations:

- Recipients age 21 and older are eligible for kidney, cornea, liver, lung, heart and bone marrow transplants when medically necessary and appropriate.
- Recipients under age 21 are eligible for transplants determined medically necessary and appropriate, including lung, heart/lung and those listed above for recipients age 21 and older.
- All out-of-state transplant referrals for organ and bone marrow transplants must be requested by a Medicaid designated transplant center. The prior authorization must be forwarded to the Medicaid office for review.
- Out-of-state evaluations and transplants are not covered if the services are available in the state of Florida.
- Physician services limitations apply.

Adult heart and liver transplants require prior authorization. Medicaid does not reimburse transplant procedures that are deemed investigational or those not yet proven clinically effective as determined by consultants within the AHCA Organ Transplant Advisory Council.

**Exceptions** Medicaid reimburses for pretransplant and posttransplant related services even if the transplant itself is not a covered service.

Medicaid does not reimburse for donor services for solid or bone marrow transplant procedures even if the donor is a Medicaid eligible recipient.

**Eligibility** Medicaid reimburses for transplant services for all Medicaid recipients, except aliens who are eligible only for emergency services due to their alien status.

**TRANSPLANT SERVICES**, continued

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**Reimbursement** Medicaid reimbursement for physicians for transplant services is the maximum Medicaid fee or the provider's customary fee, whichever is lower. Medicaid reimbursement for hospitals for transplant services is the established per diem rate for that facility.

Any organ transplant reimbursed under a global payment methodology is reimbursable to the facility and those providers under a specially designated global payment method as determined by the Florida Legislature

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**Copay** None

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## TRANSPORTATION SERVICES

<b>Description</b>	<p>Medicaid reimburses for transportation services provided by Medicaid-participating ground and air ambulance companies, wheelchair and stretcher van providers, taxicab companies, multi-passenger van and bus lines, and public and private organizations.</p> <p>To be reimbursed by Medicaid, transportation must be for the purpose of transporting the recipient to or from a Medicaid-covered service to receive medically-necessary care. When necessary, Medicaid may reimburse transportation of an escort for the recipient, such as a parent or guardian.</p>
<b>Limitations</b>	<p>Transportation services are available only to eligible recipients who cannot obtain transportation on their own through any available means such as family, friends or community resources.</p> <p>All transportation must be the most cost-effective and most appropriate method of transportation available to each transportation eligible Medicaid recipient.</p> <p>Non-emergency non-ambulance transport is scheduled through the Community Transportation Coordinator that is established through a Memorandum of Agreement with the Florida Commission for the Transportation Disadvantaged. The Area Medicaid Office must prior authorize certain trips where policy requires such authorization.</p>
<b>Exceptions</b>	<p>Post authorization for non-emergency non-ambulance transport may be granted only if the medical service is immediately necessary because of an urgent situation and the local authorizing entity is unavailable. The provider or recipient must request post authorization within a specified number of working days of the date transportation was provided.</p>
<b>Eligibility</b>	<p>Medicaid reimburses for transportation services provided for all Medicaid recipients who have no service limitations.</p>
<b>Reimbursement</b>	<p>Transportation rates are negotiated by the Area Medicaid Offices with transportation providers and should be less than the local carriers' usual and customary charges.</p> <p>Authorized private volunteer automobile transportation is compensable at 20 cents per mile.</p> <p>Medicaid reimburses non-emergency carriers the published Medicaid fee, the carrier's customary fee, or an area-negotiated rate.</p> <p>Ambulance transportation, for either the Basic Life Support or Advanced Life Support level of service, is reimbursed at the Medicaid published allowable rate or the carrier's customary fee.</p>
<b>Copay</b>	<p>There is a \$1 recipient copayment for transportation services for each one-way trip, unless the recipient is exempt.</p>

## VISUAL SERVICES

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<b>Description</b>	<p>Medicaid reimburses for visual services rendered by licensed, Medicaid-participating ophthalmologists, optometrists and opticians.</p> <p>Medicaid reimbursable services include eyeglasses, eyeglass repairs as required, prosthetic eyes, and contact lenses. Providers may use the Central Optical Laboratory, which is managed by Prison Rehabilitative Industries and Diversified Enterprises (PRIDE), for services for Medicaid recipients.</p>
<b>Limitations</b>	<p>Medicaid reimbursement for visual services has the following limitations:</p> <ul style="list-style-type: none"><li>• Eyeglasses and eyeglass repairs are limited to recipients younger than 21 years of age.</li><li>• Limited to the provision or replacement of medically necessary eyeglasses.</li><li>• Limited to no more than two pairs of eyeglasses per recipient, per 365 days.</li><li>• Services for recipients age 21 and above are limited to prosthetic eyes and contact lenses.</li></ul> <p>All special eyeglasses and contact lenses must be prior authorized.</p>
<b>Exceptions</b>	<p>The provider may request authorization for reimbursement for services in excess of the service limitations.</p>
<b>Eligibility</b>	<p>Medicaid reimburses for limited visual services for all Medicaid recipients.</p>
<b>Reimbursement:</b>	<p>Medicaid reimbursement for visual services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.</p>

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**WAIVER - ADULT CYSTIC FIBROSIS**

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**Background** Cystic fibrosis is a progressive genetic disease that causes a range of symptoms especially affecting the lungs and the digestive system. Persons with this disease are able to live a relatively normal life if they obtain appropriate treatment and support to minimize the symptoms and progression of the disease.

The Department of Children and Families, Adult Services Program Office, operates the Adult Cystic Fibrosis (CF) Waiver Program, which went into effect October 1, 2002.

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**Description** Waiver services include: acupuncture, adult companion, adult day health, chore service, counseling (individual and family), durable medical equipment, exercise therapy, massage therapy, occupational therapy, personal care, personal emergency response service, physical therapy, prescribed drugs, respiratory therapy, respite care, skilled nursing, specialized medical equipment and supplies, transportation, and vitamins and nutritional supplements.

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**Eligibility** To be eligible for CF waiver services, an individual must meet the following criteria:

- Be 18-59 years of age;
  - Diagnosed with cystic fibrosis;
  - Be determined to be at risk of hospitalization; and
  - Meet the Supplemental Security Income (SSI)-related Medicaid or the Institutional Care Program (ICP) income and asset requirements.
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**Reimbursement** Medicaid reimbursement for CF waiver services is the maximum Medicaid fee or the provider’s customary fee, whichever is lower.

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## WAIVER - AGED/DISABLED ADULT

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<b>Background</b>	<p>The Aged/Disabled Adult (A/DA) Waiver is a home and community-based services program that was implemented statewide on April 1, 1982. The Florida Department of Elder Affairs has operational responsibility for the A/DA Waiver. This is a 1915(c) waiver.</p>
<b>Description</b>	<p>The waiver includes the following services: adult companion, adult day health care, attendant care, case aide, case management, chore services, consumable medical supplies, counseling, environmental accessibility adaptation, escort, family training, financial risk reduction, health support, home-delivered meals, homemaker and personal care services, nutrition, personal emergency response systems, pest control, physical risk reduction, physical therapy, respite care, skilled nursing, specialized medical equipment and supplies, and speech therapy.</p> <p>Recipients make an informed choice of receiving home and community-based services in lieu of nursing facility care.</p>
<b>Eligibility</b>	<p>To be eligible for the Aged/Disabled Adult Waiver services, an individual must meet the following criteria:</p> <ul style="list-style-type: none"><li>● Be 65 years old or older or be ages 18 to 64 and determined disabled according to Social Security standards;</li><li>● Meet Supplemental Security Income (SSI), MEDS-AD, or Medicaid waiver assistance income and asset requirements;</li><li>● Meet nursing facility level-of-care criteria as determined by CARES; and</li><li>● Be enrolled in the waiver.</li></ul>
<b>Reimbursement</b>	<p>Authorized services provided to enrolled waiver recipients are provided on a fee-for-service basis. Medicaid reimbursement for services is the Medicaid fee or the provider's customary fee, whichever is lower.</p>

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## WAIVER - ASSISTED LIVING FOR THE ELDERLY

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<b>Background</b>	<p>The Assisted Living for the Elderly (ALE) Waiver is a home and community-based services program that was implemented statewide on February 1, 1995, for recipients who reside in qualified Assisted Living Facilities (ALFs). The Florida Department of Elder Affairs (DOEA) has operational responsibility for the ALE Waiver. This is a 1915(c) waiver.</p>
<b>Description</b>	<p>The waiver includes three services: case management, assisted living, and if needed, incontinence supplies. The components of assisted living include: an attendant call system, attendant care, behavior management, chore, companion services, homemaker, intermittent nursing, medication administration (within the ALF license), occupational therapy, personal care, physical therapy, specialized medical equipment and supplies, speech therapy, and therapeutic social and recreational services.</p> <p>Recipients make an informed choice of receiving home and community-based services in lieu of nursing facility care.</p>
<b>Eligibility</b>	<p>To be eligible for ALE Waiver services, an individual must meet the following criteria:</p> <ul style="list-style-type: none"><li>● Be age 65 and older or be ages 60 to 64 and be determined disabled according to Social Security standards;</li><li>● Meet nursing facility level-of-care criteria as determined by CARES;</li><li>● Meet Supplemental Security Income (SSI), MEDS-AD or Medicaid waiver assistance (MWA) income and asset requirements; and</li><li>● Meet one or more of the following:<ol style="list-style-type: none"><li>1. Require assistance with four or more activities of daily living (ADLs).</li><li>2. Require assistance with three ADLs plus supervision or administration of medication.</li><li>3. Require total help with one or more ADLs.</li><li>4. Have a diagnosis of Alzheimer's disease or another type of dementia and require assistance with two or more ADLs.</li><li>5. Have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard ALF, but are available in an ALF licensed for limited nursing or extended congregate care.</li><li>6. Be a Medicaid-eligible recipient who meets ALF criteria; be awaiting discharge from a nursing facility placement; and be unable to return to a private residence because of a need for supervision, personal care, periodic nursing services, or a combination of the three.</li></ol></li></ul>
<b>Reimbursement</b>	<p>Medicaid reimburses for assisted living services at a daily rate and case management services at a monthly rate. Incontinence supplies are reimbursed separately on a monthly basis.</p>

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## WAIVER - CHANNELING

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<b>Background</b>	<p>The Channeling Waiver is a home and community-based services program that was implemented on July 1, 1985, and is operated through an annual contract with an organized health care delivery system. This is a 1915(c) waiver.</p>
<b>Description</b>	<p>The Channeling Waiver offers comprehensive case management with authority to prescribe amount and duration of 19 core services described in required care plans that itemize service costs.</p> <p>The waiver includes the following services: adult day health care, case management, chore services, companion services, counseling, environmental accessibility adaptations, family training, financial education and protection services, home health aide services, occupational therapy, personal care services, personal emergency response systems, physical therapy, respite care, skilled nursing, special home delivered meals, special drug and nutritional assessments, special medical supplies, and speech therapy.</p> <p>Recipients make an informed choice of receiving care and home and community-based services in lieu of nursing facility care.</p>
<b>Eligibility</b>	<p>To be eligible for Channeling Waiver services, an individual must meet the following criteria:</p> <ul style="list-style-type: none"><li>● Be age 65 or older;</li><li>● Meet the nursing facility level-of-care criteria as determined by CARES;</li><li>● Meet the Supplemental Security Income (SSI), MEDS-AD or Medicaid waiver assistance (MWA) income and asset requirements;</li><li>● Have two or more unmet long term care service needs; and</li><li>● Reside in Dade or Broward counties.</li></ul>
<b>Reimbursement</b>	<p>Payment is based on a negotiated per diem reimbursement rate. The cost of care may not exceed 85 percent of the average Medicaid nursing facility rates in Broward and Dade counties.</p>

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## **WAIVER - CONSUMER-DIRECTED CARE RESEARCH AND DEMONSTRATION**

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<b>Background</b>	The Consumer Directed Care Research and Demonstration (1115) Waiver is a coordinated effort between the Department of Elder Affairs, Department of Children and Families, Department of Health, and Agency for Health Care Administration.
<b>Description</b>	<p>The program allows for a total of 3,300 individuals receiving services from the Developmental Services HCBS Waiver, Aged and Disabled Adult HCBS Waiver or Traumatic Brain Injury/Spinal Cord Injury HCBS waiver the opportunity to exchange their traditional waiver services for a cash option. Individuals are allowed to “cash out” services on their current care plans and receive a monthly benefit amount to purchase services directly from a provider of their choice. These providers can include members of the individual’s family. In addition, consumers can save funds for approved, medically necessary purchases that might not be affordable immediately. The monthly benefit amount goes through a fiscal intermediary under contract with the Department of Elder Affairs.</p> <p>Consumer Directed Care is available statewide.</p>
<b>Eligibility</b>	<p>To be eligible for Consumer Directed Care, an individual must be enrolled in one of the following home and community based services waivers:</p> <ul style="list-style-type: none"><li>● Developmental Services</li><li>● Aged/Disabled Adult</li><li>● Traumatic Brain Injury/Spinal Cord Injury</li></ul>
<b>Reimbursement</b>	<p>The Department of Elder Affairs files claims on behalf of the fiscal intermediary, an enrolled Medicaid provider, for the monthly benefit amount for enrolled, eligible waiver participants.</p> <p>Trained consultants in each program area who are enrolled as Medicaid waiver providers provide consultant services. Consultant services are available to Medicaid recipients eligible to enroll in the Consumer Directed Waiver.</p>

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## WAIVER - DEVELOPMENTAL SERVICES

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**Background**

The Developmental Services (DS) Waiver was implemented on April 1, 1982, as a combined waiver with Aged/Disabled Adult Services. In order to meet the needs of these two diverse client populations, the waiver was split into separate waiver programs in 1985.

The DS/HCBS Waiver Coverage and Limitations Handbook was promulgated and effective October 27, 2002. This is a 1915(c) waiver.

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**Description**

The waiver includes the following services: adult day training, adult dental, behavioral services, chore services, companion services, dietitian, environmental modification, homemaker, in-home supports, non-residential support services, occupational therapy, personal care assistance, personal emergency response systems, physical therapy, private duty nursing, psychological services, respiratory therapy, residential habilitation, residential nursing, respite, skilled nursing services, special medical equipment and supplies, special medical home care, speech, specialized mental health services, support coordination, supported employment, supported living coaching, therapeutic massage, and transportation.

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**Eligibility**

To be eligible for DS Waiver services, an individual must meet the following criteria:

- Be a Developmental Disabilities program client;
  - Meet the level-of-care criteria for intermediate care facilities for the developmentally disabled (ICF/DD);
  - Meet Supplemental Security Income (SSI)-related Medicaid or Institutional Care Program income and asset requirements; and
  - Be enrolled in the Developmental Services waiver.
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**Reimbursement**

Medicaid reimbursement for DS waiver services is based on rates approved by the Department of Children and Families, Development Disabilities Program, and the Agency for Health Care Administration, Medicaid Program.

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**WAIVER - FAMILY PLANNING**

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<b>Background</b>	The family planning waiver extends eligibility for family planning services for 24 months to postpartum women who have lost Medicaid eligibility. This is an 1115 waiver.
<b>Description</b>	Recipients are eligible for all Medicaid-covered family planning services, family-planning related pharmacy and laboratory services, antibiotics and vaginal antifungals to treat sexually-transmitted diseases, sterilization, colposcopy, and transportation to family planning services.
<b>Eligibility</b>	Medicaid reimburses family planning waiver services for non-Medicaid eligible women who have had a Medicaid-financed delivery or other pregnancy-related service within two years prior to the date of losing Medicaid eligibility.
<b>Exclusions</b>	All other Medicaid services are excluded.
<b>Reimbursement</b>	Medicaid reimbursement for family planning waiver services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

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## WAIVER - MODEL WAIVER PROGRAM

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<b>Background</b>	The Florida Medicaid Program received approval from the Centers for Medicare and Medicaid Services (CMS), in 1991 to administer a home and community-based waiver in Florida that can help maintain children with certain medical conditions in their homes instead of a hospital. This is a 1915(c) waiver.
<b>Description</b>	The waiver services include model waiver case management and respite care. Case management is provided by the Department of Health, Children's Medical Services. Individuals make an informed choice between hospital and home and community-based services.
<b>Eligibility</b>	<p>The waiver has six basic criteria for participation. If all these criteria are met, the individual may elect to participate in the model waiver if space is available. Florida can serve only five people at any one time in the waiver statewide. The six basic criteria are as follows:</p> <ul style="list-style-type: none"><li>• The individual must be diagnosed as having a degenerative spinocerebellar disease, commonly classified in the 330-337 range of ICD-9-CM diagnosis classifications.</li><li>• The individual must be under 21 years old.</li><li>• The individual must be determined disabled using criteria established by the Social Security Administration.</li><li>• The individual must require a level of care recommended by a Children's Multidisciplinary Assessment Team (CMAT) staffing that would normally be provided in an inpatient hospital setting.</li><li>• The individual must be able to remain safely in the home with a set of home and community-based services provided through Medicaid.</li><li>• The individual's total cost of care to Medicaid in the home setting cannot exceed the aggregated cost of inpatient hospital care for all Model Waiver recipients.</li></ul>
<b>Reimbursement</b>	Services are provided on a fee-for-service basis within prescribed budgets and caseloads. Medicaid reimbursement for services is the maximum Medicaid fee or the provider's customary fee, whichever is lower.

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## WAIVER - NURSING HOME DIVERSION

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**Background** Dually eligible (Medicare and Medicaid) individuals that meet clinical eligibility criteria may choose to receive long-term care and acute care services under the NHD waiver. The waiver was implemented in December 1998 in the Orlando area and expanded to the Palm Beach area in October 1999. The waiver is approved to serve up to 1,200 elders in the pilot areas. This a 1915(c) waiver.

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**Description** The Medicaid Nursing Home Diversion (NHD) waiver provides home and community-based services to functionally impaired elderly that are age 65 and over and are at risk of nursing home placement.

Long-term care waiver services include adult companion, adult day health, assisted living, case management, chore, consumable medical supplies, environmental accessibility and adaptation, escort, family training, financial assessment and risk reduction, home delivered meals, homemaker, nutritional assessment and risk reduction, personal care, personal emergency response systems, respite care, occupational, physical and speech therapies, home health and nursing facility services. The acute-care waiver services include community mental health services, dental, hearing and visual services, independent laboratory and x-ray, inpatient hospital and outpatient hospital/emergency, physicians, prescribed drugs and transportation (optional) services. Managed care providers that have contracted with the state under the NHD Waiver are responsible for Medicare co-payments and deductibles.

The Department of Elder Affairs (DOEA) has operational responsibility for the NHD Waiver.

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**Eligibility** Individuals that meet the following criteria are eligible to receive services under the Nursing Home Diversion Waiver:

- Age 65 and over
- Dually eligible for Medicaid (ICP level) and Medicare Parts A & B.
- Live in the pilot project areas of: \*
  - Orange, Osceola, Seminole and Brevard counties - Area 7
  - Palm Beach, Martin, Okeechobee, Saint Lucie and Indian River - Area 9
- Be determined by the CARES (Comprehensive Assessment and Review for long-term care Services) unit at the Department of Elder Affairs to be at nursing home level of care and meet one or more established clinical criteria.

\*Note: The Florida Legislature authorized funds for the program for state fiscal year 2003-2004, so these service areas will be expanded once authorization to do so is received from the federal Centers for Medicare and Medicaid Services.

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**Reimbursement** Providers are reimbursed at a capitated rate, on a per member, per month basis to enrolled Medicaid providers.

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## WAIVER - PROJECT AIDS CARE

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<b>Background</b>	<p>The Project AIDS Care (PAC) Waiver is administered by the Agency for Health Care Administration in collaboration with the Department of Children and Families, the Department of Elder Affairs and the Department of Health. The waiver was implemented statewide in November 1989 and served approximately 6,500 beneficiaries in 2002. This is a 1915(c) waiver.</p>
<b>Description</b>	<p>Persons with AIDS that are determined to be at risk of hospitalization or placement in a nursing facility are given the choice of remaining at home and receiving home and community based services under the PAC waiver. A case manager at a PAC waiver case management agency coordinates access to services needed based on the acuity level of the beneficiary that has been determined by the RN care manager from the Disease Management Organization..</p> <p>PAC waiver services available as of July 1, 2003 are: Adult Dental; Chore; Day Health Care; Education and Support; Environmental Accessibility Adaptations; Home Delivered Meals; Homemaker; Nutritional Risk Reduction; Personal Care; Skilled Nursing; Specialized Medical Equipment and Supplies; Specialized Personal Care Services for Foster Care Children with AIDS; Therapeutic Management of Substance Abuse; and Restorative Massage services. The case manager in consultation with the beneficiary and the care manager develop a plan of care and authorize services.</p>
<b>Eligibility</b>	<p>In order to participate in the Project AIDS Care Waiver, the individual must meet the following criteria:</p> <ul style="list-style-type: none"><li>● Have a diagnosis of AIDS;</li><li>● Be determined disabled according to Social Security Administration standards;</li><li>● Be Medicaid eligible;</li><li>● Be at risk of institutionalization in a nursing facility or placement in a hospital;</li><li>● Need and receive case management;</li><li>● Not be enrolled in a Medicaid HMO or hospice program;</li><li>● Be able to remain safely in the home and community; and</li><li>● Have completed a PAC waiver enrollment application.</li></ul>
<b>Reimbursement</b>	<p>Case management agencies bill for and are reimbursed a monthly flat-fee rate for case managing the needs of the beneficiary. All necessary services must be documented in the plan of care and be authorized by the case manager.</p>

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## **WAIVER - SUB-ACUTE INPATIENT PSYCHIATRIC PROGRAM (SIPP)**

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<b>Background</b>	<p>In 2001, a 1915(b) waiver was approved authorizing the Agency for Health Care Administration to implement a Statewide Inpatient Psychiatric Program (SIPP) for Medicaid recipients under the age of 18 who require placement in an psychiatric residential setting due to serious mental illness or emotional disturbance.</p> <p>The approved waiver provided for selection, through a competitive proposal process, of 15 SIPP providers with one or two SIPP providers located in every area of the state.</p>
<b>Description</b>	<p>Requirements for a SIPP include provision of active mental health treatment with a child and family, extensive aftercare planning and coordination, follow-up and outcome measurement.</p> <p>The objectives of the SIPP program are:</p> <ul style="list-style-type: none"> <li>● Reduce the length of stay of psychiatric-inpatient services in acute care settings;</li> <li>● Provide inpatient-psychiatric services with an expected length of stay of 120 days;</li> <li>● Provide utilization management to ensure appropriateness of admission, length of stay, and quality of care; and</li> <li>● Reduce recidivism by providing aftercare services and/or linkages with appropriate community services.</li> </ul>
<b>Eligibility</b>	<p>High-risk youth under age 18 who are Medicaid eligible and enrolled in MediPass or an HMO are potentially eligible for care in a SIPP. High-risk youth are children and adolescents with a diagnosed mental or emotional disorder who have a history of two or more psychiatric hospitalizations in a year, who require more than the state-average number of days for inpatient care annually, or those who are unable to benefit from treatment in a less restrictive setting. Children and adolescents placed in a SIPP are not eligible for any other Medicaid services. Therefore, alternative treatment settings should be sought for medically complex children with emotional disturbance or mental illness.</p>
<b>Authorization</b>	<p>Children must be referred through the Department of Children and Families District Mental Health Offices and AHCA's behavioral health care utilization management contractor must authorize all admissions and continued stays.</p>
<b>Reimbursement</b>	<p>SIPP providers are paid a negotiated per-diem rate.</p>

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## WAIVER - SUPPORTED LIVING

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<b>Background</b>	<p>The Supported Living Waiver is a home and community-based services program that was approved by the Centers for Medicare and Medicaid Services (CMS), effective October 1, 1998. This waiver replaced the Medicaid Community Supported Living Arrangement program.</p> <p>The Department of Children and Families, Developmental Disabilities Office, has operational responsibility for the Supported Living Waiver Program. This is a 1915(c) waiver.</p>
<b>Description</b>	<p>The waiver services include: adult day training, in-home support services, supported living coaching, supported employment, and transportation.</p>
<b>Eligibility</b>	<p>To be eligible for the waiver, individuals must meet the following criteria:</p> <ul style="list-style-type: none"><li>● Be age 18 or older;</li><li>● Be able to direct their own support in all but limited areas, participate in the planning and implementation of support necessary to manage their households, and participate in community life;</li><li>● Meet the level of care for intermediate care facilities for the developmentally disabled (ICF/DD);</li><li>● Meet SSI-related Medicaid or the Institutional Care Program (ICP) income and asset requirements;</li><li>● Be a client of the Developmental Disabilities program; and</li><li>● Be enrolled in the Supported Living waiver.</li></ul>
<b>Reimbursement</b>	<p>Medicaid reimbursement for Supported Living waiver services is based on rates approved by the Department of Children and Families, Developmental Disabilities, and the Agency for Health Care Administration, Medicaid Program.</p>

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## **WAIVER - TRAUMATIC BRAIN INJURY/SPINAL CORD INJURY**

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**Background** The Department of Health, Brain and Spinal Cord Injury Program, operates the Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) waiver. This is a 1915(c) waiver.

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**Description** Waiver services include: adaptive health and wellness, assistive technologies, attendant care, behavioral programming, case management, companion services, community support coordination, consumable medical supplies, environmental accessibility adaptations, life skills training, personal adjustment counseling, personal care, and rehabilitation engineering evaluation.

Recipients age 18 and older make an informed choice of receiving home and community-based services in lieu of nursing facility care.

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**Eligibility** To be eligible for TBI/SCI waiver services, an individual must meet the following criteria:

- Must have one of the following conditions:
  1. Traumatic Brain Injury. Traumatic brain injury is defined as an insult to the skull, brain or its covering from external trauma, which produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits.
  2. Spinal Cord Injury. Spinal cord injury is defined as a traumatic injury to the spinal cord with evidence of motor deficit, sensory deficit, and /or bowel and bladder dysfunction. The lesions must have significant involvement with two of the above three.
- Must be considered medically stable meaning the absence of any of the following:
  1. Active, life threatening condition (e.g., sepsis, respiratory, or other condition requiring systematic therapeutic measures);
  2. IV drip to control or support blood pressure; or
  3. Arterial monitoring of intercranial pressure.
- Meet level of care criteria for nursing facilities;
- Be age 18 or older;
- Be referred to the state’s Brain and Spinal Cord Injury Program Central Registry in accordance with 381.75, F.S.; and
- Meet the Supplemental Security Income-related or the Institutional Care Program income and asset requirement for Medicaid eligibility.

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**Reimbursement** Medicaid reimbursement for TBI/SCI waiver services is the maximum Medicaid fee or the provider’s customary fee, whichever is lower.

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