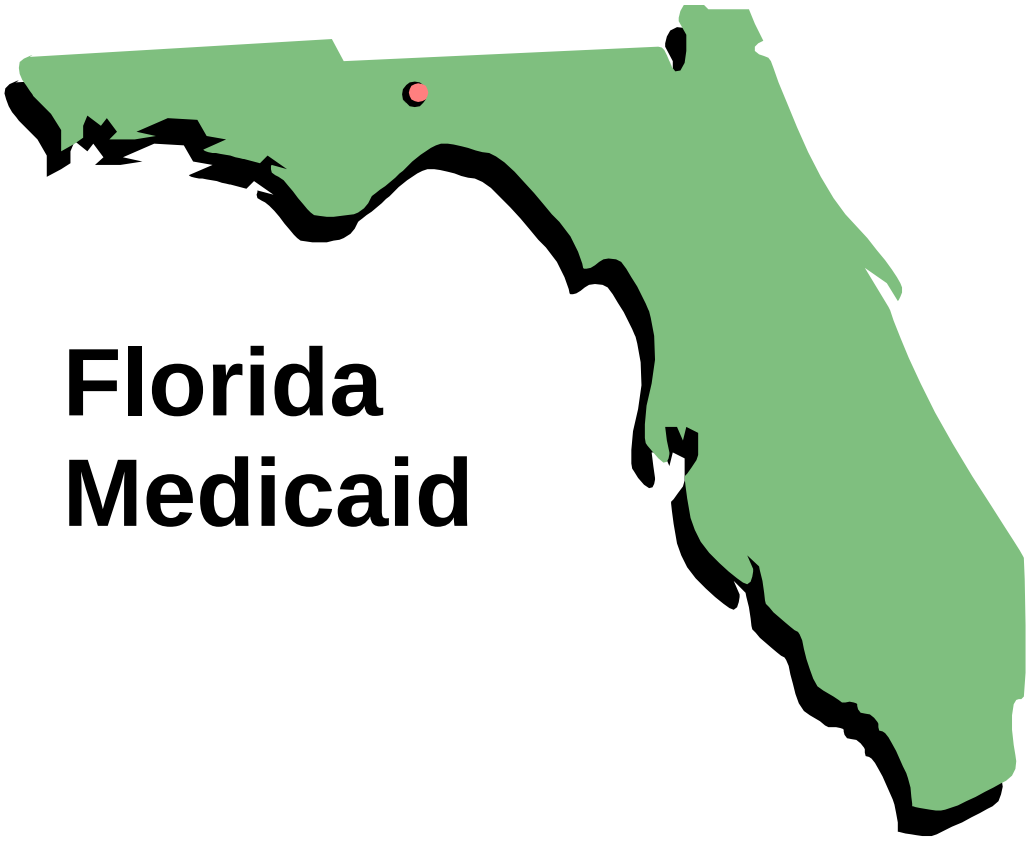

Florida Medicaid

Early Intervention Assessment and Evaluation Services Coverage Policy

Agency for Health Care Administration

Draft Rule

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1.0 Introduction

Early intervention (EI) assessment and evaluation services provide for the early identification of recipients under the age of three years (36 months) with developmental delays or related conditions.

1.1 Florida Medicaid Policies

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

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

1.2 Statewide Medicaid Managed Care Plans

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

1.3 Legal Authority

Florida Medicaid EI assessment and evaluation services are authorized by the following:

- Title 34, Code of Federal Regulations (CFR), Part 303 (34 CFR 303)
- Section 409.906, Florida Statutes (F.S.)
- Section 391, Part III, Florida Statutes (F.S.)

1.4 Definitions

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

1.4.1 Assessment

As defined in 34 CFR 303.321.

1.4.2 Claim Reimbursement Policy

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

1.4.3 Coverage and Limitations Handbook or Coverage Policy

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

1.4.4 Developmental Delay

As defined in section 391.302, F.S.

1.4.5 Developmental Domains

Include:

- Cognition
- Physical, motor, and sensory
- Communication
- Social and emotional
- Self-help and adaptive development

1.4.6 Early Steps Program

Department of Health (DOH) program that administers the Individuals with Disabilities Education Act, Part C program in Florida.

1.4.7 Evaluation
As defined in 34 CFR 303.321.

1.4.8 Individualized Family Service Plan (IFSP)
As defined in 34 CFR 303.20.

1.4.9 Infant Toddler Developmental Specialist (ITDS)
Non-licensed practitioner certified by the DOH to perform EIS.

1.4.10 Multidisciplinary Team
As defined in 34 CFR 303.24.

1.4.11 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.

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

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

2.0 Eligible Recipient

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

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

2.2 Who Can Receive
Florida Medicaid recipients under the age of three years (36 months) requiring medically necessary EI assessment and evaluation services who have been referred to, or participate in, DOH's Early Steps program.

Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments
There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

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

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

- Infant, Toddler, Developmental Specialists certified by DOH or its designee
- Practitioners licensed in accordance with Chapters 458, 459, and 464, F.S. and working within the scope of their practice, including:
  - Advance practice registered nurses
  - Audiologists
  - Clinical psychologists

- Clinical social workers
- Marriage and family counselors
- Mental health counselors
- Nutrition counselors
- Physical therapists
- Physicians
- Physician assistants
- Occupational therapists
- Registered dietitians
- Registered nurses
- School psychologists
- Speech and language pathologists

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

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

4.2 Specific Criteria

Florida Medicaid covers the following services in accordance with the applicable Florida Medicaid fee schedule, or as specified in this policy, for recipients who are referred by a physician or other licensed practitioner prior to the screening date:

- Up to three assessments per year, per recipient, to identify the presence of a developmental disability
- One initial evaluation (maximum of eight units) per lifetime, per recipient when conducted by a multidisciplinary team
- Up to three follow-up evaluations (maximum of 24 units) per year, per recipient

Florida Medicaid may cover additional assessments and evaluations through a different service benefit.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

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

5.0 Exclusion

5.1 General Non-Covered Criteria

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

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

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following under this service benefit:

- Assessments or evaluations conducted by more than one provider, on the same day, for the same recipient, separately
- Assessments or evaluations not authorized in the IFSP
- Assessments or evaluations on the same date of service as an Early Steps program targeted case management screening
- Assessments or evaluations conducted by more than one provider, on the same day, for the same recipient, separately
- Assessments or evaluations rendered in a prescribed pediatric extended care center
- Behavioral health screenings, assessments, or evaluations conducted as an EI assessment or evaluation service
- Physical or occupational therapy screenings, assessments, or evaluations conducted as an EI assessment or evaluation service
- Respite or care to facilitate a parent or legal guardian attending to personal matters
- Travel time

Florida Medicaid may cover some services listed in this section through a different service benefit.

6.0 Documentation

6.1 General Criteria

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

6.2 Specific Criteria

Providers must maintain all of the following in the recipient's file:

- The IFSP written in accordance with 34 CFR 303.340
- Plan of care (POC) developed by the IFSP team that is updated every six months, or upon a change in the recipient's condition requiring an alteration in services, whichever comes first. The POC must include the following:
  - Description of the recipient's medical diagnosis consistent with the screening
  - Developmental domain(s) for which services are being provided
  - Measurable objectives with targeted completion dates that are identified for each goal
  - Summary of specific activities that will occur during the session in order to achieve the stated goal(s) or outcome(s)
  - The amount, frequency, and duration of each service(s) to be provided
- Evaluation

Providers may use the IFSP as a substitute for the POC if the IFSP contains all of the requirements of the POC as specified in this policy.

7.0 Authorization

7.1 General Criteria

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

7.2 Specific Criteria

There are no specific authorization criteria for this service.

8.0 Reimbursement

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

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

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

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

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