



# Florida Medicaid

## **Evaluation and Management Services Coverage Policy**

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## 1.0 Introduction

### 1.1 Description

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

#### 1.1.1 Florida Medicaid Policies

This policy is intended for use by providers of evaluation and management services that render 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>.

#### 1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of evaluation and management services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in AHCA's contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

### 1.2 Legal Authority

Evaluation and management services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Parts 440 and 441
- Section 409.905, Florida Statutes (F.S.)
- Rule 59G-4.087, F.A.C.

### 1.3 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.

#### 1.3.1 Child Health Check-up

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

#### 1.3.2 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

#### 1.3.3 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

#### 1.3.4 General Policies

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

#### 1.3.5 Medically Necessary/Medical Necessity

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

**1.3.6 Normal Newborn**

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

**1.3.7 Provider**

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

**1.3.8 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 requiring medically necessary evaluation and management services. Some services may be subject to additional coverage criteria as specified in section 4.0.

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

**2.3 Coinsurance, Copayment, or Deductible**

Recipients are responsible for the following copayment, unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For information on copayment requirements and exemptions, please refer to Florida Medicaid's copayment and coinsurance policy:

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

**3.0 Eligible Provider**

**3.1 General Criteria**

Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

**3.2 Who Can Provide**

- Practitioners licensed within their scope of practice to perform this service
- County health departments administered by the Department of Health in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Rural health clinics certified by Medicare

## 4.0 Coverage Information

### 4.1 General Criteria

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

#### 4.2.1 Adult Health Screening Services

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

#### 4.2.2 Child Health Check-Up Services

Preventative medicine services for recipients under the age of 21 years, in accordance with the American Academy of Pediatrics periodicity schedule.

#### 4.2.3 Custodial Care Facility Services and Nursing Facility Services

One evaluation and management visit per month, per recipient.

#### 4.2.4 Office Visits

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

### 4.3 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 reimbursed 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 reimburse for the following:

- Child health check-up for recipients residing in an intermediate care facility
- Services for a normal newborn who remains in the hospital more than three days after birth
- Services that are included in the global surgery package for another Florida Medicaid-compensable service
- Services that are not listed on the fee schedule

- Speech or comprehensive audiometry threshold evaluations or visual field or intermediate visual field examinations, when performed as part of a child health check-up on the same day by the same provider
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy

## 6.0 Documentation

### 6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

### 6.2 Specific Criteria

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

## 7.0 Authorization

### 7.1 General Criteria

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

### 7.2 Specific Criteria

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

## 8.0 Reimbursement

### 8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

### 8.2 Specific Criteria

Providers must include the following child health check-up referral codes, as appropriate, on the claim form:

- AV Available-not used (recipient refused referral)
- NU Not used (no EPSDT recipient referral given)
- S2 Under treatment (recipient currently under treatment for referred diagnostic or corrective health problem)
- ST New service requested (recipient referred to another provider for diagnostic or corrective treatment or scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals)

### 8.3 Claim Type

Professional (837P/CMS-1500)

### 8.4 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, as incorporated by reference in Rule 59G-4.002, F.A.C.

#### 8.4.1 Modifier

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

- EP With procedure code for child health check-up for

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

**8.5 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.

**8.6 Rate**

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

**8.6.1 Enhanced Reimbursement Rate**

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