



Florida Medicaid

Medical Foster Care Services Coverage and Limitations Handbook

Agency for Health Care Administration





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Dear Medical Foster Care Services Provider:

Enclosed please find the revised Florida Medicaid Medical Foster Care Services Coverage and Limitations Handbook, February 2007. Please use this handbook in place of the October 2003 version, which is now obsolete. The revised handbook includes updated Level of Reimbursement, service authorization, and support services policies.

Please contact your area Medicaid office if you have any questions. The area Medicaid offices' phone numbers and addresses are available on the Agency's website at <http://ahca.myflorida.com>. Click on Medicaid, and then on Area Offices. They are also listed in Appendix C of the Florida Medicaid Provider General Handbook. All the Medicaid handbooks are available on the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Handbooks.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder
Chief, Bureau of Medicaid Services

MEDICAL FOSTER CARE SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exceptions: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

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.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

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Handbook Use and Format

Purpose	<p>The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.</p> <p>The handbooks provide descriptions and instructions on how and when to complete forms, letters, or other documentation.</p>
Provider	<p>The term “provider” is used to describe any entity, facility, person, or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.</p>
Recipient	<p>The term “recipient” is used to describe an individual who is eligible for Medicaid.</p>
General Handbook	<p>General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.</p>
Coverage and Limitations Handbook	<p>Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.</p>
Reimbursement Handbook	<p>Each reimbursement handbook is named for the claim form that it describes.</p>
Chapter Numbers	<p>The chapter number appears as the first digit before the page number at the bottom of each page.</p>
Page Numbers	<p>Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.</p>
White Space	<p>The "white space" found throughout a handbook enhances readability and allows space for writing notes.</p>

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.
Note	Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a topic roster on the first page which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an "Update No." and the "Effective Date".
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Handbook Updates, continued

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.

Numbering Update Pages

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

Effective Date of New Material

The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

Identifying New Information

New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

New Label and New Information Block

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

New Material in an Existing Information Block

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

New or Changed Paragraph

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

|Paragraph with new material. |

CHAPTER 1

MEDICAL FOSTER CARE SERVICES

PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter describes the Medical Foster Care (MFC) Program, provider qualifications, and the requirements for enrollment.

Legal Authority

Medical foster care services are authorized by Title XIX of the Social Security Act. The program was implemented through Chapter 409.903, Florida Statutes (F.S.), and Chapter 59G, Florida Administrative Code (F.A.C.).

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Purpose and Description

Purpose

The purpose of MFC services is to enable medically-complex children under the age of 21, whose parents cannot care for them in their own homes, to live and receive care in foster homes rather than in hospitals or other institutional settings.

Administration and Funding

The Department of Health, Children's Medical Services (CMS) helps administer the MFC program. The Department of Children and Families (DCF) licenses foster homes and reimburses the foster parent for the child's room, board, and other living expenses.

Medicaid Reimbursement

Medicaid reimburses Medicaid-enrolled MFC providers for medically necessary services rendered by the provider to children in foster care and children in shelter care status who are assigned to the provider's care by CMS.

Purpose and Description, continued

Purpose of This Handbook

This handbook is intended for use by MFC providers who provide services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General Handbook, which contains general information about the Medicaid program, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment.

Note: The Florida Medicaid provider handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C.; and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

Provider Qualifications and Enrollment

Provider Qualifications

To be eligible to enroll as a Medicaid MFC provider and to maintain enrollment, an individual must:

- Be licensed by the DCF as a foster home caretaker for children;
 - Have successfully completed the CMS MFC training;
 - Be approved as a MFC parent by the CMS MFC physician;
 - Be supervised by a CMS local service area MFC program staff or the MFC contracted agency; and
 - Be available to provide MFC services 24 hours per day (this would not preclude the use of other medically necessary services if additional medical needs are present).
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General Enrollment Requirements

MFC providers must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook.

Provider Qualifications and Enrollment, continued

Qualified at the Time of Enrollment

MFC parents must meet all provider requirements and qualifications before being enrolled as a Medicaid provider of MFC services.

Enrollment Process

Providers may obtain Medicaid Provider Enrollment packages from the Medicaid fiscal agent by calling 800-289-7799. The forms and instructions are also available on the fiscal agent's internet site at <http://floridamedicaid.acs-inc.com>. Completed enrollment packages and all required attachments should be sent to the Medicaid fiscal agent, including:

- A copy of the applicant's foster care license from DCF;
- A copy of the applicant's certificate of completion of a MFC training program conducted by CMS or their contracted agency; and
- A copy of the applicant's approval as a MFC parent by the CMS MFC physician.

The Medicaid fiscal agent will notify the applicant whether the enrollment application is approved or denied.

Provider Responsibilities

Provider Responsibilities

The MFC provider is responsible for:

- Providing personal care services prescribed by the attending physician in the child's plan of care;
 - Keeping the MFC staff informed of any non-MCF job held by the MCF provider, communicating current work schedule to the MFC staff, and obtaining approval from MFC staff for coverage of care during the MFC provider's temporary absence while at work (see Limitations on Service section in Chapter 2 of this handbook);
 - Reporting any changes in the child's medical condition to the attending physician;
 - Reporting to the MFC registered nurse any changes in the child's condition that would change the current plan of care or change the child's Level of Reimbursement;
 - Notifying the MFC staff when unable to provide services for a child assigned to their care;
 - Remaining current in all MFC training requirements such as infant, child, and adult cardiopulmonary resuscitation (CPR), first aid, and MFC training requirements of CMS; and
 - Complying with the policies established in this handbook, the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, and the Florida Medicaid Provider General Handbook.
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Provider Responsibilities, continued

**HIPAA
Responsibilities**

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbook contains the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

Documentation

The provider must maintain in-home child specific records that document all services provided. The records must accurately reflect the treatment and interventions provided. The effectiveness of the established treatment plan, including progress toward established goals, must also be documented. The documentation oversight and monitoring will be conducted by the Department of Health MFC staff and if necessary, Medicaid.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for additional information on record keeping requirements.

CHAPTER 2

MEDICAL FOSTER CARE SERVICES COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Medical Foster Care (MFC) Program, the requirements for service provision, the methodology for determining the Level of Reimbursement, and the service limits and exclusions.

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Requirements to Receive Services

Introduction

Medicaid-eligible, medically-complex, or medically-fragile children under the age of 21 are eligible to receive MFC services. Medicaid reimburses Medicaid-enrolled MFC providers for these services.

Who Can Receive Services

To receive MFC services, the recipient must be:

- Medicaid eligible;
- In the custody of the Department of Children and Families (DCF);
- Medically complex or medically fragile per definitions in this section;
- Under the age of 21; and
- Medically stable and not requiring acute hospital care at the time of placement, as determined by the MFC physician.

Requirements to Receive Services, continued

Definition of Medically Complex	Per 59G-1.010, F.A.C., a person is medically complex if he has chronic debilitating diseases or conditions of one or more physiological or organ systems that generally make the person dependent upon 24-hour per day medical, nursing, health supervision or intervention.
Definition of Medically Fragile	Per 59G-1.010, F.A.C., a person who is medically fragile is an individual who is medically complex and whose medical condition is of such a nature that he is technologically dependent, requiring medical apparatus or procedures to sustain life, i.e., requiring total parenteral nutrition (TPN), is ventilator dependent, or is dependent on a heightened level of medical supervision to sustain life and without such services is likely to expire without warning.
Definition of Medically Necessary or Medical Necessity	<p>Medicaid reimburses for services that do not duplicate another provider's service and are determined to be medically necessary. Per 59G-1.010, F.A.C., to be medically necessary, services must meet the following conditions:</p> <ul style="list-style-type: none">• Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;• Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;• Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;• Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and• Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. <p>The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.</p>

Requirements to Receive Services, continued

Medical Foster Care Staff

CMS is responsible for MFC staff assignments. The MFC staff must consist of a registered nurse specialist, a social work specialist, and a physician. Each CMS service area's MFC program must have a minimum of one of each of these staff members assigned. CMS may contract MFC staff services with a private agency.

Medical Foster Care Staff Responsibilities

The MFC staff is responsible for:

- Reviewing and assessing each child's medical condition to determine if placement in MFC is appropriate;
 - Making appropriate placement determinations, including approval of placement of MFC children in homes where the parent is employed outside of the home;
 - Establishing and maintaining a plan of care for each child in MFC;
 - Obtaining service authorization for the MFC provider (see Service Authorization section in this chapter);
 - Arranging for alternative caregivers when needed;
 - Monitoring the progress of all children in MFC; and
 - Supervising and providing child-specific training to MFC providers and any biological family members involved in the care of the child.
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Approval of Medical Foster Care Services

In order for MFC services to be reimbursable by Medicaid, the services must:

- Have a Level of Reimbursement determined as described in this chapter;
 - Be referred to the MFC staff and approved for placement; and
 - Receive service authorization from the area Medicaid office service authorization nurse or an approved designee.
-

Consent for Medical Foster Care and Other Medical Services

A child's parent or legal guardian does not have to give written consent for the child to receive MFC services, but the child must meet the DCF foster care guidelines.

In order for a child in MFC to receive other medical services or treatments administered by CMS or its contracted agency, the child's parent, legal guardian, or the juvenile court must give written consent.

Requirements to Receive Services, continued

Foster Care Placement Status

In order for a child to receive MFC services, the child must be in the custody of DCF either through voluntary placement or through a court order. DCF placement may be either foster care or shelter status.

Access to Medical Foster Care Services

A medically-fragile or medically-complex child who meets the requirements for DCF placement must meet the following criteria in order to receive MFC services:

- The child's case must be referred to the Children's Multidisciplinary Assessment Team (CMAT) for staffing, if appropriate;
- CMAT must recommend MFC services and recommend a Level of Reimbursement (except as below); and
- The MFC staff must assess the child, confirm an appropriate MFC provider, establish and maintain a plan of care, and obtain a service authorization for the provider.

If an urgent need for MFC placement arises outside of normal working hours, the MFC physician will determine an appropriate Level of Reimbursement for the child. The case will be referred to CMAT on the first working day after such a placement. CMAT will staff the case within 30 days.

Level of Reimbursement

Description

Level of Reimbursement is based on the child’s medical condition and the amount and intensity of services required to meet the child’s medical needs.

There are three MFC levels of reimbursement: Level I, II, and III.

Determining Level of Reimbursement

When a child is found to be potentially eligible for MFC services by the MFC team, he must be referred to the Children’s Multidisciplinary Assessment Team (CMAT) for staffing. The following steps will be taken by CMAT:

- Each team member is given a Validated Level of Reimbursement Tool (see Appendix A for a copy of the Level of Reimbursement Tool);
- The CMAT physician determines “Stability of the Child in the Home Setting” as found on the Level of Reimbursement Tool;
- Each team member individually totals their points for each care component and chooses the corresponding level of care number;
- The team members then share the results of their individual ratings;
- The team members review the definitions of the suggested level of care to ensure that the level describes the child’s medical condition and medical needs;
- The team members reach a consensus on the Level of Reimbursement for MFC services;
- Any additional home services that cannot be met by the MFC provider must be referred to the attending physician for additional orders; and
- The recommended Level of Reimbursement is documented.

Level One (I)

The child is at risk for or is experiencing infrequent and predictable changes in medical needs. The child’s medical needs require simple interventions, medical management, reliable observation, and documentation by a trained caregiver.

Level Two (II)

The child is experiencing frequent and predictable changes in medical needs or infrequent and unpredictable changes in medical needs. These needs can be met by a caregiver who is prepared to meet both anticipated and unanticipated events.

Level Three (III)

The child is experiencing frequent and unpredictable changes in medical needs. These needs can be met in the home setting by a caregiver who is prepared to intervene when the child experiences anticipated and unanticipated events.

Plan of Care

Description

A plan of care is an individualized written program for a specific child that is developed by licensed health care professionals. The plan of care is designed to address the medical, health, and rehabilitative needs of the child by directing the activities of the MFC provider.

Plan of Care Requirements

The plan of care will be based on an assessment of the child and an evaluation of medical conditions, medical needs, the effectiveness of current treatments, and progress achieved toward established goals. Goals must be realistic, measurable, and include time frames.

The MFC plan of care constitutes written instructions from the MFC physician to the MFC provider. These instructions must be clear and concise and direct the activity of a lay-caregiver.

Each recipient in MFC must have a current plan of care in order for Medicaid to reimburse MFC services.

Plan of Care Components

The plan of care for MFC services must include, at a minimum, the following:

- 1) The child's name, date of birth, and Medicaid ID number;
- 2) Names and phone numbers of doctors, family, case managers and other individuals familiar with the child;
- 3) Assigned Level of Reimbursement;
- 4) The start of care date, indicating the date the child entered into the MFC program;
- 5) Certification period for the plan of care (i.e., the first date of service and the last date of service of the plan's coverage);
- 6) Primary diagnosis and ICD-9 code;
- 7) Additional diagnosis(es) and ICD-9 code(s), current conditions only;
- 8) Diet, as ordered by a physician, including child-specific feeding instructions;
- 9) Treatments and interventions by the MFC provider including duration, frequency, and start and stop dates;
- 10) Treatments and interventions by other providers including specialty, duration, frequency, and start and stop dates;
- 11) Description of how treatments and interventions will be coordinated;
- 12) List of durable medical equipment and medical supplies required;
- 13) Description of child-specific safety measures ordered by a physician or otherwise identified;

Plan of Care, continued

Plan of Care Components,
continued

- 14) Child-specific functional limitations, including those related to activities of daily living (ADL);
- 15) Activities permitted or restricted;
- 16) Teaching needs of the child, the child's family, or other caregivers;
- 17) Short-term medical or rehabilitative goals;
- 18) Long-term medical or rehabilitative goals;
- 19) DCF case plan goal(s), if available;
- 20) Allergies (including food allergies), name of allergen and description of reaction;
- 21) Medication(s), including dose, frequency, route of administration, and start and stop dates; and
- 22) Discharge planning.

Plan of Care Documentation

A copy of the current plan of care must be included in the MFC in-home record and in the CMS medical record. All expired or outdated plans of care must be included in the CMS medical record.

Note: See the Florida Medicaid Provider General Handbook for additional information on record keeping requirements.

Plan of Care Updates and Revisions

A plan of care may be updated or revised during its certification period. Major updates or revisions require a new plan of care. All changes to the plan of care must be based on a physician's order. The circumstances and reasons for updates or revisions to a plan of care must be documented in the progress notes.

Plan of Care Frequency

A new plan of care must be written and approved at least once every six months. A plan of care may be updated or revised for up to six months or until the last day of the certification period of that plan.

Plan of Care Approval

The plan of care must be signed, dated, and credentialed by the MFC nurse and by the MFC physician. The MFC physician's signature indicates approval of the plan of care.

Change in Medical Foster Care Provider

Service authorization is issued to individual MFC providers. Whenever a change in MFC provider occurs, including the use of an alternative caregiver, the MFC staff must request a new service authorization.

Service Authorization

Description

Service authorization is the Medicaid approval process for MFC services. It is required prior to providing Medicaid reimbursable MFC services, except for initial MFC services and changes in Level of Reimbursement as described below.

Medicaid requires a Level of Reimbursement, as described in this chapter, in order for MFC services to be reimbursed.

Medicaid will not reimburse MFC services without a current service authorization. Authorization will not be granted until the required documentation is received from the MFC staff.

Requests for Service Authorization

Service authorization requests are submitted to the area Medicaid office that serves the county in which the recipient lives.

Note: See the Florida Medicaid Provider General Handbook for a list of the area Medicaid offices' addresses and telephone numbers.

Initial Service Authorization and Changes in Level of Reimbursement

Initial MFC services may be retroactively authorized to the date of the initiation of MFC services. For purposes of Medicaid reimbursement, initiation of MFC services begins on the day the MFC provider actually takes over care of the child. For example, when the child is physically placed in the home, when the prospective MFC provider physically stays with the child for training at the hospital, or when the prospective MFC provider travels to another area to pick up a child assigned to him. Medicaid must receive requests for initial authorizations within 10 days of the initiation of service or reimbursement will be denied until documentation is received.

Changes in Level of Reimbursement for children currently receiving MFC services will be retroactively authorized to the day after the CMAT staffing. If a Level of Reimbursement is determined by CMAT to have changed, a new service authorization is required, as well as a new plan of care. For changes in Level of Reimbursement, Medicaid must receive authorization requests within 10 days of the change in the Level of Reimbursement.

Service Authorization, continued

<p>Subsequent Service Authorization</p>	<p>Requests for authorizations for ongoing services must be received by Medicaid prior to Medicaid reimbursement.</p>
<p>Document Requirements for Service Authorization</p>	<p>The MFC staff must submit the following documentation to the area Medicaid service authorization nurse or an approved designee each time service authorization is requested:</p> <ul style="list-style-type: none"> • A signed (by both the MFC nurse and MFC physician) and dated copy of the plan of care that includes the dates of service for which authorization is requested; • The MFC provider's Medicaid provider number, name, and address; and • A copy of the CMAT summary, except when the Level of Reimbursement is determined by the MFC physician as provided in this chapter. <p>The MFC staff must send the request to the attention of the service authorization nurse at the area Medicaid office that serves the county in which the child lives.</p>
<p>Approval Process for Service Authorization</p>	<p>A service authorization nurse in the area Medicaid office or another approved designee will review each request and approve, deny, or request additional information to support the request. The area Medicaid office or another approved designee will send the MFC provider and the CMS MFC staff a service authorization verification letter indicating the status of the request.</p>
<p>Approved Service Authorization Requests</p>	<p>The approval letter for service authorization contains a service authorization number for billing and reference. It will also contain the level of reimbursement and the length of the approval period.</p> <p>An approved authorization is not a guarantee that Medicaid will reimburse the service. The provider and recipient must be eligible on the date of service, and the service must not have exceeded any applicable service limits.</p>
<p>Submission of a Service Authorization Claim for Payment</p>	<p>Claims for payment for a service-authorized procedure must be submitted in a timely manner. In order to receive reimbursement for the service, the provider must enter the authorization number on the claim form.</p> <p><u>Note:</u> See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on completing the claim form.</p>

Support Services

Purpose

When a child in MFC has additional medically-necessary needs that cannot be met by a MFC provider who is trained in his care, the child may receive other Medicaid services to support the care provided by the MFC provider. Support services include personal care (PC), private duty nursing (PDN), or Prescribed Pediatric Extended Care services (PPEC).

The provision of these services must be related to the medical needs of the child and cannot be for the convenience of the MFC provider. Support services must be included in the child's MFC plan of care.

Private Duty Nursing

MFC providers are responsible for the overall care of the children assigned to them. The use of PDN in the MFC home is intended to meet medical needs of the child that cannot be met by the MFC provider.

Support services will be reimbursed by Medicaid for the following circumstances:

- A child requires an intervention that is too complex to be provided by the MFC provider; or
- A child's medical condition requires an awake caregiver to provide continuous or frequent intervention or medically-necessary observation (usually limited to 8 hours per night).

At times, PDN may be used as a temporary form of alternative care. See the section in this chapter on Alternative Caregivers for more information. All PDN services must meet the requirements in the Florida Medicaid Home Health Services Coverage and Limitations Handbook.

Note: The Florida Medicaid Home Health Services Coverage and Limitations Handbook is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Alternative Caregivers

Purpose

At times, the assigned MFC provider might be unable to provide care. Alternative caregivers temporarily replace the care rendered by an assigned MFC provider to the MFC child or children in their care. Depending on the individual situation, alternative care may be provided by:

- Substitute MFC providers;
- Personal Care providers;
- PDN; or
- PPEC.

A support service rendered to meet the additional medical needs of a child in MFC is not a form of alternative caregiver. See the section on Support Services in this chapter.

Use of Alternative Caregivers

Alternative caregivers may only be used in the MFC home to temporarily (usually less than 30 days) replace the care rendered by the assigned provider. Ongoing or long-term (over 30 days) caregiver needs may not be met with the use of an alternative caregiver. Examples of situations that might require the use of alternative care are:

- Personal illness;
- Family illness;
- Medical condition that temporarily limits the provider's ability to provide care; or
- MFC training for CMS approval.

Substitute Medical Foster Care Providers

A substitute MFC provider is an individual who has received the required CMS competency-based training and has been approved by the MFC physician to provide care.

Alternative Caregivers, continued

Substitute Medical Foster Care Provider Training

The MFC staff provides competency-based training and child-specific training to individual substitute MFC providers. The required training must be completed before a substitute MFC provider provides MFC services during the absence of the assigned caregiver.

The MFC physician must approve each individual substitute MFC provider before the individual may provide care for a child in MFC.

Responsibilities of the Assigned Medical Foster Care Provider

The MFC provider to whom the care of a MFC child or children is assigned is responsible for ensuring, through CMS, that only substitute MFC providers who are approved in accordance with this handbook provide care for a MFC child assigned to them. The use of substitute MFC providers must be arranged by the MFC staff.

Locating a Substitute Medical Foster Care Provider

Situations requiring an alternative caregiver must be recognized and addressed as early as possible to ensure continued care for the child in MFC. When there is a need for an alternative caregiver, the MFC staff will first contact other MFC providers and substitute MFC providers to determine their availability to provide coverage.

If no substitute MFC provider is available, the MFC staff will contact the child's attending physician to obtain an order for PDN. The order must be submitted to a home health agency that will then submit the request to the appropriate contracted entity that authorizes PDN for the state of Florida.

Note: The Florida Medicaid Home Health Services Coverage and Limitations Handbook is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Urgent Need for Alternative Caregiver

In the event an urgent need for an alternative caregiver arises, the MFC staff may request an order for PDN to meet that urgent need. Requests for PDN must be based on the recipient's medical needs. An attempt to locate a substitute MFC provider should be made as soon as possible.

Alternative Caregivers, continued

Private Duty Nursing as Alternative Care

When PDN is to be used as an alternative caregiver, a written statement from the MFC physician must be provided to area Medicaid office service authorization nurse or an approved designee. The statement must indicate that no substitute MFC provider is available. Requests for PDN must be based on the recipient's medical needs.

Note: See the information on respite care in the Reimbursement Limitations section of this chapter.

Place of Service

Temporary care must be provided in the MFC home in which the child resides. If it is necessary for the substitute MFC provider to temporarily provide care in another location, the MFC physician must give approval for the child to receive MFC services in that location.

If the move is not considered temporary (usually less than 30 days), the use of an alternative caregiver is not allowed. A move that is not temporary constitutes a new placement of the child. The care of that child must be assigned to the new MFC provider in order for Medicaid to reimburse the service.

Reimbursement Limitations

Limitations on Service

Medicaid will only reimburse one MFC provider, per child, per date of service.

Medicaid will not reimburse for PDN, personal care, PPEC services or any Medicaid alternative or support care reimbursable service during the time the parent is considered on work-time.

Note: See Chapter 3 in this handbook for additional information on service reimbursement.

Interim Transitional Therapeutic Visits

Reimbursement to the MFC provider will not be interrupted during the brief time intervals when a recipient is visiting with his biological or adoptive parents or families.

Reimbursement for these dates of service may not exceed 15 days during any 90-day period.

Reimbursement Limitations, continued

Hospitalization of the Medical Foster Care Child	Medicaid may reimburse the MFC provider for up to 15 days, during any 90-day period, when the child is absent from the foster home due to hospitalization. The 15 days do not have to be consecutive. The Medicaid Field Office Manager may make exceptions to this policy on a case-by-case basis. A written request for an exception, physician statement, and supporting documentation must be provided to the Medicaid Field Office Manager or an approved designee for an exception to this policy.
Respite Care	<p>Medicaid does not reimburse for services that are for the purpose of providing the MFC provider with short-term or long-term relief of their responsibilities as a MFC provider.</p> <p>Medicaid will reimburse Medicaid-enrolled substitute MFC providers as described in the section on Alternative Caregivers in this chapter. Medicaid will only reimburse one MFC provider, per date of service, per recipient.</p>
Reimbursement of Assigned Providers and Substitute Medical Foster Care Providers	<p>Medicaid will not reimburse the assigned MFC provider and the substitute MFC provider for providing care to a child on the same date of service.</p> <p>Medicaid will not reimburse a MFC provider when they are not providing care for any period of time that exceeds 24 hours, except as described in the sections on Interim Transitional Therapeutic Visits and Hospitalization of the MFC child in this chapter.</p> <p>If the substitute MFC provider is not enrolled as a Medicaid provider, Medicaid can make no reimbursement for his service.</p>
Medicaid Transportation	<p>The Agency for Health Care Administration (AHCA), Division of Medicaid contracts with a vendor to administer the provision of Medicaid Non-Emergency Transportation (NET) services to eligible Medicaid recipients statewide including foster care children. NET providers will reimburse MFC parents for non-emergency Medicaid transportation services provided to their foster children.</p> <p>Medical foster parents must have an agreement or letter of understanding with the Community Transportation Coordinator in their county (CTC) prior to transporting their foster children. The agreement must include the circumstances under which the foster parent will be reimbursed and the procedures for reimbursement.</p>

CHAPTER 3 MEDICAL FOSTER CARE SERVICES PROCEDURE CODES

Overview

Introduction

This chapter lists the procedures and maximum fees that Medicaid will reimburse for the Medical Foster Care (MFC) Program.

In This Chapter

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-1

Reimbursement Information

Introduction

Medicaid reimbursement for MFC is based on the Level of Reimbursement for MFC services required by the child.

Note: See Appendix B for the procedure codes, descriptions, and fees paid by Medicaid.

Level of Reimbursement

Medicaid provides reimbursement for three different levels of MFC services. The levels are: I, II, and III.

Regardless of the Level of Reimbursement paid, the medical foster parent must spend whatever amount of time is necessary to meet the personal and medical needs of the child.

Units of Service

MFC reimbursement is based on units of service. Each date of service equals one unit of service.

Reimbursement Limitations

Only one provider may be reimbursed per recipient, per date of service. Medicaid will not reimburse more than one unit of service, per recipient, per date of service.

Reimbursement Information, continued

**Procedure and
Diagnosis Code
Origination**

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes, Level II. The codes are part of the standard code set described in HCPCS Level II book. Please refer to the HCPCS Level II book for complete descriptions of the standard codes. Level 2 codes are national codes usually used to describe medical services and supplies. They are distinguished from Level I codes by beginning with a single letter (A through V) followed by four numeric digits.

In compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.

Diagnosis Codes

Diagnosis codes are found in the International Classification of Diseases, Clinical Modifications (ICD-9-CM). A diagnosis code is required on the CMS-1500 claim. The most specific code, including fourth and fifth digits, when available, must be used.

Claim Form

MFC claims are billed on the CMS-1500 claim form. Claims may be submitted electronically.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for instructions on completing the CMS-1500 claim form.

**Procedure Code
Modifiers**

For MFC services, a two-digit modifier must be entered on the CMS-1500 claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.

The modifier is entered in the modifier field next to the procedure code.

MFC providers must use the modifiers with the procedure codes listed on Appendix B, Procedure Code table. The modifiers listed can only be used with the procedure codes listed. Use of an incorrect modifier will cause the claim to deny or pay incorrectly.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering modifiers on the claim form.

Required Documentation

Administrative and Provider Qualification Records

Administrative records and provider qualification records for each MFC provider must be maintained by CMS. These records must include the following information:

- Proof of Medicaid provider eligibility;
 - Copy of foster home license;
 - Documentation of the MFC physician's approval for the individual to provide MFC services;
 - MFC staff notations documenting supervision of the provider;
 - Documentation of completion of MFC provider curriculum (40 hours basic training as defined by CMS);
 - Copies of current infant, child, and adult cardiopulmonary resuscitation (CPR) and first aid training; and
 - Copies of continuing education and treatment training certificates (minimum of 12 hours annually).
-

Documentation and Records of Treatment

MFC providers must maintain daily records that accurately and clearly document all services as specified in the plan of care. These records will be used to evaluate changes to the plan of care as necessary.

CMS will obtain the completed MFC medical records from the provider and retain the records for at least five years.

Note: See the Florida Medicaid Provider General Handbook for additional information on record keeping requirements.

Required Reports and Records

The following documents and reports must be maintained in the child's in-home record by the MFC provider:

- Documentation of the child's current Medicaid eligibility;
 - Current plan of care;
 - Current medical history;
 - Physician's orders;
 - Daily documentation and flow sheets that coincide with the plan of care and indicate the child's care and condition;
 - Contact log for professionals and family;
 - Clinical notations made by medical personnel;
 - Copies of CMAT nursing assessments, psychosocial assessments, and summaries including recommended Level of Reimbursement, service to be provided;
 - Copies of legal documents;
 - Copies of consent forms; and
 - Documentation of current service authorization.
-

Note: See the Florida Medicaid Provider General Handbook for additional information on record keeping requirements.

Child's Name: _____

Staffing Date: _____

1. STABILITY OF THE CHILD IN A HOME SETTING				
<p>A. The child is at risk for or is experiencing infrequent and predictable changes in medical needs. The child is considered at risk if one or more of the following conditions is present: The child has a history of changes in medical needs; The child does not have an established regimen to manage their medical needs; or The interventions that the child receives pose a risk to the child.</p>		<p>B. The child is experiencing frequent and predictable or infrequent and unpredictable changes in medical needs.</p>	<p>C. The child is experiencing frequent and unpredictable changes in medical needs.</p>	<p>D. The child's medical stability in a home setting does not present as a current concern.</p>
2. TOLERANCE TO DELAY AND TASK ERROR BY CAREGIVER (Impact and severity of consequences of a delay or task error in the child's medical needs)				
<p>A. The child could experience a mild change in the outcome of their health care status.</p>	<p>B. The child could experience a decrease in functioning, an acute illness or a decline in general health care status.</p>	<p>C. The child could experience the loss of functioning or life.</p>	<p>D. The child's tolerance to delay and task error does not present as a current concern in the outcome of the child's health care status.</p>	
3. INTERVENTIONS (See Sample Interventions by Category on back of page)				
<p>A. The child's current medical needs require simple interventions by the caregiver. The child's needs require the caregiver to perform simple tasks and use in-home equipment and supplies.</p>	<p>B. The child's current medical needs require the caregiver to perform one or more complex interventions or treatments.</p>	<p>C. The child's current medical needs require complex interventions that involve a series of instructions or steps. The child's current medical needs require quick independent decisions made by the caregiver, without awaiting instruction by a health care professional, and the skills required to maintain life or to prevent or respond to life threatening events.</p>	<p>D. The child's current medical needs require 24-hour monitoring, intervention or treatments and documentation by a trained caregiver. The interventions are required to maintain functioning and to prevent or respond to life threatening events.</p>	<p>E. The child's interventions do not present as a current concern.</p>
4. OBSERVATION, ASSESSMENT, AND DOCUMENTATION				
<p>A. Child's current medical needs require the care giver to provide observation and limited assessment.</p>	<p>B. Child's current medical needs require the caregiver to provide frequent observation, comprehensive assessment that requires interpretation of information to formulate a plan of action, and detailed documentation.</p>	<p>C. Child's current medical needs require the caregiver to provide ongoing observation, comprehensive assessment that requires interpretation of information to formulate and implement a plan of action, and detailed documentation.</p>	<p>D. Observation, assessment and documentation does not present as a current concern.</p>	
5. PERSONAL CARE (Required care due to the child's clinical condition)				
<p>A. Child's personal care needs are chronologically age appropriate but require more time or must be done more frequently.</p>	<p>B. Child's personal care needs are not chronologically age appropriate and require some care assistance with ADLs.</p>	<p>C. Child's personal care needs are significantly chronologically delayed and require total care for majority of all ADLs.</p>	<p>D. The child's personal care needs are chronologically age appropriate and completed within expected time frames.</p>	
LEVEL OF REIMBURSEMENT SCORING: Points by Category: (See Level of Reimbursement definitions on back of page)				
		Child's Score		Child's Total Score
1. Stability of the Child in a Home Setting	A=5 B=10 C=15 D=0	_____	_____	
2. Tolerance to Delay and Task Error	A=1 B=5 C=10 D=0	_____		
3. Interventions	A=5 B=10 C=15 D=20 E=0	_____	Level of Reimbursement	
4. Observation, Assessment, and Documentation	A=1 B=5 C=10 D=0	_____	_____	
5. Personal Care	A=5 B=10 C=15 D=0	_____		

SAMPLE INTERVENTIONS BY CATEGORY (Check all interventions in each category that apply to the child.)

Category A: Simple interventions required due to the child's clinical condition

<input type="checkbox"/> Oral or bulb suctioning; <input type="checkbox"/> Simple positioning or turning; <input type="checkbox"/> Special feeding techniques; <input type="checkbox"/> Cast care; <input type="checkbox"/> Applying splints; <input type="checkbox"/> Employing standard precautions for a contagious disease; <input type="checkbox"/> Infrequent nebulizer treatments (PRN);	<input type="checkbox"/> Pulse-oximeter checks that do not typically result in an intervention; <input type="checkbox"/> Medications that have been classified as simple on the CMAT Nursing Assessment; <input type="checkbox"/> Assistance with mobilization (transfers, wheelchair); <input type="checkbox"/> Regular visits to a health care provider; <input type="checkbox"/> Other(s):
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Category B: Complex interventions

<input type="checkbox"/> Ostomy care; <input type="checkbox"/> Frequent nebulizer treatments (daily); <input type="checkbox"/> Bolus G-tube or NG-tube feeding; <input type="checkbox"/> Positioning, as with GE-reflux (aspiration prevention); <input type="checkbox"/> Skin / wound care not requiring pain medication or sterile procedures; <input type="checkbox"/> Positioning for severe contractures, scoliosis, or other physical conditions resulting in or due to immobilization of the patient; <input type="checkbox"/> Chest physiotherapy;	<input type="checkbox"/> Pharyngeal suctioning; <input type="checkbox"/> Shunt care including monitoring or assessment; <input type="checkbox"/> Administration of medications classified as complex on the CMAT Nursing Assessment; <input type="checkbox"/> Intermittent oxygen administration & care; <input type="checkbox"/> Apnea monitor; <input type="checkbox"/> Frequent visits to health care providers; <input type="checkbox"/> Other(s):
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Category C: Complex interventions involving series of instructions or steps

<input type="checkbox"/> Sterile procedure (trach or catheter procedures); <input type="checkbox"/> Skin / wound care that requires pre-medication for pain control or sterile procedures; <input type="checkbox"/> Sterile wound dressings or wounds with packing; <input type="checkbox"/> Tracheostomy suctioning or trach care; <input type="checkbox"/> Continuous G-tube or NG-tube feedings delivered via pump; <input type="checkbox"/> Continuous oxygen administration; <input type="checkbox"/> Pulse-oximeter check that typically results in a need for oxygen administration;	<input type="checkbox"/> Apnea events requiring CPR; <input type="checkbox"/> Continuous positive airway pressure; <input type="checkbox"/> Administration of medications classified as complex on the CMAT nursing assessment that require observation or assessment prior to administration; <input type="checkbox"/> Taking the child to a physician or emergency room as a result of an unanticipated event related to the child's clinical condition; <input type="checkbox"/> Other(s):
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Category D: Complex interventions or treatments requiring 24-hour monitoring and documentation

<input type="checkbox"/> Ventilator management including BiPAP and C-PAP; <input type="checkbox"/> Technology dependent interventions to sustain life; <input type="checkbox"/> Insulin dependent diabetic care;	<input type="checkbox"/> Administration of medication requiring ongoing observation to prevent loss of life; <input type="checkbox"/> Other(s):
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LEVEL OF REIMBURSEMENT DEFINITIONS

<p>Level I: 9 to 24 points The child is at risk for or is experiencing infrequent and predictable changes in medical needs. The child's medical needs require simple interventions, medical management, reliable observation, and documentation by a trained caregiver.</p>	<p>Level II: 25 to 39 points The child is experiencing frequent and predictable changes in medical needs or infrequent and unpredictable changes in medical needs. The needs can be met by a caregiver that is prepared to meet both anticipated and unanticipated events.</p>	<p>Level III: 40 to 65 points The child is experiencing frequent and unpredictable changes in medical needs. These needs can be met in the home setting by a caregiver who is prepared to intervene when the child experiences anticipated and unanticipated events.</p>
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MD Signature / Title / Date

APPENDIX B
PROCEDURE CODE TABLE

CODE	MODIFIER	DESCRIPTION OF SERVICE	MAXIMUM FEE
S5145	HA	Level I Medical Foster Care Service	\$38.80 per day
S5145	TF	Level II Medical Foster Care Service	\$48.50 per day
S5145	TG	Level III Medical Foster Care Service	\$67.90 per day



Charlie Crist
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