



Florida Medicaid

Early Intervention Services Coverage and Limitations Handbook

Agency for Health Care Administration





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SECRETARY

January 4, 2008

Dear Medicaid Early Intervention Services Provider:

The Florida Medicaid Early Intervention Services Coverage and Limitations Handbook was revised effective August 2007. We have made further revisions to the handbook to clarify the new policies. The revisions do not include any substantive changes.

The following pages were revised:

| Updated Pages |
|------------------------------------|
| Chapter 1, pages 1-4 and 1-5 |
| Chapter 2, pages 2-3, 2-8, and 2-9 |
| Chapter 3, page 3-2 |

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



UPDATE LOG

EARLY INTERVENTION SERVICES COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

The provider can use the update log to determine if all the updates to the handbook have been received.

Update No. is the number that appears on the front of the update.

Effective Date is the date that the update is effective.

Instructions

1. Make the pen and ink changes and file new or replacement pages.
2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in the Florida Medicaid Provider General Handbook.

| UPDATE NO. | EFFECTIVE DATE |
|---------------------------|-----------------------|
| New Handbook | February 1999 |
| Jul2000—Replacement Pages | July 2000 |
| Oct2003—Revised Handbook | October 2003 |
| Jul2005—Replacement Pages | July 2005 |
| Aug2007—Revised Handbook | August 2007 |

EARLY INTERVENTION 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, and who is eligible to receive them.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exception: 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.

In This Chapter

This chapter contains:

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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 is 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".

Handbook Updates, continued

| | |
|--|--|
| How Changes Are Updated | <p>The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:</p> <ol style="list-style-type: none"> 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 | <p>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.)</p> |
| Effective Date of New Material | <p>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.</p> <p>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.</p> |
| Identifying New Information | <p>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.</p> |
| New Label | <p>A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.</p> |
| New Label and New Information Block | <p>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.</p> |
| New Material in an Existing Information Block | <p>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.</p> |
| New or Changed Paragraph | <p>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.</p> <p> Paragraph with new material. </p> |

CHAPTER 1

EARLY INTERVENTION SERVICES

PROVIDER QUALIFICATIONS AND REQUIREMENTS

Overview

Introduction

This chapter describes the Medicaid Early Intervention Services (EIS) Program, the legal authority for the program, and the provider participation requirements.

Legal Authority

Medicaid early intervention services are governed by Title 42, Code of Federal Regulations (CFR) part 440 and through the authority of Chapter 409, Florida Statutes (F.S.). Medicaid policy for early intervention services is implemented through Chapter 59G, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

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Program Purpose and Description

Purpose

The purpose of the Medicaid EIS program is to provide reimbursement for early intervention services for children for whom developmental delay is known or suspected.

Early Intervention Services Coverage

Medicaid may reimburse for early intervention screenings; initial or follow-up evaluations; and individual or group sessions.

Program Purpose and Description, continued

Description

A Medicaid early intervention screening and initial or follow-up evaluation is conducted at the earliest possible age in order to identify developmental delay(s) or condition(s) that could cause a developmental delay.

A Medicaid early intervention session is a service designed to optimize the child's functioning ability and potential.

Medicaid early intervention services are designed to complement and enhance, not duplicate or replace, other Medicaid services.

Medicaid Provider Handbooks

This handbook is intended for use by Medicaid-enrolled early intervention services providers. It is to be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains information on specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid Program.

Note: The Florida Medicaid provider handbooks are available on 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

General Medicaid Enrollment Requirements

Early intervention services providers must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, early intervention services providers must meet the specific enrollment requirements listed in this chapter.

Provider Qualifications

Medicaid may only reimburse early intervention services that are provided by a:

- Medicaid-enrolled early intervention services agency or group employing staff who are Florida licensed professionals or paraprofessionals or are certified Department of Health, Children’s Medical Services (CMS) Early Steps (previously referred to as the Early Intervention Program) Infant Toddler Developmental Specialists (ITDS).
 - Medicaid-enrolled early intervention services individual who is a Florida licensed professional or paraprofessional or a certified Department of Health, CMS Early Steps Infant Toddler Developmental Specialist (ITDS).
-

Professional Early Intervention Services Enrollment Criteria

A professional early intervention services provider must either hold a current certificate from the Department of Health, CMS Early Steps as an Infant and Toddler Developmental Specialist (ITDS) OR hold a current Florida license in one of the following professions:

- Physician
- Physician’s assistant
- Advanced registered nurse practitioner (ARNP)
- Registered nurse
- Physical therapist
- Occupational therapist
- Speech-language pathologist
- Audiologist
- Respiratory therapist
- Clinical psychologist
- School psychologist
- Clinical social worker
- Marriage and family counselor
- Mental health counselor
- Registered dietitian
- Nutrition counselor

Individual providers may enroll as an early intervention provider in only one of the above professions, even if they hold licenses in more than one of the above professions. For example, a provider who is licensed as a clinical social worker and a marriage and family counselor can enroll as an early intervention services provider as either a clinical social worker or a marriage and family counselor, but not both.

Provider Qualifications and Enrollment, continued

**Paraprofessional
Early Intervention
Services Enrollment
Criteria**

A paraprofessional early intervention services provider must hold a current Florida license as a practical nurse.

**ITDS Enrollment
Criteria**

To enroll as a Medicaid provider, an ITDS must hold a bachelor level or higher degree from an accredited college or university in:

- Early childhood education,
- Early childhood and special education,
- Child and family development,
- Family life specialist,
- Communication sciences,
- Psychology,
- Social work, or
- An equivalent degree (based on transcript review).

A minimum of one year documented experience in early intervention is required for those with college degrees in the fields listed above. If the college degree is out-of-field, a minimum of five years documented experience in early intervention is required. In addition to the education and work experience requirements, all providers must complete the ITDS coursework and competencies as required by the Department of Health, CMS Early Steps state office.

The ITDS provides early intervention services under the support and direction of the Individualized Family Support Plan (IFSP) team, including a licensed physician or other health care professional acting within his scope of practice.

Enrollment Process

To become a Medicaid early intervention services provider, an agency or individual must submit a completed Medicaid enrollment application package to the Department of Health, CMS Early Steps state office. The CMS Early Steps provider enrollment specialist will review the application package and, when complete, will forward it to the Medicaid fiscal agent for processing.

Provider Qualifications and Enrollment, continued

A Complete Medicaid Enrollment Application Package

To be complete, a Medicaid enrollment application package must contain the enrollment documents specified in Chapter 2 of the Florida Medicaid Provider General Handbook and the following early intervention documentation:

- Copy of all appropriate Florida professional or paraprofessional licenses or a copy of the Department of Health, CMS Early Steps Infant Toddler Developmental Specialist certificate;
- Letter from the local Early Steps Program Director acknowledging that he is negotiating a contract with the applicant to provide services as a Medicaid Early Intervention provider; and
- Completed Children’s Medical Services, Early Steps, Certification for Provider of Early Intervention Services, AHCA-Med Serv Form 020, August 2007, from the CMS Early Steps State Office recommending enrollment as a provider for Early Steps.

Note: See page 1-3 for the list of professional licenses and page 1-4 for the type of paraprofessional license that qualify an individual to enroll as an early intervention provider.

Application Forms

The Medicaid application forms and instructions can be obtained from the Medicaid fiscal agent or its website at: <http://floridamedicaid.acs-inc.com>. The Medicaid application forms are incorporated by reference in rule 59G-5.010, F.A.C. Click on Provider Support, and then on Enrollment.

All CMS-related forms can be obtained from the Department of Health’s CMS Early Steps state office provider website at: <http://www.cms-kids.com/ESproviders.htm>. The Children’s Medical Services, Early Steps, Certification for Provider of Early Intervention Services, AHCA-Med Serv Form 020, August 2007, is incorporated by reference in rule 59G-4.085.

Medicaid Enrollment Process

The completed Medicaid application package is submitted to the Department of Health, CMS Early Steps state office, who forwards it to the Medicaid fiscal agent, Provider Enrollment Unit. The Medicaid fiscal agent assigns a:

- Medicaid early intervention group provider number to an enrolling agency and Medicaid early intervention individual provider numbers to each of the treating providers; or
- Medicaid early intervention individual provider number to the individual treating provider.

Provider Responsibilities

General Requirements

In addition to the general provider requirements and responsibilities that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook, early intervention services providers are also responsible for complying with the provisions contained in this section.

Minimum Responsibilities

A Medicaid-enrolled early intervention services provider must at a minimum:

- Participate in the development of the Individualized Family Support Plan (IFSP) based on the concerns of the family and needs of the child. The IFSP team shall discuss the activities to be included in the Plan of Care (POC) for early intervention services so that it will be completed with the input of all IFSP team members;
- Provide early intervention services as authorized in the child's IFSP and in the Early Intervention POC ;
- Review the IFSP and current Early Intervention POC at least every six months;
- Maintain records that document the services provided, and accurately reflect their effectiveness; and
- Bill and receive Medicaid reimbursement as payment in full.

Note: See the Glossary in Appendix D of the Florida Medicaid Provider General Handbook for the definition of the IFSP.

Provider Responsibility

Florida Medicaid has implemented the requirements contained in the federal 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. The Coverage and Limitation Handbooks contain information regarding changes in procedure codes mandated by HIPAA. The Medicaid Provider Reimbursement Handbooks contain 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.

Provider Responsibilities, continued

**Medicaid
Confidentiality
Requirements**

Names, treatments, payments, and other information about Medicaid recipients are confidential. Confidential information cannot be released without written consent from the recipient except by an Early Intervention Program provider who is:

- Releasing information to authorized representatives of the Medicaid program;
 - Billing another insurance carrier;
 - Releasing information to your billing agent; or
 - Providing information to the Department of Health, CMS Early Steps office or targeted case manager.
-

**Confidentiality for
AIDS**

State laws place restrictions on the release of any information about AIDS testing and treatment. A signed patient release must state what specific information the patient is giving permission to release. General medical releases are not allowed under state law.

Note: See s. 381.004, F.S., for the laws regarding AIDS testing and consent.

Provider Responsibilities, continued

Minimum Documentation of Records

A Medicaid early intervention provider must develop and maintain the following minimum documentation of services provided:

- Medicaid-eligible child's name and Medicaid identification number;
- Names of persons to whom the service was provided;
- Place the service was provided;
- Procedure code;
- Length of time required (start and stop time of each session provided, e.g., 3:00 p.m. to 3:45 p.m.);
- Date of service;
- Progress reports;
- IFSP;
- POC;
- Any medical documentation related to the diagnosis or medical condition of the recipient, including history and services;
- Third-party billing information; and
- Dated signature and title of the person who provided the service.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for general provider responsibilities and record keeping requirements.

Access to Records

Right to Review Records

In accordance with s. 409.907 and 409.913, F.S., authorized state and federal agencies and their authorized representatives may audit or examine a provider or facility's Medicaid-related records. This examination includes all records that the agency finds necessary to determine whether Medicaid payment amounts were or are due and applies to the provider's records and records for which the provider is the custodian. The provider must give authorized state and federal agencies and their authorized representatives access to all Medicaid patient records and to other information that cannot be separated from Medicaid-related records. The provider must send, at his expense, legible copies of all Medicaid-related information to the authorized state and federal agencies and their authorized representatives upon request.

Incomplete or Missing Records

Incomplete records are records that lack documentation that all requirements or conditions for service provision have been met. Medicaid may recoup payment for services or goods when the provider has incomplete records or cannot locate the records.

Access to Records, continued

Site Visits

In accordance with s. 409.907, F.S., providers may be subject to random onsite inspections before enrollment.

**Prepayment
Reviews**

Medicaid may conduct or contract for prepayment review of a provider's Medicaid claims to ensure cost-effective purchasing, billing and provision of care to Medicaid recipients. Prepayment reviews may be conducted as determined appropriate by Medicaid and without any suspicion of fraud, abuse, or neglect.

CHAPTER 2

EARLY INTERVENTION SERVICES

COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction This chapter describes who may receive Medicaid early intervention services; the specific available services; and service requirements, limitations, and exclusions.

In This Chapter This chapter contains:

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| Requesting an Exception to Medicaid Limitations | 2-13 |

Children Who Are Eligible to Receive Services

Introduction Medicaid reimburses the provider for the early intervention services described in this handbook that are provided to eligible children under the age of 21.

Program Intent Although the term “children” encompasses those up to 21 years of age for Medicaid purposes, the intent of the program is to serve young children, specifically from birth to three years of age (36 months).

Children are Eligible to Receive Services Medicaid reimburses medically necessary early intervention services for children who have:

- Developmental delay(s), or
- Established condition (s) that could result in a developmental delay(s).

Children Who Are Eligible to Receive Services, continued

**Medically
Necessary**

“Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

- 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.

“Medically necessary” or “medical necessity” for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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.

Note: See 59G-1.010 (166), F.A.C., for the Medicaid definition of medically necessary.

Children Who Are Eligible to Receive Services, continued

Developmental Delay

Children with a developmental delay are children whose development is delayed in one or more of the following domains:

- Cognition;
- Physical or motor;
- Sensory (including vision and hearing);
- Communication;
- Social;
- Emotional; or
- Adaptive development.

Developmental Delay Defined

A developmental delay must be defined according to the corrected gestational age, for the first 24 months of age. Beyond 24 months of age, the developmental delay will be defined according to the child's chronological age.

Verification of Developmental Delay

A developmental delay must be verified by the use of two or more of the following:

- Appropriate standardized instrument(s);
- Observational assessments;
- Parent report(s);
- Developmental inventories;
- Behavioral checklists;
- Adaptive behavior scales; or
- Professional judgment.

It is highly recommended that a standardized test be used to verify a developmental delay.

Criteria for Eligibility by Testing

Standardized instruments used for evaluation must be administered by the provider. To establish developmental delay(s), the following criteria are used:

- A score that equals or exceeds 1.5 standard deviations below the mean in at least one of the identified domains; or
- A 25 percent delay or greater on measures yielding scores in months in at least one of the identified domains.

Children Who Are Eligible to Receive Services, continued

Observational Assessment

An observational assessment must be documented by qualified professionals from two or more disciplines and must include observation of atypical functioning in one or more of the following areas:

- Sensory-motor responses;
- Activity level;
- Emotional or behavioral interactions; or
- Behavior patterns.

Established Conditions

An established condition is a condition that is verified by a licensed professional's written statement of the confirmed diagnosis or suspected diagnosis of a condition that has a high probability of resulting in a developmental delay. Diagnoses must be made in accordance with each provider's scope of practice.

Examples of established conditions are:

- Genetic and metabolic disorders;
 - Neurological abnormalities and insults;
 - Severe attachment disorder; or
 - Significant sensory impairments.
-

Basic Program Requirements

Electronic Documentation and Signatures

Electronic documentation and electronic signatures are allowed but hard copies of all records must be readily available upon request in the event of an audit. If electronic documentation and electronic signatures are used, written security procedures must be in place to prevent unauthorized access, use, or changes.

Family Support Plan Team

The purpose of the family support plan team is to develop, review and update the child's Individual Family Support Plan (IFSP).

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of the IFSP.

Basic Program Requirements, continued

Authorizing Documents

The IFSP and plan of care (POC) authorize Medicaid early intervention services. The signature and credentials of the licensed professional IFSP team member(s) are required on the IFSP and POC.

A copy of the IFSP and POC must be maintained in the child's file at the local CMS Early Steps office.

Screenings and initial evaluations do not require IFSP or POC authorization.

Note: See Plan of Care in this chapter for the POC requirements.

Other Service Authorizations

The Medicaid early intervention services described in this handbook do not require MediPass, Provider Service Network (PSN), or HMO prior authorization.

A provider may need to obtain MediPass, PSN, HMO, or service authorization for other Medicaid service(s) listed in the IFSP.

Freedom of Choice of Providers and Conflict of Interest Statement

Florida Medicaid policy requires the Department of Health, CMS Early Steps local office to obtain a signed and dated Early Steps, Children's Medical Services, Medicaid Freedom of Choice/Conflict of Interest Statement, AHCA-Med-Serv Form 021, August 2007, prior to the IFSP. The completed form must be maintained in the in the child's file at the local CMS Early Steps office. The form can be obtained from the CMS Early Steps website at <http://www.cms-kids.com/ESproviders.htm>. It is incorporated by reference in rule 59G-4.085, F.A.C.

Florida Medicaid allows dual enrollment of targeted case managers and early intervention service providers for the same child. Medicaid allows billing for both services if not duplicative.

No Recipient Contact

Medicaid does not reimburse for services that are unsuccessful attempts to contact the recipient. An example is a home visit when the recipient is not at home.

Non-Duplication of Services

Medicaid does not reimburse for early intervention services if the service overlaps or duplicates other Medicaid services available to the recipient.

Developing a Plan of Care

Plan of Care (POC)

An early intervention plan of care (POC) is an individualized written program developed by a physician or other health care professional for a child. An ITDS may assist with the development of the POC; however, a licensed professional must sign the POC. The POC is designed to meet the medical and developmental needs of the child, to maximize reduction of identified disabilities or deficits, and to identify the appropriate early intervention session (individual or group) to be provided.

Plan of Care Requirement

The early intervention services provider must write a POC for the child based on the most current early intervention interdisciplinary psychosocial and developmental evaluation or more current assessment information. The POC can also include other current appropriate medical documentation. A POC must address each type of early intervention session (individual or group) to be provided. The POC must reflect the service period authorized on the IFSP, and the authorizing period cannot be more than six months. Changes or revisions may require the development of a new POC earlier than six months.

A copy of each individual child's POC must be kept on file by the provider and in the child's local CMS Early Steps record.

Plan of Care Components

The POC must include the following information:

- Name, Medicaid ID number, date of birth and sex of the child;
- Description of the child's medical diagnosis;
- Current interdisciplinary evaluation date;
- Date services are to begin and end (no more than 6 months);
- Appropriate early intervention services procedure code(s) and title(s);
- Name of the agency or individual to provide the service(s);
- Domain(s) for which services are being provided;
- Outcome(s) or goal(s) to be achieved;
- Specific activities that will occur in order to achieve the stated goal(s) or outcome(s);
- Frequency, length, and location of the service(s) to be provided; and
- Printed name, title, signature and signature date of the professional who prepares and reviews the document.

The Individualized Family Support Plan may be used as a substitute for the POC if the IFSP contains all the above components and requirements of the POC.

| | |
|--|---|
| Screenings | |
| Introduction | Medicaid may reimburse for screenings to identify the presence of a high probability of delayed or abnormal development which may require further evaluation and assessment. |
| Required Recommendation and Documentation | <p>A screening must be recommended by a physician or other licensed professional acting within his scope of practice under state law and be authorized by the local CMS Early Steps office.</p> <p>A recommendation may be in the form of a referral on letterhead from a physician or other licensed professional. The recommendation must occur prior to the screening date.</p> |
| Description of Screening | A screening is a brief assessment of a child that is intended to identify the presence of a high probability of delayed or abnormal development. The screening determines the child's potential eligibility for early intervention services and the child's need for further evaluation. Screening reports must include the date and the signature and title of the person who performed the screening. |
| Reimbursement Limitations | Reimbursement for screenings is limited to three per year, per child. Reimbursement for additional screenings may be authorized based on medical necessity and must be approved through the exception to limitations process described in this chapter. Screenings cannot be reimbursed under this program and the Children's Medical Services Targeted Case Management Program for the same child on the same date of service. |

| Evaluations | |
|--|--|
| Introduction | Medicaid may reimburse for an initial or follow-up comprehensive, interdisciplinary psychosocial and developmental evaluation to determine a child's level of functioning. |
| Provider Requirements | <p>Initial and follow-up evaluations must be:</p> <ul style="list-style-type: none">• Performed by two or more early intervention professionals. At least one of these professionals must be licensed and acting within the scope of his practice under state law;• Authorized by the local CMS Early Steps office; and• Necessary based on presenting concerns of the child. <p><u>Note:</u> See Chapter 1 in this handbook for the types of professional licenses that qualify an individual to enroll as a professional early intervention services provider.</p> |
| Required Recommendation and Documentation | <p>An initial or follow-up evaluation must be recommended by a licensed professional or paraprofessional acting within his scope of practice under state law.</p> <p>A recommendation may be in the form of a referral on letterhead from a physician or other licensed professional. The recommendation must occur prior to the screening date.</p> <p>A written narrative report of the evaluation and results are required, including the date, signatures, and titles of each interdisciplinary evaluation team member. This narrative report may be separate or be included in the IFSP and POC. Evaluation results must be used to develop the IFSP and the POC.</p> <p>A follow-up evaluation must be authorized in the IFSP.</p> |

Evaluations, continued

Description of an Initial or Follow-up Interdisciplinary Psychosocial and Developmental Evaluation

The purpose of an initial or follow-up interdisciplinary psychosocial and developmental evaluation is to determine a child's level of functioning in each of the following developmental areas:

- Gross motor;
- Fine motor;
- Communication;
- Self-help and self-care;
- Social and emotional development; and
- Cognitive skills.

An evaluation is based on informed clinical opinion of the providers participating in the evaluation gained through:

- A review of pertinent records related to the child's current health status and medical history;
- An assessment of the unique strengths and needs of the child in terms of each of the developmental areas above; and
- Identification of services appropriate to meet the needs of the child.

When therapists are a part of the interdisciplinary evaluation team, the methodology for evaluation outlined in the Florida Medicaid Therapy Services Coverage and Limitations Handbook should be utilized. If Medicaid reimburses for a psychosocial and developmental evaluation under early intervention services, appropriate therapy treatments may be based on this evaluation and, if necessary, billed under the Medicaid Therapy Services Program. These evaluations are subject to audit.

Reimbursement Limitations

Medicaid reimbursement for an initial evaluation is limited to one per lifetime, per child.

Reimbursement for follow-up evaluations is limited to three per year, per recipient. Follow-up evaluations can be conducted on children who were found not to be eligible for services during an initial evaluation or for eligible children for whom additional concerns arise.

Reimbursement for initial and follow-up evaluations is limited to a maximum of two hours, per team member, per event.

Additional follow-up evaluations in excess of the three per year limit may be authorized based on medical necessity and must be approved through the exceptions to limitations process described in this chapter.

Medicaid will not reimburse for duplicative evaluations. If duplicative services are billed to Medicaid and paid, then recoupment will be sought.

Covered Sessions

Description of a Covered Session

An early intervention session is a face-to-face encounter of at least 30 minutes (two 15 minute units) with the child or the child's parent(s), family member(s) or caregiver(s) or both the child and the child's parent(s), family member(s) or caregiver(s). These sessions are to take place in the home or other locations identified as the natural environment for the child.

The purpose of a session is to provide medically necessary services to alleviate or minimize the child's developmental disability or the condition that could lead to a developmental disability or delay.

Medical Necessity Basic Requirement

A basic requirement of the program is that the services provided in the form of a session are documented as medically necessary.

Note: See the description and requirements of the Early Intervention Sessions POC and Medically Necessary in this chapter.

Provider Requirements

Early intervention sessions must be provided by a Medicaid-enrolled professional or paraprofessional early intervention provider in order to be reimbursed.

Note: See Chapter 1 in this handbook for the definition of a Medicaid professional and paraprofessional early intervention provider.

Provider Level

The profession of the Medicaid-enrolled early intervention provider that will provide the service, i.e., physical therapist, speech pathologist, ITDS, etc., must be authorized in the child's IFSP and identified in the Early Intervention Sessions POC.

ITDS Direction Requirement

As part of the IFSP process, the POC for early intervention services will be developed and signed by the appropriate licensed professional member(s) of the IFSP team. All activities of the ITDS delineated in the IFSP must be directed and supported by a licensed professional acting within his scope of practice, ideally the licensed professional member(s) of the IFSP team who signed the POC for early intervention services.

If the licensed professional member of the IFSP team who signed the POC is not providing direction and support for the activities of the ITDS, the IFSP document must state who is providing these activities. Support and direction of the ITDS must take place either through consultation at team meetings or by accompanying the ITDS on visits with the child and family, one of which must occur every six months and be documented in the child's progress reports.

Covered Sessions, continued

| | |
|------------------------------|---|
| Types of Sessions | <p>There are two types of Medicaid early intervention sessions:</p> <ul style="list-style-type: none"> • Individual, and • Group. |
| Individual Session | <p>An individual session is held with one child or one of the child’s parents, family member or caregiver or both.</p> |
| Group Session | <p>A group session is held with:</p> <ul style="list-style-type: none"> • More than one child; • More than one of an individual child’s parents, family members or caregivers; or • More than one child and each child’s parent(s), family member(s) or caregiver(s). <p>The minimum number of participants in a group is two. The recommended maximum for a group is four.</p> |
| Service Documentation | <p>Service documentation must include the Minimum Documentation of Records requirement stated in Chapter 1 and must describe each session billed to Medicaid as follows:</p> <ul style="list-style-type: none"> • Whether individualized or group services were provided; • Details of provided activities; • Carryover activities suggested for caregivers to do between sessions; and • Progress achieved. <p><u>Note:</u> See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for more information on record keeping and documentation requirements.</p> |

Covered Sessions, continued

Progress Report

Progress reports summarize the services provided during a reporting period. Service documentation describing each encounter and service provided to an Early Steps child or family member must be kept in the provider's treatment record for the child. A separate progress report must be prepared by the provider and submitted to the family and service coordinator prior to each IFSP review. The progress report must include:

- Child's name;
- Date;
- Period of time covered;
- Number of sessions that took place during the time period;
- Reason(s) for any missed sessions;
- Progress toward meeting IFSP outcomes;
- Suggestions for family follow through;
- Assistive technology use recommendations; and
- Provider's name, signature, and title.

Non-Reimbursable Services

Sessions conducted for family support, educational, recreational, or custodial purposes, including respite or child care, cannot be reimbursed by Medicaid.

Sessions will not be reimbursed by Medicaid if they duplicate or replace other available Medicaid reimbursable services, are not authorized in the IFSP or POC, or are not medically necessary.

Travel cannot be reimbursed as part of any early intervention session.

Reimbursement Limitations

Medicaid will reimburse a provider for only one type of early intervention session (group or individual) per day, per child. A session cannot be split between providers, nor can more than one type of provider (e.g., ITDS and paraprofessional) conduct a session in a given day for the same child.

Medicaid will not reimburse the same licensed practitioner to provide services under both the Early Intervention and Therapy Services Programs to the same child on the same day.

The maximum amount of time that will be reimbursed by Medicaid for early intervention services will be 60 minutes per day per child.

Session Reimbursement Exceptions

Exceptions to the frequency and length of Medicaid early intervention services individual or group service limitations (excluding travel) may be granted based on medical necessity and must be approved through the exception to the limitations process.

Requesting an Exception to Medicaid Limitations

Introduction

An exception to the limitation of frequency or length of time reimbursed by Medicaid may be granted when it is medically necessary for the child.

Frequency and Time Limits

Authorization to increase the limitation of frequency or time for an early intervention service must be authorized on the IFSP and approved by Medicaid prior to providing the service. Such authorization can be granted for up to three months based on the documentation of medical necessity for greater intensity.

Request to Exceed Medicaid Limitations Form

Early intervention providers requesting authorization to exceed the Medicaid covered frequency and length of time limitations must submit the Request to Exceed Medicaid Limitations Form, AHCA Med-Serv Form 019, August 2007.

Note: See Appendix B for a copy of the Request to Exceed Medicaid Limitations Form, AHCA Med-Serv Form 019. Providers may photocopy the form from Appendix B.

Processing Requests for Exceptions

When the IFSP team recommends services that exceed the limitation of frequency or length of time of an early intervention service, the provider must send the following information to the Agency for Health Care Administration, Medicaid office:

- A cover letter requesting the exception signed and dated by the child's physician;
- A description regarding the type of service(s) to be provided, an explanation of the medical necessity for the intensity of the service, the additional Medicaid services to be provided and how the exception for services would not be duplicative. A copy of the child's IFSP and POC must be submitted with the Request to Exceed Medicaid Limitations Form.

In order for the exception consideration to be completed and communicated in a timely manner by Medicaid staff to the provider requesting the exception, the request must be submitted within five working days of the IFSP decision to the following address:

Medicaid Early Intervention Services
 Bureau of Medicaid Services
 2727 Mahan Drive, Mail Stop #20
 Tallahassee, FL 32308-5407

Medicaid staff will advise the requesting provider whether the request was approved and for what period of time or if denied, the reason for denial.

Requesting an Exception to Medicaid Limitations, continued

Billing for Sessions

Once a request is approved and the service has been provided, the provider can bill for the service by submitting a paper CMS-1500 claim with approval form to the area Medicaid office. The area Medicaid office will override the appropriate limits. The original of the approved Request to Exceed Medicaid Limitations Form should be kept in the provider's office records for audit purposes.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for information on billing procedures.

Note: The phone numbers and addresses for the area Medicaid offices are listed on AHCA's website at <http://ahca.myflorida.com>. Click on Medicaid. They are also listed in Appendix C of the Florida Medicaid Provider General Handbook.

CHAPTER 3

EARLY INTERVENTION SERVICES

PROCEDURE CODES

Overview

Introduction

This chapter identifies the early intervention services eligible for Medicaid reimbursement by name, service procedure code, and the maximum fee that can be reimbursed for each service.

In This Chapter

This chapter contains:

| TOPIC | PAGE |
|---------------------------|------|
| Reimbursement Information | 3-1 |
| Procedure Code Modifiers | 3-2 |

Reimbursement Information

Procedure Codes

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. CPT codes and descriptions are copyright 2007 by the American Medical Association. All rights reserved.

Diagnosis Code

A diagnosis code is required for the CMS-1500 claim form for all medical procedures. Use the most specific code available. Fourth and fifth digits are required when available.

Reimbursement Information, continued

Fee Schedule

Each procedure code on the Early Intervention Services Fee Schedule, Appendix A, corresponds to an early intervention service. The descriptor gives a brief description of the service; the maximum fee shows the maximum amount that Medicaid will reimburse for the procedure code, per unit of service.

Government and Private Non-Profit Agencies

Government and private non-profit agencies must bill Medicaid the cost for providing the service or the maximum fee for the service as established by Medicaid, whichever is less.

An agency determines the cost of providing the service in accordance with the Office of Management and Budget Circular A-87 (Revised 5/4/95, As Further Amended 8/29/97) for public agencies, and Circular A-122 (Revised May 10, 2004), for private non-profit agencies.

Units of Service

Early intervention sessions are reimbursed in time increments. Each time increment is called a unit of service. For an individual and group sessions, 15 minutes constitutes one unit of service.

Medicaid ID Number

An early intervention session must be billed using the Medicaid-eligible child's Medicaid identification number, even if the session was with the child's parent(s), caregiver(s) or family member(s).

Procedure Code Modifiers

Definition of Modifier

For certain types of services, one or two two-digit modifiers must be entered on the CMS-1500 claim form. Modifiers more fully describe the procedure performed so that accurate payment may be determined.

The modifiers must be entered in the field next to the procedure code field under Modifier.

Early intervention services providers must use the modifiers with the procedure codes listed on Appendix A, Early Intervention Services Fee Schedule, when billing for the specific services in the procedure code descriptions. The modifiers listed in Appendix A can only be used with the procedure codes listed. Use of modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering modifiers on the claim form.

APPENDIX A PROCEDURE CODES AND MAXIMUM FEES

| CODE | MOD 1 | MOD 2 | DESCRIPTION OF SERVICE | MAXIMUM FEE |
|-------|-------|-------|--|---|
| T1023 | | | Screening (Maximum 3 per calendar year per child) | \$50.00 |
| T1024 | GP | UK | Initial Interdisciplinary Psychosocial and Developmental Evaluation rendered by a Physical Therapist (Maximum 1 per lifetime per child) | \$37.50 30 minute unit— maximum 4 units |
| T1024 | GN | UK | Initial Interdisciplinary Psychosocial and Developmental Evaluation rendered by a Speech Therapist (Maximum 1 per lifetime per child) | \$37.50 30 minute unit— maximum 4 units |
| T1024 | GO | UK | Initial Interdisciplinary Psychosocial and Developmental Evaluation rendered by an Occupational Therapist (Maximum 1 per lifetime per child) | \$37.50 30 minute unit— maximum 4 units |
| T1024 | TL | | Initial Interdisciplinary Psychosocial and Developmental Evaluation rendered by a Licensed Early Intervention Professional (Maximum 1 per lifetime per child) | \$37.50 30 minute unit— maximum 4 units |
| T1024 | HN | UK | Initial Interdisciplinary Psychosocial and Developmental Evaluation rendered by an ITDS (Maximum 1 per lifetime per child) | \$27.75 30 minute unit— maximum 4 units |
| T1024 | GP | TS | Follow-up Psychosocial and Developmental Evaluation rendered by a Physical Therapist (Maximum 3 per calendar year per child) | \$37.50 30 minute unit— maximum 4 units |
| T1024 | GN | TS | Follow-up Psychosocial and Developmental Evaluation rendered by a Speech Therapist (Maximum 3 per calendar year per child) | \$37.50 30 minute unit— maximum 4 units |
| T1024 | GO | TS | Follow-up Psychosocial and Developmental Evaluation rendered by a Occupational Therapist (Maximum 3 per calendar year per child) | \$37.50 30 minute unit— maximum 4 units |
| T1024 | TL | TS | Follow-up Psychosocial and Developmental Evaluation rendered by a licensed Early Intervention professional (Maximum 3 per calendar year per child) | \$37.50 30 minute unit— maximum 4 units |
| T1024 | TS | | Follow-up Psychosocial and Developmental Evaluation rendered by an ITDS (Maximum 3 per calendar year per child) | \$27.75 30 minute unit— maximum 4 units |

Early Intervention Services Coverage and Limitations Handbook

| CODE | MOD 1 | MOD 2 | DESCRIPTION OF SERVICE | MAXIMUM FEE |
|-------------|--------------|--------------|--|-----------------------|
| T1027 | HM | | Early Intervention Individual Session Provided by a paraprofessional (Maximum 1 hour per day) | \$6.25 15 minutes |
| T1027 | SC | | Early Intervention Individual Session Provided by an EIS professional (Maximum 1 hour per day) | \$12.50 15 minutes |
| T1027 | TT | HM | Early Intervention Group Session Provided by a paraprofessional (Maximum 1 hour per day) | \$3.13 15 minutes |
| T1027 | TT | SC | Early Intervention Group Session Provided by an EIS professional (Maximum 1 hour per day) | \$6.25 15 minutes |

APPENDIX B
EARLY INTERVENTION SERVICES
REQUEST TO EXCEED MEDICAID LIMITATIONS FORM

| | | | |
|--|-----------------------|---|----------------------|
| I. GENERAL INFORMATION (to be completed by the provider) | | | |
| Recipient Medicaid Number (10-digits) | Last Name | First Name | Date of Birth |
| Diagnosis Codes and Descriptions | Procedure Code | Procedure Description | |
| Units of Services Requested | | Services Dates for Additional Services | |
| | | FROM: _____ TO: _____ | |
| Explanation of Necessity (Attach copy of Individualized Family Support Plan and Plan of Care) | | | |
| Individual or Group Provider Medicaid Number | | Individual or Group Provider Name | |
| Treating Provider Medicaid Number | | Treating Provider Name | |
| Individual or Group Provider Address and Phone | | Signature and Date | |
| | | _____ Signature | _____ Date |

AHCA-Med Serv Form 019, August 2007 (incorporated by reference in 59G-4.085, F.A.C.)

Request to Exceed Medicaid Limitations Form, continued

| II. EARLY INTERVENTION PROGRAM CONCURRENCE (to be completed by the EIP Director) | |
|--|-------|
| I Concur _____ | |
| Recommended: | |
| Units of Services _____ | |
| Dates of Service FROM: _____ TO: _____ | |
| I Do Not Concur _____ | |
| Reason for Not Concurring | |
| Signature of EIP Director: | |
| _____ | _____ |
| Signature | Date |

| III. MEDICAID AUTHORIZATION (to be completed by Medicaid) | |
|--|-------|
| Approved _____ | |
| Units of Service _____ | |
| Dates of Service FROM: _____ TO: _____ | |
| Denied _____ | |
| Reason for Denying | |
| Authorized by: | |
| _____ | _____ |
| Signature | Date |

AHCA-Med Serv Form 019, August 2007 (incorporated by reference in 59G-4.085, F.A.C.)

Instructions for the Request to Exceed Medicaid Limitations Form

I. General information to be completed by the provider:

| ITEM TITLE | ACTION |
|--|---|
| Recipient Medicaid Number | Enter the Medicaid eligible child's I.D. Number. |
| Last Name | Enter the child's last name as it appears on the Medicaid identification card. |
| First Name | Enter the child's first name as it appears on the Medicaid identification card. |
| Date of Birth | Enter the child's date of birth. |
| Diagnosis | Enter both the ICD-9 code and description. List the diagnosis(es) that is most relevant to the child's need for additional services. |
| Procedure Code | Enter the procedure code for which you are requesting authorization. |
| Procedure Description | Enter a description of the procedure for which you are requesting authorization. |
| Units of Service | Enter the total number of units of services that you are requesting. For example, if you are requesting one additional individual session per week from June 1 through July 31, enter 9 units of service. |
| Service Dates | Enter the FROM and TO dates for the additional services that you are requesting. <u>Note:</u> There is a three-month maximum. |
| Explanation of Necessity | Attach a copy of the Medicaid eligible child's Individualized Family Support Plan and Plan of Care. |
| Individual or Group Provider Medicaid Number | Enter the individual or group provider's Medicaid number. |
| Individual or Group Provider Name | Enter the individual or group provider's name. |
| Treating Provider Medicaid Number | Enter the treating provider's Medicaid number. |
| Treating Provider's Name | Enter the treating provider's name. |
| Individual or Group Provider's Phone Number, Address, Signature, Date | Enter the individual or group provider's address, phone number, signature and date. |

AHCA-Med Serv Form 019, August 2007 (incorporated by reference in 59G-4.085, F.A.C.)

Instructions for the Request to Exceed Medicaid Limitations Form, continued

III. Medicaid Authorization -- To be completed by Medicaid

| ITEM TITLE | ACTION |
|--------------------|--|
| Approved | The authorizing person checks if the request is approved and enters the number of additional units of services and the dates of service that have been approved. |
| Denied | The authorizing person checks if the services are denied and gives the reason for the denial. |
| Reviewed by | The authorizing person signs and dates the form. |

AHCA-Med Serv Form 019, August 2007 (incorporated by reference in 59G-4.085, F.A.C.)



Charlie Crist
Governor

Andrew C. Agwunobi, M.D.
Secretary

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