



# Florida Medicaid

## County Health Department Clinic Services Coverage and Limitations Handbook

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Agency for Health Care Administration







CHARLIE CRIST  
GOVERNOR

HOLLY BENSON  
SECRETARY

March 11, 2008

Dear Medicaid County Health Department Clinic Provider:

Florida Medicaid updated the County Health Department Clinic Services Coverage and Limitations Handbook effective April 2008. The handbook was updated to add the range of codes for billing administration of vaccines to Medicaid recipients from birth to 18 years of age and to add immunization codes for rabies vaccine; tetanus and diphtheria vaccine, preservative free; and an "unlisted vaccine." The update also corrects the code for tetanus, diphtheria, acellular pertussis vaccine.

The following pages were replaced in the attached handbook:

Updated Pages
Update Log
Appendix A, Page A-6

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

## COUNTY HEALTH DEPARTMENT CLINIC SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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### *How to Use the Update Log*

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#### **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.

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#### **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 month and year that the update was issued.  
Effective Date is the date that the update is effective.

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#### **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.

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UPDATE NO.	EFFECTIVE DATE
Oct2000—Revised Handbook	October 2000
Oct2003—Revised Handbook	October 2003
Jan2007—Revised Handbook	January 2007
Apr08—Replacement Pages	April 2008



# COUNTY HEALTH DEPARTMENT CLINIC SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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## INTRODUCTION TO THE HANDBOOK

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### **Overview**

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#### **Introduction**

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

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#### **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.

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

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#### **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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#### **In This Chapter**

This chapter contains:

<b>TOPIC</b>	<b>PAGE</b>
Handbook Use and Format	ii
Characteristics of the Handbook	iii
Handbook Updates	iii

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**Handbook Use and Format**

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<b>Purpose</b>	<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>
<b>Provider</b>	<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>
<b>Recipient</b>	<p>The term "recipient" is used to describe an individual who is eligible for Medicaid.</p>
<b>General Handbook</b>	<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>
<b>Coverage and Limitations Handbook</b>	<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>
<b>Reimbursement Handbook</b>	<p>Each reimbursement handbook is named for the claim form that it describes.</p>
<b>Chapter Numbers</b>	<p>The chapter number appears as the first digit before the page number at the bottom of each page.</p>
<b>Page Numbers</b>	<p>Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.</p>
<b>White Space</b>	<p>The "white space" found throughout a handbook enhances readability and allows space for writing notes.</p>

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***Characteristics of the Handbook***

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**Format**

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

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**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.

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**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.

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**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.

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**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.

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***Handbook Updates***

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**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

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**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.

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**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.)

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**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.

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**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.

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**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.

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**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.

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**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.

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**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.

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# CHAPTER 1

## COUNTY HEALTH DEPARTMENT CLINIC SERVICES PROVIDER QUALIFICATIONS AND REQUIREMENTS

**Overview**

**Introduction**

This chapter describes County Health Department Clinic Services, the provider qualifications, and enrollment policies.

**Background**

The federal authority governing the provisions, requirements, benefits, and service payment of the County Health Department Clinic Services program is in the Code of Federal Regulations, Title 42, Parts 440.90. Chapter 409, Florida Statutes and Chapter 59G, Florida Administrative Code establish Medicaid reimbursement by the Agency for Health Care Administration for County Health Department Clinic Services.

**In This Chapter**

This chapter contains:

TOPIC	PAGE
Purpose and Definition	1-1
Provider Qualifications	1-2
Provider Enrollment	1-3
Provider Requirements	1-6

**Purpose and Definition**

**Purpose of this Handbook**

This handbook is intended for use by county health departments (CHDs) for clinic services provided to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, and the Florida Medicaid Provider Reimbursement Handbook, Dental 111, which contain specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program in general.

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.; the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.; and the Florida Medicaid Provider Reimbursement Handbook, Dental 111, is incorporated by reference in 59G-4.060, F.A.C.

***Purpose and Definition***, continued

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<b>Purpose of a CHD</b>	CHDs are administered by the Department of Health for the purpose of providing public health services in accordance with Chapter 154, F.S.
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<b>CHD Clinic Services Definition</b>	Medicaid CHD clinic services consist of primary and preventive health care, related diagnostic services, and dental services.  A CHD employs, contracts with, or obtains volunteer services from licensed health care practitioners to provide the above services.
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<b>CHD Satellite Definition</b>	A CHD satellite clinic is a clinic that is located in the same county as the CHD and is administered by the CHD. In addition to community-based satellite clinics, CHDs have school and mobile satellite clinics.
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***Provider Qualifications***

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<b>CHD Qualifications</b>	To be reimbursed by Medicaid, a CHD must be enrolled as a Medicaid provider and submit an annual cost report to:  Medicaid Program Analysis P.O. Box 12300 Tallahassee, Florida 32317-2300
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<b>Operational at the Time of Enrollment</b>	CHDs must meet all the provider requirements and qualifications and must be fully operational before they can be enrolled as Medicaid CHD providers.
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<b>Supervising Physician</b>	The CHD clinic and its satellite clinics must have a licensed physician on staff or a physician supervising the clinic. The supervising physician must be available at all times in person or by direct telecommunication for advice and assistance on patient referrals and emergencies.
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**Provider Qualifications**, continued

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**Treating Providers**

Medicaid reimburses for CHD clinic services rendered by the following practitioners:

- Advanced registered nurse practitioners (ARNP) licensed in accordance with Chapter 464, F.S.;
  - Dentists licensed in accordance with Chapter 466, F.S.;
  - Medical physicians licensed in accordance with Chapter 458, F.S.;
  - Osteopathic physicians licensed in accordance with Chapter 459, F.S.;
  - Physician assistants licensed in accordance with Chapter 458, F.S.; and
  - Registered nurses and licensed practical nurses licensed in accordance with Chapter 464, F.S. (Nurses are not enrolled as individual treating providers; their services are billed using the supervising practitioner's treating provider number.)
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**Members of the Public Health Service and Armed Forces**

Physicians who perform services in Florida, but who are not licensed in Florida, may enroll as Medicaid providers if they are commissioned medical officers of the Public Health Service or Armed Forces of the United States, on active duty, and acting within the scope of their public health service or military responsibilities.

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**Provider Enrollment**

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**Enrollment in One Clinic Program**

Medicaid reimburses CHD clinics, rural health care (RHC) clinics, and federally qualified health center (FQHC) clinics. A CHD clinic can enroll as only one type of clinic: CHD, RHC or FQHC at a time.

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**Enrollment Requirements**

To enroll in Medicaid, a CHD must submit a complete Medicaid Provider Enrollment Application package to the Medicaid fiscal agent. All individual professionals providing Medicaid services in a CHD must also submit an enrollment application to enroll as an individual Medicaid treating provider.

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**Provider Enrollment**, continued

**Criminal History Background Check**

CHDs are not required to submit fingerprint cards to enroll as Medicaid providers. Instead, CHDs submit an FDLE Criminal History and Fingerprinting Exemption Request noting that they are a "Unit of Local Government."

When a physician (MD or DO) or ARNP who is employed by, contracted with, or volunteers services to the CHD enrolls in Medicaid, he must submit with his Medicaid application a copy of the Department of Health (DOH) screen print of their professional license as proof of background screening.

A dentist or physician assistant (PA) providing services must submit either a fingerprint card or proof of a prior screening within the previous 12 months through another department or agency. Proof of prior screening is a letter or official form from the department or agency that performed the screening. The letter must specify the applicant's name, the date of the screening, the level of the screening and the results.

Note: DOH professional license screens can be obtained at the Department of Health's website at <http://ww2.doh.state.fl.us/IRM00PRAES/PRASLIST.ASP>

Note: The FDLE Criminal History and Fingerprinting Exemption Request form can be obtained from the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Enrollment. The form is included in the Florida Medicaid Provider Enrollment Application, which is incorporated by reference in 59G-5.010, F.A.C.

**CHD Categories of Service**

When completing a Medicaid provider enrollment application, the CHD must enter the Category of Service Code for each service that it will be providing:

<u>Service</u>	<u>Category of Service Code</u>
Nurse Practitioner	30
Dental Care	35
Child Health Check Up	55
Physician	25
Physician Assistant	30

**Individual Treating Providers Categories of Service**

When completing a Medicaid provider enrollment application, a CHD's individual treating provider must enter Code 55 for Child Health Check-Up (formerly EPSDT) if the provider performs Child Health Check-Ups.

**Provider Numbers**

CHDs are assigned two group provider numbers: one to bill for services that are reimbursed as clinic encounters and one to bill for services that are reimbursed on a fee-for-service basis.

**Provider Enrollment**, continued

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**CHD Provider Number for Clinic Services**

CHDs are assigned clinic group provider numbers to bill for clinic services.

The CHD may have more than one provider number for clinic services to assist with its cost reporting. For example, a CHD may have a specific provider number to bill for Child Health Check-Up or dental services.

Clinic services are reimbursed an “all inclusive” encounter rate that is determined yearly for each CHD.

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**CHD Provider Number Fee-For-Service Procedures**

Each CHD is assigned a fee-for-service group provider number to bill for services rendered away from the CHD clinic or satellite clinic and for immunization services.

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**Treating Providers**

The CHD’s treating practitioners, including volunteers, must enroll as Medicaid treating providers affiliated with the CHD. Volunteers must meet all the Medicaid provider enrollment qualifications for the specific provider type for which they are enrolling.

Treating providers will automatically be affiliated with both the CHD’s clinic group provider number and the fee-for-service group provider number.

RNs and LPNs providing billable services in the CHD Clinic Service Program do not enroll as Medicaid treating providers.

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**Termination from the Medicaid CHD Program**

When a CHD individual treating provider no longer wants to participate in the Medicaid CHD Clinic Services Program, the CHD must notify the Medicaid fiscal agent in writing on letterhead stationery. Mail the letter to:

Provider Services  
P.O. Box 7070  
Tallahassee, FL 32314-7070

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**Provider Enrollment**, continued

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**County Health Department Certified Match Program**

The purpose of the Medicaid CHD certified match program is to provide reimbursement to CHDs for medically-necessary nursing and medication administration services provided in a school setting to Medicaid-enrolled students. The services are provided by the CHD's Medicaid-enrolled registered nurses (RNs) and licensed practical nurses (LPNs).

To bill Medicaid under the certified match program, the CHD must enroll as a CHD certified match provider. Each of the registered nurses (RN) and licensed practical nurses (LPN) who will be providing services must enroll as individual treating providers in the CHD group.

Note: See the Florida Medicaid CHD Certified Match Coverage and Limitations Handbook for additional information. The 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.

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**Provider Requirements**

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**General Requirements**

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

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**Provider Responsibility**

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 effective April 14, 2006. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. This coverage and limitation handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida 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 reimbursement handbooks that apply to the services that you provide.

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

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## CHAPTER 2

### COUNTY HEALTH DEPARTMENT CLINIC SERVICES COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

**Overview**

**Introduction**

This chapter describes the services that can be reimbursed by the Florida Medicaid county health department (CHD) program. It also designates limited or excluded services.

**In This Chapter**

This chapter contains:

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Immunization Services	2-21
Medical Primary Care Services	2-25
Registered Nurse Services	2-28

***General Service Requirements, Limitations and Exclusions***

**Clinic Services**

Medicaid reimburses CHDs for the following clinic services:

- Adult health screening services
- Child Health Check-Up
- Dental services
- Family planning services
- Medical primary care
- Registered nurse services

These services are considered to be “clinic” services, because they are billed using the CHD clinic group provider number and are reimbursed the CHD clinic-specific, all-inclusive encounter rate. The CHD must choose the procedure code in Appendix A that is most applicable to the service that was provided.

Note: See the service-specific topic in this chapter for additional information on a particular type of service.

**General Service Requirements, Limitations and Exclusions**, continued

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**Non-Clinic Services**

Medicaid reimburses the CHD for the following services on a fee-for-service basis rather than its clinic encounter rate:

- Services rendered away from the CHD clinic or satellite clinic, as described below;
- Immunization services, as described in this chapter; and
- Colposcopy surgeries for family planning waiver participants, as described in this chapter.

These services are billed using the CHD fee-for-service group provider number and must be in compliance with the treating practitioner's coverage and limitations handbook.

Note: See Family Planning Waiver Services and Immunization Services in this chapter for additional information.

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**Services Rendered Away from the Clinic**

When a CHD renders a service away from the CHD clinic or satellite clinic, Medicaid reimburses the CHD for the applicable procedure code from the appropriate treating practitioner's Coverage and Limitations Handbook. For example, if a CHD physician renders a service at a hospital, the CHD bills the applicable procedure code from the Florida Medicaid Physician Services Coverage and Limitations Handbook.

Note: See the service-specific Coverage and Limitations Handbooks for the treating practitioners' procedure codes. 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.

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**Laboratory Tests**

Reimbursement for all laboratory tests that are performed by the CHD is included in the encounter rate for the service with which the laboratory tests are associated. For example, laboratory tests that the CHD performs as part of an adult health screening are included in the encounter rate for the adult health screening. Laboratory tests that the CHD performs cannot be reimbursed to the CHD as separate procedures.

Medicaid does not reimburse for venipuncture, collection, handling or transportation of specimens.

The CHD may refer the recipient for necessary laboratory procedures that exceed the minimum required for the specific procedure that the CHD is rendering. The laboratory that performs the tests bills Medicaid directly.

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**General Service Requirements, Limitations and Exclusions**, continued

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**Medically Necessary**

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- The services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- The services cannot be experimental or investigational;
- The services must reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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 covered service.

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

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**Who Can Provide Services**

Medicaid reimburses a CHD for specific services rendered by the following health care practitioners who are employed, under contract, or volunteer services to the CHD:

- Advanced registered nurse practitioners (ARNPs)
- Dentists
- Dental assistants\*
- Dental hygienists\*
- Licensed practical nurses (LPNs)\*
- Medical physicians
- Osteopathic physicians
- Physician assistants
- Registered nurses (RNs)\*

\*These practitioners cannot enroll as Medicaid providers. The services that they provide are billed using the supervising physician's or dentist's treating provider number.

Note: RNs and LPNs can enroll as individual treating providers in the Medicaid CHD Certified Match Program. Please refer to the Florida Medicaid Certified Match Program Coverage and Limitations Handbook for additional information.

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**General Service Requirements, Limitations and Exclusions**, continued

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**Service Reimbursement**

Only services rendered by health care practitioners who are employed, under contract, or volunteer services to the CHD and are enrolled as treating providers associated with the CHD group can be billed as CHD services to Medicaid. Exceptions are services rendered by dental assistants, dental hygienists, licensed practical nurses (LPNs), and registered nurses (RNs). These practitioners cannot enroll as individual treating providers associated with a CHD group. The services that they provide are billed using the CHD clinic physician's or dentist's treating provider number.

Medicaid will not reimburse an individual practitioner for health care services that are rendered in a CHD. Payment for services rendered in a CHD will be made only to the CHD.

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**Registered Nurses and Credentialed Registered Nurses**

Registered nurses (RNs) may provide family planning supply and counseling visits, immunizations, and certain other services that are authorized by the Florida Department of Health (DOH). All RN services must be provided under properly executed written standard of care protocols and direct or indirect supervision.

Registered nurses credentialed by DOH may provide adult health screenings, Child Health Check-Up screenings, and annual family planning visits. An RN becomes credentialed by completing a specific academic course in health assessments and a preceptorship under a physician.

Services provided by an RN when an ARNP cosigned the clinic record entry are not reimbursable by Medicaid.

Note: See Registered Nurse Services in this chapter for additional information.

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**Licensed Practical Nurses (LPNs)**

Reimbursable services rendered by a LPN are limited to immunizations. Other services are not reimbursable even when cosigned by a higher level of licensed health care professional.

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**Volunteers and Consultants**

CHDs can bill Medicaid for services rendered by volunteers and consultants who are enrolled as treating providers. Since RNs, LPNs, dental assistants, and dental hygienists cannot enroll as Medicaid providers, their volunteer services are billed using the supervising physician's or dentist's treating provider number.

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**Place of Service Requirement**

CHD clinic services must be rendered in the CHD clinic or its satellite clinics. Services rendered away from the clinic cannot be reimbursed as CHD clinic services; they are reimbursed on a fee-for-service basis using the CHD's fee-for-service group provider number.

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**General Service Requirements, Limitations and Exclusions**, continued

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**Clinic Encounter  
Limitation**

Medicaid reimbursement for clinic services is limited to one encounter per day, per recipient. An encounter is a single day, face-to-face visit between a recipient and health care professional(s). Two encounters cannot be reimbursed on the same day even if the visits are for different types of services such as a Child Health Check-Up screening and a dental service.

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**Documenting  
Encounters on the  
Claim Form**

Although Medicaid reimburses only one encounter per day, per recipient, the CHD must list on the claim form all encounters provided on the same day. This is for accountability and tracking services for Medicaid recipients.

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**Excluded Services**

Medicaid cannot reimburse the following services as CHD clinic services:

- Ambulance services\*
- Home health services\*
- Prescription drug services\*
- WIC certifications and recertifications
- Basic school health services\* and mass health screenings
- Experimental and investigative procedures

\*If the CHD meets the provider qualifications, it can enroll as a Medicaid ambulance, county health department certified school match, home health, or pharmacy provider; and provide those services through those Medicaid programs respectively.

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**Health  
Examinations,  
Health Physicals  
and Health  
Screenings**

Physical examinations for school attendance, sports and employment are not reimbursable unless the examinations meet the required components of an adult health screening, Child Health Check-Up screening, or family planning annual physical examination.

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## **Adult Health Screening Services**

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**Description** An adult health screening is an assessment of the health status of a Medicaid recipient age 21 and older. It is used to detect and prevent disease, disability and other health conditions or monitor their progressions. It must be provided by a physician, ARNP, credentialed RN, or physician assistant.

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**Screening Schedule** Medicaid will reimburse for one adult health screening every 365 days. Adult health screenings are recommended for:

- Age 21 through 39, one screening every five years.
- Age 40 and over, one screening every two years.

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**Required Service Components** The treating provider who provides adult health screenings must be able to provide or refer and coordinate the provision of all required screening components. The required components must be documented in the recipient's medical record. Required components include the following:

- Health history,
- Physical examination,
- Visual acuity testing,
- Hearing screen,
- Laboratory procedures, and
- Referral for or provision of treatment when health problems or deficiencies are diagnosed.

Descriptions of these components follow.

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**Health History** At a minimum, the following items must be documented in the recipient's medical record:

- Present history, including pertinent psychiatric history;
  - Past history;
  - Family history;
  - Dietary history;
  - Nutritional assessment;
  - Use of alcohol, drugs, and tobacco; and
  - List of all known risk factors.
-

**Adult Health Screening Services**, continued

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**Physical Examination**

At a minimum, the following items must be documented in the recipient's medical record:

- Measurements of height, weight, blood pressure and pulse; and
  - Physical inspection to include assessment of general appearance, skin, eyes, ears, nose, throat, teeth, thyroid, heart, lungs, abdomen, breasts, extremities, and performance of pelvic, testicular, rectal, and prostate exam as appropriate per recipient gender.
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**Visual Acuity Testing**

At a minimum, visual acuity testing must document a recipient's ability to see at 20 feet.

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**Hearing Screen**

At a minimum, a hearing screen must document a recipient's ability to hear by air conduction.

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**Required Laboratory Procedures**

The following laboratory procedures are required and are included in the reimbursement of an adult health screening:

- Urinalysis dipstick for blood, sugar, and acetone; and
  - Hemoglobin or hematocrit.
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**Urinalysis, Hemoglobin and Hematocrit**

Manual or automated dipstick urine, hemoglobin and hematocrit tests performed as part of an adult health screening are not reimbursed in addition to the adult health screening. The provider may not bill for them as separate procedures when performing an adult health screening.

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**Recommended Service Components**

The following screening components are recommended:

- Mammography screening referral,
- Laboratory procedures,
- Screening for prostate cancer, and
- Body mass index measurement.

Descriptions of these recommended components follow.

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**Adult Health Screening Services**, continued

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**Recommended Mammography Screening Referral**

Referral for routine screening mammography is recommended by the American Cancer Society for all females age 35 and older.

Mammography screening guidelines are as follows:

- Age 35 to 39, one screening baseline mammogram;
- Age 40 and over, one screening mammogram every year.

A screening mammogram is limited to one a year.

A diagnostic mammogram that is used to evaluate or monitor an abnormal finding is allowed more than once a year.

Mobile mammograms services must be performed by a Food and Drug Administration (FDA) approved mammography unit that is affiliated with a hospital or physician office. Medicaid does not reimburse independent mobile diagnostic units.

Mammograms are reimbursed to the radiologist performing the service according to the Florida Medicaid Physician Services Coverage and Limitations Handbook.

Note: See Appendix C in this handbook for the list of diagnosis codes required for reimbursing screening mammograms.

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**Recommended Laboratory Procedures**

The following laboratory procedures are recommended when medically indicated:

- Stool for occult blood,
- Tuberculin skin test,
- Collection of cervical pap smear for sexually active females or all females 21 years old and older;
- Prostatic specific antigen (PSA) for male recipients aged 45 and older, or beginning at age 40 for males with a family history of prostate cancer; and
- Collection and testing of specimens for sexually transmitted diseases.

All laboratory tests that are performed by the CHD are included in the reimbursement of an adult health screening. The CHD may not be reimbursed for them as separate procedures. Medicaid does not reimburse for venipuncture, collection, handling, or transportation of specimens.

The CHD may refer the recipient for necessary laboratory procedures that exceed the minimum required tests. The laboratory that performs the tests bills Medicaid directly.

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**Adult Health Screening Services, continued**

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**Reimbursement Information**

Medicaid reimburses the CHD its clinic-specific, all-inclusive encounter rate for adult health screenings. To receive reimbursement, the CHD must bill for the services with the appropriate adult health screening procedure code using its CHD clinic services group provider number. The treating practitioner provider number must be entered in item 24J on the CMS-1500 claim form.

When billing for a service that was provided by a credentialed RN, the supervising physician's Medicaid provider number must be entered as the treating provider number.

Note: See Appendix A in this handbook for the adult health screening procedure codes that Medicaid will reimburse to a CHD.

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**Child Health Check-Up Screenings**

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**Description**

Child Health Check-Up is a comprehensive, preventive health screening examination for Medicaid recipients from birth through age 20. A licensed physician, ARNP, credentialed RN, or physician assistant must provide Child Health Check-Up screenings.

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**Service Requirements**

To be reimbursed for Child Health Check-Up screenings, the CHD and the treating provider must enroll to provide Child Health Check-Up screenings as an additional category of service. The Child Health Check-Up category of service code is 55.

The CHD must provide the screenings in accordance with the policies in the Florida Medicaid Child Health Check-Up Coverage and Limitations Handbook.

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.

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**Child Health Check-Up Screenings**, continued

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**Hearing and Visual Screenings in Conjunction with Child Health Check-Up Visits**

When a Child Health Check-Up is performed, separate billing with the fee-for-service number for the following procedures is not allowed:

- Speech audiometry threshold,
- Comprehensive audiometry threshold evaluations,
- Visual field examinations, or
- Intermediate visual field exams.

Note: See Chapter 2 in the Florida Medicaid Hearing Services Coverage and Limitations Handbook and the Medicaid Optometric Services Coverage and Limitations Handbook for specific billing policy and limitations related to the procedures listed above.

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**Reimbursement Information**

Medicaid reimburses the CHD its clinic-specific, all-inclusive encounter rate for Child Health Check-Up screenings.

The CHD bills the Child Health Check-Up procedure code using its CHD clinic services provider number. The treating practitioner provider number must be entered in item 24J on the claim form. When billing for a service that was provided by a credentialed RN, the supervising physician's Medicaid provider number must be entered as the treating provider number.

Supplies and services that are provided in addition to the Child Health Check-Up screening may not be reimbursed separately. They are included in the CHD's annual cost report.

Note: See Appendix A in this handbook for the Child Health Check-Up procedure codes that Medicaid will reimburse to a CHD.

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**Dental Services**

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**Description**

Medicaid reimburses the CHDs for the dental services covered by the Medicaid dental services program. Dental services must be provided by licensed, Medicaid-enrolled dentists or licensed dental hygienists or dental assistants.

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**Dental Treatment Plan**

On the initial non-emergency visit, the dentist must evaluate the patient's needs and write a comprehensive dental treatment plan. If the initial visit is on an emergency basis, services should be provided to alleviate pain or infection. In the treatment plan, the dentist identifies the services that the dental hygienist or assistant may provide. These services must be within the dental hygienist's or assistant's scope of practice.

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**Dentist Supervision**

Services rendered by dental hygienists and assistants must be under the supervision of the dentist as required by Chapter 59Q-16, F.A.C.

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**Billing for Dental Encounters**

Medicaid reimburses CHDs one encounter rate for preventative dental services for recipients under age 21. Services described below must be provided on the same date of service and billed as one encounter rate using either procedure code D0120 (periodic oral evaluation) or D0150 (comprehensive oral evaluation), whichever is appropriate:

- Prophylaxis;
- Topical application of fluoride; and
- Oral hygiene instructions.

Unbundling of the services noted above is prohibited. If more than one encounter occurs to complete the services listed above, the provider must bill one encounter on the date of service that the procedures were completed.

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**Comprehensive Dental Exam and Adult Dental Services**

Medicaid reimburses for an adult comprehensive dental exam for the purpose of determining the need for complete or partial dentures.

Medicaid reimburses for medically-necessary emergency dental procedures to alleviate pain and or infection for adult Medicaid recipients.

---

**Service Limitations**

In addition to the one visit per day per recipient limitation, the limitations and prior authorization requirements that apply to the Dental Services Program also apply to dental services provided by a CHD. Medicaid reimburses complete and partial dentures for all recipients. Partial dentures must be prior authorized.

Note: See the Florida Medicaid Dental Coverage and Limitations Handbook for the service limitations. See the Medicaid Provider Reimbursement Handbook, Dental 111 for prior authorization procedures. 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.

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**Dental Services**, continued

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**Reimbursement  
Information**

Medicaid reimburses the CHD a clinic-specific, all-inclusive encounter rate for dental services. The CHD must bill for the services on the Dental 111 claim form.

To receive reimbursement, the CHD bills for either procedure code D0150 (Comprehensive Oral Evaluation) or D0120 (Periodic Oral Evaluation) for all dental services except for partial dentures. For partial dentures, the CHD bills for the specific partial denture procedure code once and only when the denture is seated.

The CHD bills with its clinic services group provider number. The treating practitioner provider number must be entered in item 6 on the claim form. When billing for a service that was provided by a dental assistant or hygienist, the supervising dentist's Medicaid provider number must be entered as the treating provider number.

Note: See Appendix A in this handbook for the dental procedure codes that Medicaid will reimburse to a CHD.

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**Family Planning Services**

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**Description**

Family planning services can be provided to Medicaid-eligible persons who desire family planning services and supplies. The services are for the purpose of spacing children or preventing pregnancies.

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**Family Planning Services**

Medicaid reimburses CHDs for the following family planning services:

- Initial and annual visits
- Family planning counseling visit
- HIV counseling visit
- Supply visit

Note: For sterilization procedures, see surgery services in the Florida Medicaid Physician Services Coverage and Limitations Handbook. 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.

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**Who Can Provide Family Planning Services**

Family planning services must be provided by a physician, ARNP, physician assistant or RN. A credentialed RN may provide annual visits; all RNs may provide supply and counseling visits.

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**Services for Minors**

Medicaid does not reimburse for family planning services for a minor (under age 18) unless the minor meets at least one of the following criteria:

- Has his or her parent's or legal guardian's consent;
- Is married;
- Is a parent;
- Is pregnant; or
- Will suffer from probable health hazards if such services are not provided as determined by a physician, ARNP or physician assistant based on sexual activity or other medical reasons.

The recipient's medical record must reflect the specific basis for the provision of family planning services to the minor.

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**Family Planning Services**, continued

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**Initial Visit Components**

Only one initial family planning visit per recipient, per provider, or provider group, can be reimbursed.

The following minimum components must be provided and documented in the recipient's medical record:

- Health history;
  - Pre-examination education session;
  - Physical examination;
  - Required laboratory tests;
  - Selection of contraceptive method and provision of supplies; and
  - Post-examination interview.
- 

**Annual Visit Components**

The following minimum components must be provided during an annual family planning visit and documented in the recipient's medical record:

- Updating the original data in the patient record,
- Physical examination,
- Required laboratory tests,
- Addressing renewal needs of contraceptive method, and
- Post-examination interview.

Annual visit reimbursements are limited to one every 365 days.

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**Required Laboratory Tests**

A cervical pap smear is required for an initial or annual family planning visit.

If a cervical pap smear was performed within the past three months, and results are available, it does not need to be repeated.

Laboratory tests performed by the CHD as part of a family planning service are not reimbursed in addition to the family planning service, because they are included in the encounter rate. The CHD may not be reimbursed for them as separate procedures. Medicaid does not reimburse for venipuncture, collection, handling, or transportation of specimens.

If the tests are performed by an outside laboratory, the outside laboratory bills Medicaid directly and is directly reimbursed by Medicaid.

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**Family Planning Services**, continued

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**Recommended Laboratory Tests**

The following laboratory tests are recommended for an initial or annual family planning visit, when indicated:

- Hemoglobin or hematocrit,
- Urinalysis,
- Screening for sexually transmitted diseases,
- Rubella titer, and
- Tuberculin skin test.

Reimbursement for the tuberculin skin test is included in the “all-inclusive” encounter rate the CHD receives for family planning. The rubella and sexually transmitted disease laboratory tests are billed by the pathologist or independent laboratory providing the service.

---

**Family Planning Counseling Visit**

A counseling visit is rendered to discuss the family planning method chosen or to discuss other available methods. Counseling visits should include information on natural family planning methods.

The following components must be provided and documented in the recipient’s medical record:

- All information necessary to increase the recipient’s understanding of and motivation for family planning;
- Provision of supplies for the contraceptive method, if indicated; and
- Identification of any problems with current birth control method.

Supply visit reimbursements are limited to once per month.

A counseling visit and supply visit are not reimbursable for same date of service, same recipient, same provider, or provider group.

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**Supply Visit**

Supply visits are rendered to assess the recipient and to provide family planning supplies such as birth control pills or condoms.

The following minimum components must be provided and documented in the recipient’s medical record:

- Check of weight and blood pressure,
- Check for any side effect of medications, and
- Provision of supplies or prescriptions for the contraceptive method.

Supply visit reimbursements are limited to once every 28 days.

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**Family Planning Services**, continued

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**HIV Counseling**

HIV counseling services are rendered for the purpose of determining a Medicaid family planning recipient's risk factor(s) associated with HIV and to provide necessary prevention education and to make referrals as needed.

HIV counseling is reimbursable using procedure codes 99401 or 99402 when HIV testing is indicated. Medicaid will reimburse for a counseling session performed prior to obtaining the specimen for HIV screening and again when blood screening test results are available.

HIV counseling must clearly relate to a family planning visit on the same date of service or within the previous 12 months. A family planning ICD-9-CM diagnosis code (V25.01 through V25.9) must be entered on the claims submitted for procedure codes 99401 and 99402.

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**HIV Counseling Visit Limits**

HIV counseling sessions are limited to four per year, per recipient who acknowledges HIV risks. They are limited to two per lifetime, per recipient for preventive counseling.

An HIV counseling session cannot be reimbursed in addition to a clinic visit on the same day, for the same recipient.

---

**HIV Documentation**

Medical records documentation must identify risk factors as appropriate or state, "no acknowledged risk."

Documentation for post-test HIV counseling sessions must minimally contain referrals as appropriate to programs such as the Department of Health's Partner Elicitation/Notification Program and community behavioral health agencies.

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**Appropriate Permission for Record Release**

Agencies or organizations with special record release policies for HIV services must obtain all necessary consent forms prior to billing Medicaid for the HIV counseling.

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**Family Planning Services**, continued

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**Intrauterine Device (IUD)**

Intrauterine device (IUD) services include the insertion and removal of the device. A visit for the sole purpose of obtaining IUD services may be reimbursed as a family planning supply visit if the required components of a family planning supply visit are documented in the recipient's record.

CHDs with pharmacies may bill Medicaid their contract price for IUDs. Those CHDs without pharmacies may receive separate reimbursement from Medicaid through the central pharmacy facility at the Department of Health.

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**DepoProvera or Lunelle**

All documented family planning services associated with the decision to use DepoProvera or Lunelle as a contraceptive method are covered using the appropriate family planning code. The decision to use Depo-Provera may occur during the initial, annual, or supply visit.

CHDs with pharmacies may bill Medicaid their contract price for DepoProvera and Lunelle. Those CHDs without pharmacies may receive separate reimbursement from Medicaid through the central pharmacy facility at the Department of Health.

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**Family Planning Services**, continued

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**Diaphragms And Cervical Caps**

Provision of diaphragms and cervical caps are by prescription. A visit for the sole purpose of a diaphragm or cervical cap fitting may be reimbursed as a family planning supply visit if the required components of a family planning supply visit are documented in the recipient's record.

CHDs with pharmacies may bill Medicaid their contract price for diaphragms and cervical caps. Those CHDs without pharmacies may receive separate reimbursement from Medicaid through the central pharmacy facility at the Department of Health.

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**Pregnancy Testing**

A pregnancy test may be indicated prior to the use of a particular contraceptive method. Pregnancy testing may not be reimbursed separately. All laboratory tests performed in the CHD are included in the all inclusive encounter rate. Specimens for pregnancy testing sent to an independent lab may be reimbursed to the laboratory.

A family planning service can be billed, as appropriate, on the same day when a pregnancy test is administered. The CHD provider must fully document in the medical record, as specified in this handbook, the specific family planning service.

---

**Urinalysis, Hemoglobin and Hematocrit**

Manual and dipstick urine, hemoglobin and hematocrit tests performed as part of a family planning service are included in the reimbursement for the family planning service. The CHD may not bill for them as separate procedures.

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**Service Exclusion**

Medicaid does not reimburse for fertility evaluation and treatment.

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**Reimbursement Information**

Medicaid reimburses the CHD its clinic-specific, all-inclusive encounter-rate for family planning services. To receive reimbursement, the CHD must bill for the services with the appropriate family planning procedure codes using its CHD clinic services provider number. The treating practitioner provider number must be entered in item 24J on the claim form.

When billing for a service rendered by a RN, the supervising practitioner's Medicaid provider number must be entered as the treating provider number.

Medicaid reimburses the CHD for the provision of a Norplant kit, IUD, Lunelle, diaphragms, cervical caps, and Depo-Provera on a fee-for-service basis.

Note: See Appendix A in this handbook for the family planning services procedure codes that Medicaid will reimburse to a CHD.

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**Family Planning Waiver Services**

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**Eligibility**

The family planning waiver extends eligibility for family planning services for 24 months to postpartum women who have had a Medicaid-financed delivery or pregnancy-related service within two years prior to the date of losing Medicaid eligibility.

Note: See Chapter 3 in the Florida Medicaid Provider General Handbook for additional information on family planning waiver services.

---

**Covered Services**

Recipients are eligible for all the Medicaid-covered family planning services listed under the “family planning services” topic, family-planning related pharmacy services, antibiotics and vaginal antifungals and anti-infectives to treat sexually-transmitted diseases (STDs), sterilization, and colposcopy.

Colposcopy and treatment of STDs are limited to a six week period after a family planning examination, a family planning counseling visit, or a family planning supply visit.

Recipients are not eligible for Medicaid transportation services.

Pharmaceutical services to family planning waiver recipients are billed by the pharmacy dispensing the prescription. Prescribed drugs are reimbursed by the Medicaid Prescribed Drug Services Program.

Note: See the Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook for additional information. The handbook is available on the Florida Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent’s website at <http://floridamedicaid.asc-inc.com>. Click on Provider Support, and then on Handbooks.

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**Evaluation and Management Codes**

Evaluation and management procedure codes 99201 and 99211 are reimbursable when the recipient either returns for STD counseling and treatment or has been referred to the CHD for this service.

Documentation in the recipient’s medical record must include all components of the evaluation and management service and the status of the recipient related to either the initial or established visit. If initial visit (99201) is billed, the provider must state that the recipient was referred and include the name of referring provider in the recipient’s medical record.

The provider must enter diagnosis code 099.9 (venereal disease, unspecified) on the claim form.

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**Service Exclusions**

All other Medicaid services are excluded from coverage or reimbursement.

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**Family Planning Waiver Services**, continued

**Service Requirements** Claims for family planning waiver services must be submitted with the following diagnosis codes:

E&M codes 99201 and 99211	099.9
Family planning	V25.01-V25.9
Colposcopy	622.1, 795.0, or 795.1
*Lab procedure for sexually transmitted diseases	634.0-634.9, 054.0-054.9, 078.0-078.19, 079.88, 079.98, 090.3-099.9, 112.0-112.9, 131.0-131.9, or V25.09

\*Place the appropriate diagnosis code on the order for the tests.

**Reimbursement for Colposcopy** CHDs who provide colposcopy surgery for family planning waiver patients are not reimbursed their encounter rate, but the “fee schedule” rate for the surgery. CHDs providing colposcopy surgery must bill Medicaid with their “fee-for-service” provider number.

The reimbursement for colposcopy surgery is limited to only family planning waiver patients.

**Prescriptions** Prescriptions to treat sexually transmitted diseases must have “FP” written on them.

**Reimbursement Information** To receive reimbursement, the provider must enter an appropriate family planning diagnosis code, V25.01 through V25.9, on the claim.

Medicaid clinics (county health departments, RHCs, and FQHCs) will be reimbursed their all inclusive clinic encounter rate for covered family planning waiver services. To receive reimbursement, the CHD enters the appropriate family planning code for the services on the claim.

For family planning waiver services performed in the outpatient setting, Medicaid reimburses the CHD for the applicable procedure code from the treating practitioner’s Coverage and Limitations Handbook. The CHD bills for the service with its fee-for-service provider number.

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***Immunization Services***

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**Description**

Immunization services provide vaccines to induce a state of being immune to or protected from a disease. Medicaid reimburses for these services for recipients birth through 20 years of age. Immunization services must be provided by a licensed physician, ARNP or physician assistant. They may also be provided by a registered nurse (RN) or licensed practical nurse (LPN) under the supervision of a licensed physician, ARNP or physician assistant.

The recipient's Record/Signature Card, HRS Form 687, is adequate documentation of immunizations for individuals under age 21.

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**Eligible Recipients**

Medicaid eligible recipients through 18 years of age are eligible to receive free vaccines through the federal Vaccine For Children (VFC) program. The provider is reimbursed only for the administration of the vaccine. The vaccine is free to the provider through the Vaccine For Children (VFC) program.

Immunizations provided by CHDs in the community, such as during school outreach programs, are reimbursable by Medicaid.

Medicaid eligible recipients 19 through 20 years of age may receive vaccines through their health care provider. These vaccines are not free to the provider and are reimbursed by Medicaid. Reimbursement includes the administration fee and the cost of the vaccine.

Medicaid does not reimburse for immunization services for recipients who are 21 years of age and older.

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**Immunization Services**, continued

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**Vaccines For Recipients Birth through 18 Years**

For eligible recipients from birth through 18 years of age, vaccines and combination vaccines providing protection against the following diseases are available free to the VFC-enrolled provider through the VFC program:

- Diphtheria, Tetanus and Pertussis (DTaP)
- Haemophilus Influenzae Type b (HIB)
- Hepatitis B (pediatric and adult)
- Meningococcal Conjugate (MCV4)
- Pneumococcal (PCV 7)
- Polio (IPV)
- Measles, Mumps, and Rubella (MMR)
- Tetanus and Diphtheria (Td) (Adult)
- Influenza
- Varicella
- Rotavirus

The following vaccines are available by request or for high-risk areas only through the VFC program:

- Hepatitis A
- Diphtheria and Tetanus (DT) (Pediatric)
- Pneumococcal Polysaccharide (PPV)
- Meningococcal Polysaccharide (MPSV4)

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**Vaccines for Recipients 19 Through 20 Years**

For eligible recipients ages 19 through 20 years, vaccines and combination vaccines providing protection against the following diseases are reimbursable:

- Hepatitis A
- Hepatitis B
- Human Papilloma
- Influenza
- Measles, Mumps, and Rubella (MMR)
- Meningococcal Conjugate (MCV 4)
- Meningococcal Polysaccharide (MPSV4)
- Pneumococcal Polysaccharide (PPV)
- Tetanus and Diphtheria (Td)
- Varicella

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**HPV Vaccine**

Medicaid will reimburse for the HPV vaccine with CPT 90649 for 9-18 year olds and 90649-HA for 19-20 year olds. Reimbursement includes the cost of the vaccine and the administration fee. Medicaid will reimburse the cost of the vaccine until coverage is provided through the Vaccine for Children Program for 9 through 18 year olds. Follow the recommendations of the Advisory Committee on Immunization Practices for use of this vaccine.

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**Immunization Services**, continued

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**Vaccine for Children Program (VFC)**

Providers must enroll in the VFC program to receive free vaccines for 0-18 year olds through the VFC program.

Information regarding the Vaccine for Children (VFC) Program is available by calling the State of Florida Department of Health, Bureau of Immunization, at 800-4-VFC-KID or 800-483-2543.

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**Vaccines Excluded from VFC Program**

Medicaid may reimburse the cost of the vaccine and an administration fee for all recipients 0-18 years of age who receive vaccines not covered by the VFC program.

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**Administration Fee Reimbursement**

Medicaid reimburses the CHD an administration fee to provide free vaccines through the VFC program to Medicaid-eligible recipients, birth through 18 years. To receive reimbursement, the CHD must bill for the service with the appropriate immunization procedure code using its CHD fee-for-service group provider number. The treating provider number must be entered in item 24J on the claim form.

When billing for vaccine administered by a RN or LPN, the supervising practitioner's Medicaid provider number must be entered as the treating provider number.

Note: See Appendix A in this handbook for the immunization procedure codes.

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**Vaccine Reimbursement for Recipients 19-20 Years**

Medicaid reimburses the CHD an administration fee and the cost of the vaccine for Medicaid eligible recipients 19-20 years. To receive reimbursement, the CHD must bill for the service with the appropriate immunization procedure code using its CHD fee-for-service group provider number. The treating provider number must be entered in item 24J on the claim form.

When billing for vaccine administered by a RN or LPN, the supervising practitioner's Medicaid provider number must be entered as the treating provider number.

Note: See Appendix A in this handbook for the immunization procedure codes.

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**Immunization Services**, continued

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**Rabies Vaccine**

CHDs may obtain rabies vaccine from the Central Pharmacy. Medicaid will reimburse the Central Pharmacy for the vaccine.

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**Child Health  
Check-Up**

A Child Health Check-Up screening can be reimbursed in addition to the administration fee for the vaccines. The Child Health Check-Up is billed with the CHD's clinic services number, and the vaccines are billed with the CHD's fee-for-service number.

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**Clinic Services**

A clinic service may be reimbursed in addition to the administration fee for vaccines provided the visit is for a separate and identifiable service, and the services are documented in the medical record. If the visit to the clinic is for the sole purpose of receiving an immunization, only the immunization service may be reimbursed.

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**Immunization  
Schedule**

Providers should use the current Recommended Childhood Immunization Schedule that was developed and endorsed by the Advisory Committee on Immunization Practices, the Committees on Infectious Diseases of the American Academy of Pediatrics, and Infectious Diseases of the American Academy of Family Physicians. The most recent schedule is available on the Centers for Disease Control Website at <http://www.cdc.gov>.

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**Medical Primary Care Services**

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**Description**

Medical primary care services are basic diagnostic and therapeutic services and supplies and antepartum and postpartum obstetrical care. Licensed physicians, ARNPs, or physician assistants must provide the services.

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**Required Prenatal Services at Each Visit**

The following components must be provided at each prenatal visit and documented in the recipient's medical record:

- Physical examination;
  - Recording of weight, blood pressure;
  - Recording of fetal heart tones when clinically appropriate;
  - Urinalysis and collections of specimens for the laboratory once per pregnancy and at subsequent visits if medically indicated;
  - Hemoglobin or hematocrit once per pregnancy and at subsequent visits if medically indicated;
  - Recipient education as appropriate; and
  - Plan of treatment.
- 

**Other Required Prenatal Services During Pregnancy**

The following components must be provided at some point during the pregnancy and documented in the recipient's medical record:

- Initial and subsequent history.
  - Florida's Healthy Start Prenatal Risk Screening or documentation of refusal.
  - HIV counseling and the offer of HIV testing at the initial prenatal visit and again at 28-32 weeks, in accordance with s.384.31, Florida Statutes; Ch. 64D-3.019, Florida Administrative Code. If the recipient refuses testing, documentation of refusal must be made.
  - Screening of all pregnant women for tobacco use with provision of smoking cessation counseling and appropriate treatment as needed.
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**Medical Primary Care Services, continued**

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**Prenatal Visit Frequency**

Prenatal visits are limited to a maximum of 10 per recipient. Additional visits, up to a total of 14, may be reimbursed if the diagnosis is listed in Appendix B, Diagnosis Code List for Additional Prenatal Services for Pregnant Women.

Payment for prenatal care is based on a total amount for complete care. Reimbursement for the 10 or 14 visits is the maximum reimbursement for the full course of prenatal care. If additional visits are provided, payment is considered already made in full. The provider may not bill the additional visits to Medicaid or the recipient.

To prevent inappropriate claim denials, the provider should bill prenatal visits as they occur.

Conditions related to the prenatal period must be billed as prenatal visits. Services provided during the pregnancy that are not related to the pregnancy may be billed as evaluation and management visits with the appropriate non-pregnancy diagnosis code.

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**Florida's Healthy Start Prenatal Risk Screening**

The Healthy Start Prenatal Risk Screening should be offered at the first antepartum visit. Payment for the Healthy Start Prenatal Risk Screening is included in the encounter rate for the antepartum visit.

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**Florida's Healthy Start Prenatal Risk Screening Form**

The CHD must retain a copy of the Healthy Start Prenatal Risk Screening form in the recipient's medical record to indicate that the screening was completed. Do not submit the Healthy Start Prenatal Risk Screening form with the CMS-1500. (Follow the instructions on the form for the distribution of copies.)

If the recipient declines the Healthy Start Prenatal Screening, the CHD must document the refusal in the recipient's medical record.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for a copy of Florida's Healthy Start Prenatal Risk Screening form.

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**Delivery Services**

If the CHD does not provide delivery services, the CHD must make provisions for the delivery and care of the mother and the newborn.

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**Medical Primary Care Services, continued**

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**Postpartum Services**

The following components of a postpartum clinic visit must be provided and documented in the recipient's medical record:

- Subsequent history and physical exam;
  - Urinalysis, hemoglobin or hematocrit, and collection of specimens for the laboratory as indicated;
  - Counseling regarding family relationships;
  - Education regarding breast self-exam;
  - Referrals and counseling as indicated; and
  - Provision of family planning method chosen by recipient.
- 

**Postpartum Visit Frequency**

Two postpartum visits within 90 days following delivery may be reimbursed per pregnancy when medically necessary.

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**Laboratory Tests**

Laboratory tests, including dipstick urine, fingerstick hemoglobin and hematocrit, are not reimbursed in addition to the medical primary care service. The provider may not bill for them as separate procedures. Medicaid does not reimburse for the collection of specimens and smears, because reimbursement is included in the encounter rate.

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**Presumptively Eligible Pregnant Women (PEPW)**

During the period of presumptive eligibility, services provided in the CHD are reimbursable, except for delivery services or postpartum care. No inpatient hospital services can be reimbursed.

Note: See Chapter 3 in the Florida Medicaid Provider General Handbook for additional information on Presumptively Eligible Pregnant Women.

---

**Reimbursement Information**

Medicaid reimburses the CHD a clinic-specific, all-inclusive encounter rate for medical primary care services. To receive reimbursement, the CHD must bill the applicable Evaluation and Management (E&M) procedure code for the office or other outpatient service or the applicable obstetrical care procedure code. The clinic bills with its clinic services group provider number. The treating provider number must be entered in item 24J on the claim form.

When billing for services that were provided by an RN, the supervising physician's Medicaid provider number must be entered as the treating provider number.

Note: See Appendix A in this handbook for the Medical primary care procedures that Medicaid reimburses to a CHD.

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**Registered Nurse Services**

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**Description**

Registered nurses may provide certain Medicaid services that are authorized by the Department of Health. The CHD and its satellite clinics must have written standard of care protocols for the services that RNs may provide. In addition, RNs must be credentialed to provide adult health screenings, Child Health Check-Up screenings, and annual family planning visits.

Note: The list of services that RNs may provide under standard of care protocols is available from the Department of Health.

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**Standard of Care Protocol Definition**

Standard of care protocols are the written documentation of medications, procedures, patient teaching objectives, special diet and instructions, durable medical equipment, and other supplies that may be provided by RNs.

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**Standard of Care Protocols**

The standard of care protocols must be developed by the supervising physician and signed and dated by the supervising physician, CHD administrator, nursing director, and registered nurses. They must be retained at the clinic.

The protocols must be reviewed and updated when necessary, but at least annually. The protocols are valid for 12 months, unless a shorter period of time is proposed by the supervising physician.

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**Indirect Physician Supervision**

Services rendered by an RN must be under indirect physician supervision. The supervising physician must be available at all times in person or by direct telecommunication.

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**Reimbursement Information**

Medicaid reimburses the CHD a clinic-specific, all-inclusive encounter rate for registered nurse services.

To receive reimbursement for adult health screenings, Child Health Check-Up screenings, and family planning services rendered by credentialed RNs, the CHD must bill the applicable procedure code for the service.

For family planning services (annual, supply and counseling visits) rendered by RNs, the CHD must bill the applicable family planning procedure code for the service. RNs who provide annual family planning visits must be credentialed by the Department of Health to perform such services.

For other registered nurse services, the CHD must bill the procedure code 99211 with TD modifier.

The CHD bills with its clinic services group provider number. The supervising physician's provider number must be entered in item 24J on the CMS-1500 claim form.

Note: See Appendix A in this handbook for CHD procedure codes.

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## CHAPTER 3 COUNTY HEALTH DEPARTMENT CLINIC SERVICES PROCEDURE CODES

**Overview**

**Introduction**

This chapter describes the procedure codes and reimbursement for recipients receiving County Health Department (CHD) Clinic Services.

**In This Chapter**

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-1
Procedure Code Modifiers	3-4

**Reimbursement Information**

**Procedure Codes**

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes, Level I and Level II. 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 copyrighted 2006 by the American Medical Association. All rights reserved.

Level I procedure codes (CPT) are a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five digit numeric code.

Level II procedure codes are national codes used to describe medical services and supplies. They are distinguished from Level 1 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.

**Reimbursement Information**, continued

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**Diagnosis Code**

A diagnosis code is required on the CMS-1500 claim form for all medical procedures. Use the most specific code available in the ICD-9-CM. Fourth and fifth digits are required when available.

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**CHD Clinic Services**

Medicaid reimburses the CHDs a clinic-specific, all-inclusive encounter rate for clinic services. Each clinic's rate is computed by Medicaid from the CHD's annual cost report.

A visit to the CHD for the sole purpose of obtaining a laboratory specimen or to obtain results from a diagnostic test may not be billed as an encounter.

To receive reimbursement for a clinic service, the CHD bills for the appropriate procedure code using its clinic services group provider number. The treating practitioner's Medicaid number must be entered in item 24J on the CMS-1500 claim form.

Note: See Appendix A in this handbook for the procedure codes that Medicaid will reimburse to a CHD for clinic services.

Note: See the Medicaid Provider Reimbursement Handbook, CMS-1500, and the Medicaid Provider Reimbursement Handbook, Dental 111, for information on completing the claim form.

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**Immunization Services**

Medicaid reimburses the CHD an administration fee for immunization services for recipients birth through age 18 and on a fee-for-service basis for immunization services for recipients age 19 through 20.

To receive reimbursement, the CHD bills for the applicable procedure code using its group practitioner provider number. The treating practitioner's Medicaid number must be entered in item 24J on the CMS-1500 claim form.

Note: See Appendix A in this handbook for the immunization procedure codes and fees.

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**Polio Immunizations**

Claims for polio immunizations for recipients age 19 through 20 years are priced by report. By report means the provider must attach a report (invoice price) to a claim in order for the procedure to be priced correctly. The CHD must attach a copy of the vaccine invoice to the claim for pricing.

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**Reimbursement Information**, continued

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**Services  
Rendered Away  
from the Clinic**

Medicaid reimburses the CHD for services rendered away from the clinic on a fee-for-service basis.

To receive reimbursement, the CHD bills for the applicable procedure code using its group practitioner fee-for-service provider number. The treating practitioner's Medicaid number must be entered in item 24J on the CMS-1500 claim form.

Note: See the service-specific Coverage and Limitations Handbooks for the treating practitioners' procedure codes. 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.

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**Services  
Rendered by RNs**

The CHD bills for adult health screenings, Child Health Check-Up screenings, and family planning services rendered by RNs, as appropriate, with the applicable service procedure code.

All other RN services are billed with procedure code 99211 with modifier TD.

When billing for a service provided by an RN, the supervising practitioner's Medicaid provider number must be entered as the treating provider number on the claim form.

Note: See Procedure Code Modifiers in this chapter for additional information on modifiers.

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***Procedure Code Modifiers***

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**Definition of Modifier**

For certain types of 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 field next to the procedure code field in item 24D, under Modifier.

CHDs must use the modifiers with the procedure codes listed on Appendix A, Procedure Codes and Maximum Fees, 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.

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## APPENDIX A PROCEDURE CODES AND MAXIMUM FEES

### CLINIC SERVICES (Billed with the Clinic Services Provider Number)

<i>Adult Health Screening Codes</i>		
CODE	DESCRIPTION OF SERVICES*	MAXIMUM FEE
99385	Adult Health Screening, new patient, age 21-39 yrs.	Cost based
99386	Adult Health Screening, new patient, age 40-64 yrs.	Cost based
99387	Adult Health Screening, new patient, age 65 yrs. and over	Cost based
99395	Adult Health Screening, established patient, age 21-39 yrs.	Cost based
99396	Adult Health Screening, established patient, age 40-64 yrs.	Cost based
99397	Adult Health Screening, established patient, 64 yrs. and over	Cost based

<i>Dental Services Codes (Must be billed on the Dental 111 claim form.)</i>		
CODE	DESCRIPTION OF SERVICES*	MAXIMUM FEE
D0150	Comprehensive Oral Evaluation	Cost-based
D0120	Periodic Oral Evaluation	Cost based
D5211	Upper Partial-Resin Base	Cost-based**
D5212	Lower Partial-Resin Base	Cost-based**
D5213	Maxillary Partial Denture	Cost-based**
D5214	Mandibular Partial Denture	Cost-based**
D5820	Interim Partial Denture	Cost-based**

\* See the Physicians' CPT book for complete code descriptions.

\*\* Requires prior authorization

**Appendix A, CLINIC SERVICES, continued**  
**(Billed with the Clinic Services Provider Number)**

<b>Child Health Check-Up Codes (Must be billed on the CMS-1500 claim form.)</b>			
CODE	MODIFIER	DESCRIPTION OF SERVICES*	MAXIMUM FEE
99381		Child Health Check-Up Screening – new patient <1year	Cost-based
99382		Child Health Check-Up Screening – new patient 1 through 4 years	Cost-based
99383		Child Health Check-Up Screening – new patient 5 through 11 years	Cost-based
99384		Child Health Check-Up Screening – new patient 12 through 17 years	Cost-based
99385	EP	Child Health Check-Up Screening – new patient 18 through 20 years	Cost-based
99391		Child Health Check-Up Screening – established patient <1 year	Cost-based
99392		Child Health Check-Up Screening – established patient 1 through 4 years	Cost-based
99393		Child Health Check-Up Screening – established patient 5 through 11 years	Cost-based
99394		Child Health Check-Up Screening – established patient 12 through 17 years	Cost-based
99395	EP	Child Health Check-Up Screening – established patient 18 through 20 years	Cost-based

\* See the Physicians' CPT book for complete code descriptions.

**Appendix A, CLINIC SERVICES, continued**  
**(Billed with Clinic Services provider number)**

<b>Family Planning Codes</b>			
CODE	MODIFIER	DESCRIPTION OF SERVICES*	MAXIMUM FEE
99383	FP	Family Planning—Initial Family Planning Examination – age 5-11 years	Cost-based
99384	FP	Family Planning—Initial Family Planning Examination – age 12-17 years	Cost-based
99385	FP	Family Planning—Initial Family Planning Examination – age 18-39 years	Cost-based
99386	FP	Family Planning—Initial Family Planning Examination – age 40-64 years	Cost-based
99393	FP	Family Planning—Annual Family Planning Examination – age 5-11 years	Cost-based
99394	FP	Family Planning—Annual Family Planning Examination – age 12-17 years	Cost-based
99395	FP	Family Planning—Annual Family Planning Examination – age 18-39 years	Cost-based
99396	FP	Family Planning—Annual Family Planning Examination – age 40-64 years	Cost-based
99403	FP	Family Planning Counseling Visit	Cost-based
99211	FP	Family Planning Supply Visit	Cost-based
99401 99402		HIV Counseling	Cost-based

- See the Physicians' CPT book for complete code descriptions.

**Appendix A, CLINIC SERVICES, continued**  
**(Billed with Clinic Services provider number)**

<b>Family Planning Waiver Codes</b>			
CODE	MODIFIER	DESCRIPTION OF SERVICES	MAXIMUM FEE
99393	FP	Family Planning—Initial Family Planning Examination – age 5-11 years	Cost-based
99394	FP	Family Planning—Initial Family Planning Examination – age 12-17 years	Cost-based
99395	FP	Family Planning—Initial Family Planning Examination – age 18-39 years	Cost-based
99396	FP	Family Planning—Initial Family Planning Examination – age 40-64 years	Cost-based
99383	FP	Family Planning—Annual Family Planning Examination – age 5-11 years	Cost-based
99384	FP	Family Planning—Annual Family Planning Examination – age 12-17 years	Cost-based
99395	FP	Family Planning—Annual Family Planning Examination – age 18-39 years	Cost-based
99396	FP	Family Planning—Annual Family Planning Examination – age 40-64 years	Cost-based
99403	FP	Family Planning--Counseling Visit	Cost based
99211	FP	Family Planning--Supply Visit	Cost based
99401, 99402		HIV Counseling	Cost based
57452, 57454, 57460		Colposcopy Surgeries (Billed with the Fee-For-Service Group Practitioner Provider Number)	Fee schedule

\* See the Physicians' CPT book for complete code descriptions.

**Appendix A, CLINIC SERVICES**, continued  
**(Billed with the Clinic Services Provider Number)**

<b>Primary Medical Care Codes</b>		
CODE	DESCRIPTION OF SERVICES*	MAXIMUM FEE
99201	Office or other outpatient visit	Cost-based
99202	Office or other outpatient visit	Cost-based
99203	Office or other outpatient visit	Cost-based
99204	Office or other outpatient visit	Cost-based
99205	Office or other outpatient visit	Cost-based
99211	Office or other outpatient visit	Cost-based
99212	Office or other outpatient visit	Cost-based
99213	Office or other outpatient visit	Cost-based
99214	Office or other outpatient visit	Cost-based
99215	Office or other outpatient visit	Cost-based
H1000	Antepartum Care only	Cost-based
59430	Postpartum Care only	Cost-based

<b>Registered Nurse Services Code</b>			
CODE	MODIFIER	DESCRIPTION OF SERVICES	MAXIMUM FEE
99211	TD	Services provided by registered nurses  <u>Exception:</u> Bill adult health screenings, Child Health Check-Up screenings, family planning services, and antepartum services rendered by RNs with the applicable service procedure code rather than 99211 TD.	Cost-based

\* See the Physicians' CPT book for complete code descriptions.

**IMMUNIZATION SERVICES**  
**(Billed with the Fee-For-Service Group Practitioner Provider Number)**

<i>Immunization Codes for Recipients Birth through 18 Years</i>			
CODE	MODIFIER	DESCRIPTION OF SERVICES	MAXIMUM FEE
90471— 90474		Administration of Vaccines to Medicaid recipients from birth through 18 years	\$5.00 per vaccine dose

<i>Immunization Codes for Recipients Age 19 through 20</i>			
CODE	MODIFIER	DESCRIPTION OF SERVICES	MAXIMUM FEE
90632		Hepatitis A Vaccine	Fee schedule
90649	HA	HPV Vaccine	Fee schedule
90656	HA	Influenza Vaccine, Preservative Free	Fee schedule
90658	HA	Influenza Vaccine	Fee schedule
90660		Influenza, intranasal	Fee schedule
90675		Rabies Vaccine	Fee schedule
90676		Rabies Vaccine	Fee schedule
90704	HA	Mumps Vaccine	Fee schedule
90705	HA	Measles Vaccine	Fee schedule
90706	HA	Rubella Vaccine	Fee schedule
90707	HA	Mumps and Rubella Vaccine	Fee schedule
90708	HA	Measles and Rubella Vaccine	Fee schedule
90714	HA	Tetanus and Diphtheria Vaccine, Preservative Free	Fee schedule
90715	HA	Tetanus, Diphtheria, Acellular Pertussis Vaccine	Fee schedule
90716	HA	Varicella Vaccine	Fee schedule
90718	HA	Tetanus and Diphtheria Vaccine	Fee schedule
90732	HA	Pneumococcal Vaccine	Fee schedule
90733		Meningococcal Vaccine	Fee schedule
90746		Hepatitis B Vaccine	Fee schedule
90749		Unlisted Vaccine	By Report

**SERVICES RENDERED AWAY FROM THE CLINIC**  
**(Billed with the Fee-For-Service Group Practitioner Provider Number)**

See the practitioner-specific Coverage and Limitations Handbook for the procedure codes and fees.

## APPENDIX B DIAGNOSIS CODE LIST FOR ADDITIONAL PRENATAL SERVICES FOR PREGNANT WOMEN

• Baby with Known or Suspected Genetic Disorder	655.23
• Systemic Malignancy	199.0, 199.1
• Age 35 years and above	659.53, 659.63
• Diabetes Mellitus, Including Gestational Diabetes	648.03, 648.83
• Hyperthyroidism	648.13
• Asthma Requiring Medication	493.00-493.91
• HIV Positive	V08
• Acquired Immune Deficiency Syndrome	042
• Seizure disorders	345.00-345.91
• Hemoglobinopathies, Including Sickle Cell	282.0-282.9
• Severe Anemia (less than 8 grams Hgb. or 24% Hct.)	648.23
• Cardiac Disease	648.53, 648.63
• Thromboembolic Disease	671.23, 671.33, 671.53
• Pre-Eclampsia or Eclampsia	642.43, 642.53, 642.63, 642.73
• Hypertension	642.03, 642.13, 642.23, 642.33
• Alcohol or Drug Dependence	655.43, 648.33
• Isoimmunization	656.23
• Suspected Abnormality of the Fetus	655.03, 655.13, 655.23, 655.33, 655.43, 655.53, 655.63, 655.73, 655.83, 655.93
• Abruptio Placenta	641.23
• Premature Rupture of Membranes and/or Premature Labor with Estimated Fetal Weight of 2000 grams or less	658.13, 644.03
• Multiple Gestation	651.03, 651.13, 651.23, 651.83, 651.93
• Psychiatric Disorders Under Therapy	648.43
• Poor Fetal Growth	656.53
• Grand Multiparity	659.43
• Tuberculosis	647.33
• Chronic Liver Disease	646.73
• Chronic Kidney Disease	646.23
• Carcinoma In Situ of Cervix	233.1
• Placenta Previa	641.03
• Habitual Aborter	646.33
• Pyelonephritis	646.63
• Cervical Incompetence	654.53
• Excessive Fetal Growth	656.63



## APPENDIX C

### MAMMOGRAPHY DIAGNOSIS CODES

#### ***Screening Mammography***

DX Code	Description
V10.3	Personal History of malignant neoplasm; breast
V15.89	Other specified personal history presenting hazards to health
V16.3	Family history of malignant neoplasm; breast
V70.0	Routine general medical examination at a health care facility

#### ***Diagnostic Mammography***

DX Code	Description
V10.3	Personal History of malignant neoplasm; breast
V15.89	Other specified personal history presenting hazards to health
V16.3	Family history of malignant neoplasm; breast
V70.0	Routine general medical examination at a health care facility
V10.3	Personal history of malignant neoplasm; breast
V10.40	Personal history of malignant neoplasm; female genital organ unspecified
V10.41	Personal history of malignant neoplasm; cervix uteri
V10.42	Personal history of malignant neoplasm; other parts of uterus
V10.43	Personal history of malignant neoplasm; ovary
V10.44	Personal history of malignant neoplasm; other female genital organs
V10.45	Personal history of malignant neoplasm; male genital organ unspecified
V10.46	Personal history of malignant neoplasm; prostate
V10.47	Personal history of malignant neoplasm; testis
V10.48	Personal history of malignant neoplasm; epididymis
V10.49	Personal history of malignant neoplasm; other male genital organs
V10.71	Lymphosarcoma and reticulosarcoma
V10.72	Hodgkin's disease
V10.79	Other lymphatic and hematopoeitic neoplasms
V10.81	Personal history of malignant neoplasm; bone
V10.82	Malignant melanoma of skin
V10.83	Other malignant neoplasm of skin
V10.84	Personal history of malignant neoplasm; eye
V10.85	Personal history of malignant neoplasm; brain
V10.86	Personal history of malignant neoplasm; other parts of the nervous system
V10.87	Personal history of malignant neoplasm; thyroid
V10.88	Personal history of malignant neoplasm; other endocrine glands and related structures
V10.79	Other lymphatic and hematopoeitic neoplasms
V10.81	Personal history of malignant neoplasm; bone
V10.82	Malignant melanoma of skin
V10.83	Other malignant neoplasm of skin
V10.89	Personal history of malignant neoplasm; other sites

**Diagnostic Mammography, continued**

DX Code	Description
V52.4	Fitting and adjustment of breast prosthesis and implant
V71.1	Observation for suspected malignant neoplasm
V76.10-76.12	Special screening for malignant neoplasms; breast
174.0	Malignant neoplasm of female breast; nipple and areola
174.1	Malignant neoplasm of female breast; central portion
174.2	Malignant neoplasm of female breast; upper-inner quadrant
174.3	Malignant neoplasm of female breast; lower-inner quadrant
174.4	Malignant neoplasm of female breast; upper-outer quadrant
174.5	Malignant neoplasm of female breast; lower-outer quadrant
174.6	Malignant neoplasm of female breast; axillary tail
174.8	Malignant neoplasm of female breast; other specified sites
174.9	Malignant neoplasm of breast (female); unspecified
175.0	Malignant neoplasm of breast (male); nipple and areola
175.90	Malignant neoplasm of breast (male); other and unspecified sites
198.2	Secondary malignant neoplasm, skin
198.81	Secondary malignant neoplasm, breast
214.1	Lipoma, skin and subcutaneous tissue
217	Benign neoplasm of breast
233.0	Carcinoma in situ; breast
238.3	Neoplasm of uncertain behavior; breast
239.3	Neoplasm of unspecified nature; breast
457.0	Postmastectomy lymphedema syndrome
457.1	Other lymphedema
610.0	Solitary cyst of breast
610.1	Diffuse cystic mastopathy
610.2	Fibroadenosis of breast
610.3	Fibrosclerosis of breast
610.4	Mammary duct ectasia
610.8	Other specified benign mammary dysplasias
611.0	Inflammatory disease of breast
611.1	Hypertrophy of breast
611.2	Fissure of nipple
611.3	Fat necrosis of breast
611.4	Atrophy of breast
611.5	Galactocele
611.6	Galactorrhea not associated with childbirth
611.71	Mastodynia
611.72	Lump or mass in breast
611.79	Other signs and symptoms in breast
611.8	Other specified disorders of breast
611.9	Unspecified breast disorder

**Diagnostic Mammography**, continued

DX Code	Description
757.6	Specified anomalies of breast
771.5	Neonatal infective mastitis
785.6	Enlargement of lymph nodes
793.8	Nonspecific abnormal findings on radiological and other examination of breast
879.0	Open wound of breast, without mention of complication
879.1	Open wound of breast, complicated
926.19	Crushing injury of breast
942.11	Burn of breast
942.31	Burn of breast; full thickness skin loss (third degree, not otherwise specified)
942.41	Burn of breast; deep necrosis of underlying tissues (deep third degree) without mention of loss of a body part
942.51	Burn of breast; deep necrosis of underlying tissues (deep third degree) with loss of a body part
996.54	Complication of breast prosthesis
V15.89	Other specified personal history presenting hazards to health







Charlie Crist  
Governor

Holly Benson  
Secretary

2727 Mahan Drive  
Tallahassee, FL 32308

<http://ahca.myflorida.com>