



Florida Medicaid

Federally Qualified Health Center Services Coverage and Limitations Handbook

Agency for Health Care Administration





CHARLIE CRIST
GOVERNOR

HOLLY BENSON
SECRETARY

March 11, 2008

Dear Medicaid Federally Qualified Health Center Services Provider:

Florida Medicaid updated the Federally Qualified Health Center 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 an immunization code for an "unlisted vaccine." The update corrects the codes for tetanus and diphtheria vaccine, preservative free, and tetanus, diphtheria, acellular pertussis vaccine. The update also replaces "Norplant Kit" with "Implanon."

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

FEDERALLY QUALIFIED HEALTH CENTER SERVICES COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages. It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

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

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

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

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

UPDATE NO.	EFFECTIVE DATE
New Handbook	December 1995
96-1-Replacement Pages	September 1996
96-2-Replacement Pages	September 1996
97-1 Pen and Ink	April 1997
April 2001 Revised Handbook	April 2001
April 2001-Errata	April 2001
Oct2003 – Revised Handbook	October 2003
Jan2007 – Revised Handbook	January 2007
Apr2008 – Replacement Pages	April 2008

FEDERALLY QUALIFIED HEALTH CENTER SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Table of Contents

Chapter/Topic	Page
Introduction	
Handbook Use and Format.....	ii
Characteristics of the Handbook.....	iii
Handbook Updates	iii
Chapter 1 – Provider Qualifications and Requirements	
Purpose and Definition.....	1-1
Provider Qualifications	1-3
Provider Enrollment.....	1-4
Provider Requirements	1-7
Chapter 2 - Covered Services, Limitations, and Exclusions	
General Service Requirements, Limitations and Exclusions	2-2
Adult Health Screening Services	2-8
Child Health Check-Up Screenings	2-11
Chiropractic Services	2-12
Dental Services	2-13
Family Planning Services.....	2-15
Family Planning Waiver Services	2-21
Immunization Services	2-23
Medical Primary Care Services.....	2-27
Mental Health Services	2-30
Optometric Services.....	2-32
Podiatry Services	2-33
Chapter 3 - Procedure Codes	
Reimbursement Information.....	3-1
Procedure Code Modifiers	3-4
Appendices	
Appendix A: Procedure Codes and Maximum Fees.....	A-1
Appendix B: Trauma and Accident Diagnosis Codes.....	B-1
Appendix C: Diagnosis Code List for Additional Prenatal Services for Pregnant Women	C-1
Appendix D: Mammography Diagnosis Codes.....	D-1

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

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

Background

There are three types of Florida Medicaid handbooks:

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

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

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
- Title 42 of the Code of Federal Regulations,
- Chapter 409, Florida Statutes, and
- Chapter 59G, Florida Administrative Code.

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

In This Chapter

This chapter contains:

TOPIC	PAGE
Handbook Use and Format	ii
Characteristics of the Handbook	iii
Handbook Updates	iii

Handbook Use and Format

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

Characteristics of the Handbook

Format

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

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

Note

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a topic roster on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an "Update No." and the "Effective Date".

Handbook Updates, continued

How Changes Are Updated

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

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

Numbering Update Pages

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

Effective Date of New Material

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

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

Identifying New Information

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

New Label

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

New Label and New Information Block

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

New Material in an Existing Information Block

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

New or Changed Paragraph

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

Paragraph with new material.

CHAPTER 1

FEDERALLY QUALIFIED HEALTH CENTER SERVICES PROVIDER QUALIFICATIONS AND REQUIREMENTS

Overview

Introduction

This chapter describes Federally Qualified Health Center services, defines clinics that are eligible providers, and gives the qualifications for enrollment.

Background

The federal authority governing the provisions, requirements, benefits, and service payment of the Federally Qualified Health Center Program is in the Code of Federal Regulations, Title 42, Part 491 and the State Medicaid Manual, Section 4231.

Section 409, Florida Statutes and Chapter 59G-4.100, Florida Administrative Code, establish Medicaid reimbursement by the Agency for Health Care Administration (AHCA) for federally qualified health center services.

In This Chapter

This chapter contains:

TOPIC	PAGE
Purpose and Definition	1-1
Provider Qualification	1-3
Provider Enrollment	1-4
Provider Requirements	1-7

Purpose and Definition

Purpose of this Handbook

This handbook is intended for use by federally qualified health centers (FQHCs) that provide services 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.

Purpose and Definition, continued

Purpose of this Handbook,
continued

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 of an FQHC

The purpose of an FQHC is to provide ambulatory primary care to a medically underserved population.

FQHC Definition

An FQHC is a clinic that is receiving a grant from the Public Health Service under the Public Health Service (PHS) Act.

An FQHC provides primary health care and related diagnostic services. In addition, an FQHC may provide dental, optometric, podiatry, chiropractic, and mental health services.

An FQHC employs, contracts or obtains volunteer services from licensed health care practitioners to provide the above services.

FQHC Satellite Definition

An FQHC satellite clinic is a clinic approved by the PHS and is affiliated with an FQHC. FQHC satellite clinics can be mobile.

FQHC Look-a-Like Clinic Definition

An FQHC look-alike clinic is a clinic that has fulfilled the requirements to receive a grant from the PHS, but does not actually receive the grant. FQHC look-alike clinics are eligible to participate in the Medicaid FQHC program.

Provider Qualifications

**FQHC
Qualifications**

To participate in Medicaid, an FQHC must:

- Receive a 329, 330, or 340 Public Health Services grant;
 - Meet the requirements to receive one of the grants listed above; or
 - Receive a waiver of the requirements listed above from the Secretary of Health and Human Services.
-

**Operational at the
Time of Enrollment**

FQHCs must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid FQHC providers.

Treating Providers

Medicaid reimburses for FQHC services rendered by the following practitioners:

- Advanced registered nurse practitioners (ARNP) licensed in accordance with Chapter 464, F.S.;
 - Chiropractors licensed in accordance with Chapter 460, 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.;
 - Optometrists licensed in accordance with Chapter 463, F.S.;
 - Physician assistants licensed in accordance with Chapter 458, F.S.; and
 - Podiatrists licensed in accordance with Chapter 461, F.S.
-

**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.

Provider Enrollment

Enrollment in One Clinic Program

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

Enrollment Requirements

The general Medicaid enrollment requirements are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. To enroll in Medicaid, an FQHC must submit a completed Medicaid Provider Enrollment Application package and the following documents to the Medicaid fiscal agent:

- Copy of the 329, 330 or 340 Public Health Services grant; or
- Waiver of the grant requirements from the Secretary of Health and Human Services.

FQHC Categories of Service

When completing a Medicaid Provider Enrollment Application, the FQHC must enter the Category of Service Code (COS) for each service that it will be providing in addition to COS 66 (Rural Health Clinic):

<u>Service</u>	<u>Category of Service Code</u>
Nurse Practitioner	30
Child Health Check-Up	55
Chiropractic	28
Dental	35
Physician	25
Physician Assistant	30
Podiatry	27
Visual	62

Individual Treating Providers Categories of Service

When completing a Medicaid Provider Enrollment Application, an FQHC's individual treating provider must enter the following Category of Service Codes on the Enrollment Application:

- Code for the provider's service (see codes listed above under FQHC Categories of Service), and
- Code 55 for Child Health Check-Up if the provider performs Child Health Check-Ups.

Provider Numbers

FQHCs 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.

FQHCs will need to crosswalk their National Provider Identifier (NPI) to both Medicaid provider numbers. The FQHCs can crosswalk its NPI plus the taxonomy for FQHC to its clinic encounter number and its NPI with no taxonomy to its fee-for-service group number.

Provider Enrollment, continued

FQHC Provider Number for Clinic Services

An FQHC is assigned a clinic group provider number to bill for clinic services.

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

FQHC Provider Number for Fee-For-Service Procedures

Each FQHC is assigned a fee-for-service group provider number to bill for services rendered at an inpatient or outpatient hospital and for the following services that are reimbursed on a fee-for-service basis:

- Emergency services;
 - Services rendered away from the clinic;
 - Immunization services; and
 - Newborn hearing screening services.
-

Treating Providers

The FQHC’s treating practitioners, including volunteers, must enroll as Medicaid treating providers affiliated with the FQHC. 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 FQHC clinic group provider number and the fee-for-service group provider number.

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

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

Provider Enrollment, continued

Multiple Locations

FQHCs that have satellite clinics must notify the Medicaid fiscal agent of the satellite clinics. The provider must submit a completed Declaration of Service Address form to identify additional FQHC sites.

The FQHC must include a written statement from the Public Health Services that the satellite clinic is “an approved grant site” with the Declaration of Service Address form.

Note: The Declaration of Service Address form may be obtained from the Medicaid fiscal agent by calling ACS Provider Enrollment at 800-377-8216 or from the Medicaid fiscal agent’s website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, then on Enrollment. The form is incorporated by reference in 59G-5.010, F.A.C.

Termination from the FQHC Program

When an FQHC, an FQHC satellite clinic, or an FQHC individual treating provider no longer wishes to participate in the Medicaid FQHC program, the FQHC must notify the Medicaid fiscal agent in writing on letterhead stationery.

Mail the letter to:
Provider Services
P.O. Box 7070
Tallahassee, FL 32314

Provider Requirements

General Requirements

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

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 with the implementation of HIPAA. This coverage and limitation handbook contains information regarding changes in procedure codes mandated by HIPAA. The Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

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

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

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the fiscal agent EDI help desk at 800-820-0218.

CHAPTER 2

FEDERALLY QUALIFIED HEALTH CENTER SERVICES COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter describes the services that can be reimbursed by the Florida Medicaid Federally Qualified Health Center (FQHC) program. It also designates limited or excluded services.

In This Chapter

This chapter contains:

TOPIC	PAGE
General Service Requirements, Limitations and Exclusions	2-2
Adult Health Screenings Services	2-8
Child Health Check-Up Screenings	2-11
Chiropractic Services	2-12
Dental Services	2-13
Family Planning Services	2-15
Family Planning Waiver Services	2-21
Immunization Services	2-23
Medical Primary Care Services	2-27
Mental Health Services	2-30
Optometric Services	2-32
Podiatry Services	2-33

General Service Requirements, Limitations and Exclusions

Clinic Services

Medicaid reimburses FQHCs for the following clinic services:

- Adult health screening services
- Child Health Check-Up
- Chiropractic services
- Dental services
- Family planning services
- Medical primary care
- Mental health services
- Optometric services
- Podiatric services

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

Certain services rendered by an FQHC practitioner that are not FQHC services are noted in this handbook, as well as information concerning Medicaid reimbursements for the services.

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

FQHC Encounter

An FQHC encounter is a medically-necessary primary or preventive care service as defined in this handbook. It is all-inclusive and is billed with the FQHC clinic group provider number and the appropriate encounter CPT code. This means when an FQHC bills an encounter CPT code, the FQHC may not additionally bill Medicaid for components of the encounter.

A visit to the center for the sole purpose of obtaining a laboratory specimen or to obtain results from a diagnostic test is prohibited from being billed as an encounter.

Note: See Appendix A for a categorical listing of FQHC all-inclusive CPT codes.

What is Included in an FQHC Encounter

The encounter includes the professional services rendered by one or more licensed health care or mental health care practitioners for a Medicaid recipient, including diagnosis, therapy, surgery, and consultation. Additionally, the encounter includes all services and supplies that are incidental, although integral, to the practitioner’s encounter services.

General Service Requirements, Limitations and Exclusions, continued

Non-Clinic Services

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

- Emergency services;
- Services rendered away from the FQHC clinic or satellite clinic, as described below; and
- Immunization services, as described in this chapter.

These services are billed using the FQHC fee-for-service group provider number and must be in compliance with the appropriate practitioner's Medicaid Coverage and Limitations Handbook.

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

Services Rendered Away from the Clinic

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

Note: See the 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.

Emergency Services

When an FQHC renders an emergency service, Medicaid reimburses the FQHC for the applicable procedure code from the treating practitioner's Coverage and Limitations Handbook. For example, if an FQHC physician renders an emergency service, the FQHC would bill the applicable procedure code from the Florida Medicaid Physician Coverage and Limitations Handbook using the FQHC fee-for-service provider number.

To receive reimbursement for an emergency service, the FQHC must complete the treatment. If the FQHC provides first response to a life-threatening injury or acute illness, and the recipient is transferred to another medical facility for remaining treatment, the FQHC cannot be reimbursed for the service.

Treatment for certain trauma and accident diagnoses is considered to be medical primary care rather than an emergency service.

Note: See Medical Primary Care Services in this chapter for additional information on treating accident and trauma diagnoses that are not considered to be emergency services.

General Service Requirements, Limitations and Exclusions, continued

Emergency Services,
continued

Note: See Appendix B in this handbook for a list of trauma and accident diagnosis codes that the FQHC treats as medical primary care services.

Laboratory Tests

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

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

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

Radiology Services

The FQHC encounter rate includes all diagnostic and treatment radiology services performed in an FQHC.

Radiology services are represented in the 70000 CPT code range.

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.

General Service Requirements, Limitations and Exclusions, continued

Who Can Provide Services

Medicaid reimburses an FQHC for services rendered by the following health care practitioners who are employed, under contract, or volunteer services to the FQHC. All services reimbursed must be within the individual practitioner's scope of practice and specifically defined in this handbook.

- Advanced registered nurse practitioners (ARNPs)
- Chiropractors
- Dentists
- Dental assistants*
- Dental hygienists*
- Licensed practical nurses (LPNs)*
- Licensed clinical psychologists*
- Licensed clinical social workers*
- Medical physicians
- Osteopathic physicians
- Optometrists
- Physician assistants
- Podiatrists
- Registered nurses (RNs)*

*The services that these practitioners provide are billed using the supervising physician's or dentist's treating provider number.

Tobacco Dependency

Medicaid encourages providers to screen all recipients for tobacco dependency and provide tobacco cessation counseling and therapy, as appropriate. To assist with tobacco cessation therapy, Medicaid reimburses nicotine gums, patches, and Zyban as a pharmacy benefit.

General Service Requirements, Limitations and Exclusions, continued

Service Reimbursement

Only services rendered by health care practitioners who are employed, under contract, or volunteer services to the FQHC and are enrolled as treating providers associated with the FQHC group can be billed as FQHC services to Medicaid. Exceptions are services rendered by dental assistants, dental hygienists, licensed clinical social workers, licensed psychologists, licensed practical nurses (LPNs), and registered nurses (RNs). These practitioners cannot enroll as individual treating providers associated with a FQHC group. The services that they provide are billed using the FQHC 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 FQHC. Payment for services rendered in a FQHC will be sent only to the FQHC.

Volunteers and Consultants

FQHCs can bill Medicaid for volunteer services rendered by volunteers who are enrolled as treating providers. To bill for the volunteer services of dental assistants, dental hygienists, licensed clinical social workers, licensed psychologists, licensed practical nurses and registered nurses use the supervising physician's or dentist's treating provider number. All reimbursed services must be within the scope of practice for the individual practitioner.

Place of Service Requirement

FQHC clinic services must be rendered in the FQHC clinic or its recognized satellite clinic.

Services rendered in a doctor's office that is not an FQHC clinic or satellite clinic cannot be reimbursed as FQHC services. The services can be reimbursed directly to the treating provider.

Services rendered in an inpatient or outpatient hospital setting are reimbursed on a fee-for-service basis using the FQHCs fee-for-service group provider number.

General Service Requirements, Limitations and Exclusions, continued

**Clinic Encounter
Limitation**

Medicaid reimbursement for clinic services is limited to one visit per day, per recipient. A visit is a face-to-face encounter between a recipient and health care professional(s). Two clinic visits 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 family planning service or if they occur at different places of service.

An exception is when a recipient has had a visit on a particular day, leaves the clinic, suffers an additional illness or injury requiring additional diagnosis or treatment, and returns to the clinic on the same day. To request an exception, the FQHC must submit the claim and documentation of the need for the second visit to the area Medicaid office for special consideration.

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

**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.

Excluded Services

Medicaid cannot reimburse the following services as FQHC clinic services:

- Home health services,
 - Prescription drug services, and
 - WIC certifications and recertifications.
-

Adult Health Screening Services

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. The service must be provided by a physician, ARNP, or physician assistant.

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; and
- Age 40 and over, one screening every two years.

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 are provided on the following pages.

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, continued

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.
-

Hearing Screen

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

Visual Acuity Testing

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

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.
-

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 them as separate procedures when performing an adult health screening.

Recommended Service Components

The following components are recommended:

- Mammography screening referral,
- Laboratory procedures,
- Screening for prostate cancer;
- Body mass index measurement; and
- Provide smoking cessation counseling and appropriate treatment as needed.

Descriptions of these recommended components follow.

Adult Health Screening, continued

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.

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

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

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

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 18 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 FQHC are included in the reimbursement of an adult health screening. The FQHC may not be reimbursed for them as separate procedures. Medicaid does not reimburse for venipuncture, collection, handling, or transportation of specimens.

Reimbursement Information

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

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

Child Health Check-Up Screenings

Description

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

Service Requirements

To be reimbursed for Child Health Check-Up screenings, the FQHC 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 FQHC 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.

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

When a Child Health Check-Up is performed, separate billing under the FQHC's 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 Florida Medicaid Optometric Services Coverage and Limitations Handbook for specific billing policy and limitations related to the procedures listed above.

Child Health Check-Up Screenings, continued

Reimbursement Information

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

The FQHC bills the Child Health Check-Up procedure code using its FQHC services provider number. The treating practitioner provider number must be entered in item 24J on the claim form.

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 FQHC encounter rate.

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

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

Chiropractic Services

Description

Medicaid reimburses FQHCs for the chiropractic services covered by the Medicaid Chiropractic Services Program. The services must be provided by licensed and Medicaid-enrolled chiropractors.

Service Limitations

In addition to the one-visit-per-day-per-recipient limitation, the service limitations that apply to the Medicaid Chiropractic Services Program apply to chiropractic services rendered by an FQHC.

Note: See the Florida Medicaid Chiropractic Coverage and Limitations Handbook for the covered services and limitations. 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.

Reimbursement Information

Medicaid reimburses a clinic-specific, all-inclusive encounter rate for chiropractic services rendered by an FQHC. To receive reimbursement, the FQHC, not the chiropractor, must bill the applicable chiropractic procedure code using its clinic services provider number. The treating practitioner provider number must be entered in item 24J on the claim form.

Note: See Appendix A in this handbook for the chiropractic procedure codes that Medicaid reimburses to an FQHC.

Dental Services

Description

Medicaid reimburses the FQHCs for the dental services covered by the Florida Medicaid Dental Services Program. Dental services must be provided by licensed and Medicaid-enrolled dentists or licensed dental hygienists or dental assistants.

Dental Treatment Plan

On the initial non-emergency visit, the dentist must evaluate the patient's needs and write a comprehensive dental treatment plan. Should the initial visit be 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.

Dental Encounters

Medicaid reimburses FQHCs 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.

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.

Dentist Supervision

Services rendered by dental hygienists and assistants must be under the supervision of the dentist as required by Chapter 64B-16, F.A.C.

Dental Services, continued

**Service
Limitations**

In addition to the one FQHC visit per day per recipient limitation, the limitations and prior authorization requirements that apply to the Medicaid Dental Services Program also apply to dental services provided by a FQHC. 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.

**Reimbursement
Information**

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

To receive reimbursement, the FQHC must bill procedure code D0150 for a comprehensive oral evaluation. For all return visits that do not require prior authorization, the provider must bill D0120 (Periodic Oral Evaluation). For partial dentures, the FQHC bills for the specific, partial denture procedure code once and only when the denture is seated.

The FQHC 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 FQHC.

Family Planning Services

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.

Family Planning Services

Medicaid reimburses FQHCs 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.

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.

Family Planning Services, continued

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, provision of supplies; and
- Post-examination interview.

* Health history should include all known risk factors including tobacco use.

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, including the use of tobacco products;
- 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.

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 FQHC 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 FQHC 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.

Family Planning Services, continued

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 FQHC receives for family planning services. The rubella and sexually transmitted disease laboratory tests are billed by the pathologist or independent laboratory providing the service.

Family Planning Counseling Visit

Counseling visits are 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.

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

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 one per month.

Covered prescriptions for family planning supplies are reimbursed through the Medicaid Prescribed Drug Program.

Family Planning Services, continued

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.

HIV Counseling Visits Limitations

HIV counseling sessions are limited to four per calendar year, per recipient acknowledging 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.

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.

Family Planning Services, continued

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.

The FQHC may bill for the IUD device separately using its fee-for-service group provider number.

Depo-Provera or Lunelle

All documented family planning services associated with the decision to use Depo-Provera 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, counseling, or supply visit.

The FQHC may bill for the Depo-Provera or Lunelle separately using its fee-for-service group provider number and the appropriate J procedure code, or they may be billed through the Medicaid Prescribed Drug Program as a prescription.

Diaphragms and Cervical Caps

Provision of diaphragms and cervical caps are by prescription and paid for by the Medicaid Prescribed Drug Program. 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.

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 FQHC are included in the all inclusive encounter rate. Specimens for pregnancy testing sent to an independent lab may be reimbursed to the independent laboratory.

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

Family Planning Services, continued

**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 FQHC may not bill for them as separate procedures.

**Service
Exclusion**

Medicaid does not reimburse for fertility evaluation and treatment.

**Reimbursement
Information**

Medicaid reimburses the FQHC its clinic-specific, all-inclusive encounter-rate for family planning services. To receive reimbursement, the FQHC must bill for the services with the appropriate family planning procedure codes using its FQHC 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 FQHC for the provision of a Norplant kit, IUD, and Depo-Provera or Lunelle on a fee-for-service basis. To receive reimbursement, the FQHC must bill for the services with the appropriate procedure codes from the treating provider's Coverage and Limitations Handbook, using its FQHC fee-for-services group provider number. The treating practitioner's provider number must be entered in item 24J on the claim form.

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

Family Planning Waiver Services

Description

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.

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 covered prescribed medication. 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.

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 FQHC 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.

Service Exclusions

All other Medicaid services are excluded from coverage or reimbursement.

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.

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 FQHC enters the appropriate family planning code for the services on the claim.

Colposcopies performed in the FQHC are not billed as a separate procedure, but are included in the encounter rate.

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

Immunization Services

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.

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.

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.

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

Immunization Services, continued

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)
-

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
-

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.

Immunization Services, continued

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.

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.

Administration Fee Reimbursement

Medicaid reimburses the FQHC an administration fee to provide free vaccines through the VFC program to Medicaid eligible recipients, birth through 18 years. To receive reimbursement, the FQHC must bill for the service with the appropriate immunization procedure code using its FQHC 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.

Vaccine Reimbursement for Recipients 19-20 Years

Medicaid reimburses the FQHC for the cost of providing a vaccine to Medicaid eligible recipients 19-20 years. To receive reimbursement, the FQHC must bill for the service with the appropriate immunization procedure code using its FQHC 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.

Immunizations, continued

**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 under the clinic encounter number and the vaccines are billed under the fee-for-service number.

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.

**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 Internet site at www.cdc.gov.

Medical Primary Care Services

Description

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

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.
-

Medical Primary Care Services, continued

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 C, 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.

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.

Florida's Healthy Start Prenatal Risk Screening Form

The FQHC 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 FQHC must document the refusal in the recipient's medical record.

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

Delivery Services

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

Medical Primary Care Services, continued

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.

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.

Presumptively Eligible Pregnant Women (PEPW)

During the period of presumptive eligibility, services provided in the FQHC 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 FQHC a clinic-specific, all-inclusive encounter rate for medical primary care services. To receive reimbursement, the FQHC 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.

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

Mental Health Services

Description Mental health services include individual therapy and group therapy by certain mental health professionals.

Who Can Provide the Services The services must be personally rendered by a Florida licensed, Medicaid-enrolled physician, ARNP, physician assistant, or clinical social worker, or a licensed clinical psychologist.

ARNPs and physician assistants must have a specialty in mental health.

Physicians must have a psychiatric specialty on file with the fiscal agent or be a resident under the direct supervision of a psychiatrist who is a member of the medical faculty at an accredited medical school or teaching hospital as defined in section 408.07(45), F.S.

Recipient Eligibility Medicaid FQHCs cannot be reimbursed for mental health services rendered to a Medicaid recipient who is also receiving services from a Medicaid community behavioral health services provider.

FQHCs may provide services to a recipient who is enrolled in the Prepaid Mental Health Plan (PMHP).

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for information on the PMHP.

Service Limitations In addition to the one visit per day, per recipient limitation, mental health services, both group and individual therapy, by a mental health professional are limited to 26 aggregate mental health visits per recipient, per state fiscal year. The other service coverage and limitations in the Medicaid Community Behavioral Health Services Program do not apply to FQHCs.

Mental Health Services, continued

**Group Size
Restrictions**

Medicaid will not reimburse for group therapy where total group size exceeds 10 participants for recipients with a mental health diagnosis and 15 for participants with a substance abuse diagnosis.

**Non-Reimbursable
Mental Health
Services**

Medicaid does not reimburse FQHCs for the following mental health services:

- Any service that does not have a specific treatment goal;
 - Biofeedback therapy for ordinary muscle tension or psychosomatic conditions;
 - Electroconvulsive therapy (ECT);
 - Transcendental meditation; and
 - Treatment of chronic conditions without acute exacerbation.
-

Treatment Plan

An individualized formal treatment plan must be signed and dated by a clinic physician within 72 hours of the initiation of psychotherapy. The treatment plan must be updated on a regular basis, but no less often than every 6 months.

The treatment plan must contain the following:

- Specific problems to be addressed through psychotherapy;
- Frequency and duration of psychotherapy treatments;
- A list of all the psychotherapeutic medications that the recipient is taking; and
- Short and long term goals;

Treatment goals must be measurable, functional, time-framed, and directly related to the psychiatric diagnosis.

**Required Medical
Record
Documentation**

The mental health practitioner must keep an account of all psychotherapeutic services in a recipient's general medical record.

Record entries should minimally include:

- The start and end time of the service.
 - The problem or functional deficit to be addressed during the session.
 - The recipient's status and response during the session. The response should be identified as to how it relates to the progress being made in achieving long and short-term goals.
-

Mental Health Services, continued

Covered ICD-9 Codes

Medicaid will reimburse FQHC claims only for the following diagnosis codes 298.9 through 301.9, 302.7, 303 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9. Diagnosis codes are found in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

Reimbursement Information

Medicaid reimburses the FQHC a clinic-specific, all-inclusive encounter rate for mental health services. The cost of providing psychometric testing is included in the cost report. To receive reimbursement, the FQHC must bill the applicable mental health procedure code using its clinic services provider number. The treating provider number must be entered in item 24J on the claim form.

When billing for mental health services that were provided by a licensed clinical social worker or a psychologist, the supervising physician's Medicaid provider number must be entered as the treating provider number.

Note: See Appendix A in this handbook for the mental health procedure codes that Medicaid will reimburse to an FQHC.

Optometric Services

Description

Medicaid reimburses FQHCs for the optometric services covered by the Medicaid optometric services program. Licensed, Medicaid-enrolled optometrists must provide the services.

Service Limitations

In addition to the one visit per day, per recipient limitation, the service limitations that apply to the Medicaid Optometric Services Program apply to optometric services rendered by an FQHC.

Note: See the Florida Medicaid Optometric Services Coverage and Limitations Handbook for the covered services and limitations. 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.

Optometric Services, continued

Reimbursement Information

Medicaid reimburses a clinic-specific, all-inclusive encounter rate for optometric services rendered by an FQHC. To receive reimbursement, the FQHC must bill the applicable FQHC optometric procedure code. Although the FQHC may render any Medicaid covered optometric service, a limited number of optometric procedure codes are available for the FQHCs use. The FQHC must choose the procedure code that is most applicable to the service that was provided.

The FQHC bills for optometric services with its clinic services provider number. The treating practitioner provider number must be entered in item 24J on the claim form.

The provision of eyeglasses and contact lens cannot be reimbursed separately. The costs of supplying eyeglasses and contact lens are included in the FQHC's annual cost report.

Note: See Appendix A in this handbook for the optometric procedure codes that Medicaid will reimburse to an FQHC.

Podiatry Services

Description

Medicaid reimburses the FQHC for podiatry services covered by the Medicaid Podiatry Services Program. The services must be provided by licensed, Medicaid-enrolled podiatrists.

Service Limitations

In addition to the one visit per day, per recipient limitation, the service limitations that apply to the Medicaid Podiatry Services Program also apply to podiatry services rendered by an FQHC.

Note: See the Florida Medicaid Podiatry Services Coverage and Limitations Handbook for the covered services and limitations. 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.

Reimbursement Information

Medicaid reimburses a clinic-specific, all-inclusive encounter rate for podiatry services rendered by an FQHC. To receive reimbursement, the FQHC must bill the applicable FQHC evaluation and management (E&M) procedure code. Although the FQHC may render any Medicaid covered podiatry service, a limited number of procedure codes are available for the FQHCs use. The FQHC must choose the procedure code that is most applicable to the service that was provided.

The FQHC bills using its clinic services provider number. The treating practitioner provider number must be entered in item 24J on the claim form.

Note: See Appendix A in this handbook for the procedure codes that Medicaid will reimburse to an FQHC for podiatry services.

CHAPTER 3

FEDERALLY QUALIFIED HEALTH CENTER SERVICES PROCEDURE CODES

Overview

Introduction

This chapter describes the procedure codes, fees and the copayment requirements for recipients receiving federally qualified health center (FQHC) 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

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.

Copayment Medicaid recipients, unless they are exempt, are responsible to pay a copayment of \$3.00 per day for FQHC services.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for categories of recipients and services that are exempt from the copayment.

Clinic Services Medicaid reimburses the FQHCs a clinic-specific, all-inclusive encounter-rate for clinic services. Medicaid computes each clinic's rate from the FQHCs annual cost report.

To receive reimbursement for a clinic service, the FQHC 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 claim form.

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

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

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

To receive reimbursement, the FQHC 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 claim form.

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

Reimbursement Information, continued

Emergency Services

Medicaid reimburses the FQHC for completed emergency services on a fee-for-service basis.

To receive reimbursement, the FQHC 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 claim form. Treatment for certain trauma and accident diagnosis codes is considered a medical primary care service rather than an emergency service. Medicaid reimburses the FQHC its clinic-specific encounter rate for treating these trauma and accident diagnosis codes.

Note: See Appendix B in this chapter for a list of the trauma and accident diagnosis codes that are treated as medical primary care services.

Services Rendered Away from the Clinic

Medicaid reimburses the FQHC for services rendered away from the clinic on a fee-for-service basis provided the service is in compliance with the applicable Medicaid provider coverage and limitation handbook.

To receive reimbursement, the FQHC 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.

Procedure Code Modifiers

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.

Federally qualified health centers 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.

APPENDIX A PROCEDURE CODES AND MAXIMUM FEES

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

Adult Health Screening Codes		
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

Chiropractic Services Codes		
CODE	DESCRIPTION OF SERVICES*	MAXIMUM FEE
99203	New Patient Visit	Cost-based
98940, 98941, 98942	Chiropractic Manipulation	Cost-based

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

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

Child Health Check-Up Codes			
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

Dental Services Codes		
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 Clinic Services Provider Number)

Family Planning Codes			
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)

Family Planning Waiver Codes			
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
99211	FP	Family Planning--Supply Visit	Cost based
99403	FP	Family Planning--Counseling 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 the Clinic Services Provider Number)

Primary Medical Care Codes		
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

Mental Health Services Code		
CODE	DESCRIPTION	MAXIMUM FEE
H0004	Individual and/or Group Therapy by Mental Health Practitioner (45--50 minutes)	Cost-based

Optometric Services Codes		
CODE	DESCRIPTION	MAXIMUM FEE
99201-99205	Optometric Care-New patient	Cost-based
99211-99215	Optometric Care-Established patient	Cost-based

Podiatry Services Codes		
CODE	DESCRIPTION	MAXIMUM FEE
99201-99215	See Primary Medical Care for descriptors.	Cost-based

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

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

CODE	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
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
90734	HA	Meningococcal Conjugate Vaccine	Fee schedule
90746		Hepatitis B Vaccine	Fee schedule
90749		Unlisted Vaccine Code	By Report

EMERGENCY SERVICES; SERVICES RENDERED AWAY FROM THE CLINIC; IUD, DEPO-PROVERA, LUNELLE, AND IMPLANON

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

APPENDIX B

TRAUMA AND ACCIDENT DIAGNOSIS CODES

Treatment for the following trauma and accident codes is considered to be a medical primary care service. The service is billed using the FQHC's clinic group provider number. See the ICD-9-CM book for the code descriptions.

826.0	830.0	833.0	839.00-839.08
839.2-839.21	839.4-839.49	839.6-839.69	839.8
840.0-848.9	850.0-851.1	851.2	851.4
872.00-872.02	873.0	890.0	891.0
892.0	893.0	894.0	910.0-910.9
911.0-911.9	912.0-912.9	913.0-913.9	914.0-914.9
915.0-915.9	916.0-916.9	917.0-917.9	918.0-918.9
919.0-919.9	920.0-920.9	921.0-921.9	922.0-922.9
923.0-923.9	924.0-924.9	930.0-933.1	935.0-938
939.2	939.9	941.1-941.2	942.2
946.0-946.2	949.0-949.2	958.3	959.0-959.9
980.0	991.0-991.9	992.0-992.9	993.0-993.1
994.5-994.6	995.1-995.3	995.5	995.8-995.81
998.9-999.3			

APPENDIX C

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 D 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>