

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

The following ambulatory services are provided:

1. Inpatient hospital services other than those provided in an institution for mental diseases
2. Outpatient hospital services
3. Rural health clinic services and other ambulatory services furnished by a rural health clinic
4. Laboratory and X-ray services
5. Early and periodic screening diagnosis of individuals under 21 years of age, and treatment of conditions found
6. Family planning services
7. Physician services
8. Podiatry services
9. Optometric services
10. Advanced Registered Nurse Practitioners services
11. Home Health services
12. Clinic services
13. Dental services
14. Hearing services
15. Prescribed drugs
16. Dentures
17. Prosthetic devices
18. Eyeglasses
19. Rehabilitative services
20. Emergency hospital services
21. Nurse-midwife services (Included in ARNP program)
22. Transportation services
23. Hospice care services
24. Case management
25. Chiropractor services
26. Federally qualified health center services
27. Respiratory therapy
28. Personal care
29. Private duty nursing
30. Therapies

* Description provided on attachment.

TN No. 90-60
Supersedes
TN No. 90-59

Approval Date 2-14-91

Effective 10/1/90

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: No limitations With limitations*

2.a. Outpatient hospital services.

Provided: No limitations With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).

Provided: No limitations With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: No limitations With limitations*

3. Other laboratory and X-ray services.

Provided: No limitations With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Not Provided
 Provided: No limitations With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

c. Family planning services and supplies for individuals of childbearing age.

Provided: No limitations With limitations*

*Description provided on attachment.

TN No. 92-40

Supersedes

Approval Date

JUL 30 1993

Effective Date 10/1/92

TN No. 92-39

HCFA ID: 7986E

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY
GROUP(s): _____

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: No limitations With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: No limitations With limitations:

*Description provided on attachment.

TN No. 93-44
Supersedes
TN No. 93-13

Approval Date 11-19-93

Effective Date 7/1/93

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

Provided: No limitations With limitations*

b. Optometrists' Services

Provided: No limitations With limitations*

c. Chiropractors' Services

Provided: No limitations With limitations*

d. Other Practitioners' Services (Includes ARNP, Nurse-midwife)

Provided: No limitations With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: No limitations With limitations*

b. Home health aide services provided by a home health agency.

Provided: No limitations With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: No limitations With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided: No limitations With limitations*

*Descriptor provided on attachment.

TR No. 90-55
Supersedes
TR No. 88-13

Approval Date 2-6-91

Effective Date 10/1/90

HCFA ID: 0140P/0102A

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

-
8. Private duty nursing services.
 Provided: No Limitations With limitations*
9. Clinic services.
 Provided: No Limitations With limitations*
10. Dental services.
 Provided: No Limitations With limitations*
11. Physical therapy and related services.
a. Physical therapy.
 Provided: No Limitations With limitations*
- b. Occupational therapy
 Provided: No Limitations With limitations*
- c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.
 Provided: No Limitations With limitations*
12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist.
a. Prescribed drugs.
 Provided: No Limitations With limitations*
- b. Dentures.
 Provided: No Limitations With limitations*

*Description provided on attachment.

TN. No.: 05-005
Supersedes
TN. No.: 03-20

Approval Date: 08/24/05

Effective Date: 04/01/05

State/Territory: FLORIDA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

-
- c. Prosthetic devices.
 Provided: No Limitations With limitations*
- d. Eyeglasses. Not provided
 Provided: No Limitations With limitations*
13. Other diagnostic, screening, preventative and rehabilitative services, i.e., other than those provided elsewhere in the plan.
- a. Diagnostic Services
 Provided: No Limitations With limitations*
- b. Screening services.
 Provided: No Limitations With limitations*
- c. Preventative services. Not provided
 Provided: No Limitations With limitations*
- d. Rehabilitative services.
 Provided: No Limitations With limitations*
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services. Not provided
 Provided: No Limitations With limitations*
- b. Nursing facility services. Not provided
 Provided: No Limitations With limitations*

*Description provided on attachment.

Revision: HCFA-PM-86-20 (BERC)
September 1986

State/Territory: Florida

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED
TO THE MEDICALLY NEEDY

c. Intermediate care facility services.

Provided No limitation With limitations* Not Provided

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Provided No limitation With limitations* Not Provided:

b. Including such services in a public institution (or district part thereof) for the mentally retarded or persons with related conditions.

Provided No limitation With limitations* Not Provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided No limitation With limitations* Not Provided:

17. Nurse-midwife services.

Provided No limitation With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

Provided No limitation

Provided in accordance with section 2302 of the Affordable Care Act

With limitations*

*Description provided on attachment-

TN 2012-001
Supersedes
TN 91-03

Approval Date 6-21-12 Effective Date 1/1/12

State/Territory: FLORIDA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

___ Provided: ___ With limitations*

X Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

___ Provided: ⁺ ___ Additional coverage ⁺⁺

b. Services for any other medical conditions that may complicate pregnancy.

X Provided: ⁺ ___ Additional coverage ⁺⁺ ___ Not provided.

21. Certified pediatric or family nurse practitioners' services.

X Provided: ___ No limitations ___ With limitations*

___ Not provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

TN No. 94-17
Supersedes 91-50 Approval Date 10/6/94 Effective Date 7/1/94

State/Territory: Florida

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): ALL

22. Respiratory care services (in accordance with section 1902 (e)(9)(A) through C of the Act).
 Provided No Limitations With Limitations
 Not Provided
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.
 Provided No limitations With limitations
 Not Provided
- b. Services of Christian Science nurses.
 Provided No limitations With limitations
 Not Provided
- c. Care and services provided in Christian Science sanatoria.
 Provided No limitations With limitations
 Not Provided
- d. Nursing facility services for patients under 21 years of age.
 Provided No limitations With limitations
 Not Provided
- e. Emergency hospital services.
 Provided No limitations With limitations
 Not Provided
- f. Personal care services furnished in recipient's home, and at the state's option, in another location, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.
 Provided No limitations With limitations
 Not Provided

TN No. 2011-001

Supersedes

Approval Date: 1/17/12

Effective Date: 10/1/11

TN No. 96-06

State of FLORIDA
PACE State Plan Amendment Pre-Print

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Medically Needy

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

provided not provided

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

provided not provided

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State of Florida

1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Medically Needy

28. Self-Directed Personal Assistance Services, as described in Supplement 4 to Attachment 3.1-A.

Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.

TN No: 2007-007

Supersedes

TN No: NEW

Approval Date: 03/28/08

Effective Date: 3/01/08

TELEMEDICINE SERVICES

Telemedicine services under Florida Medicaid are subject to the specifications, conditions, and limitations set by the State. Telemedicine is defined as the practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.

Providers rendering telemedicine within their scope of practice must involve the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between the recipient and the practitioner to provide and support care when distance separates participants who are in different geographical locations. Telephone conversations, chart review, electronic mail messages, or facsimile transmissions are not considered telemedicine.

All equipment required to provide telemedicine services is the responsibility of the providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA
AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED

DESCRIPTION OF LIMITATIONS
FOR MEDICALLY NEEDY: ALL GROUPS

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF FLORIDA

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED

DESCRIPTION OF SERVICE LIMITATIONS
FOR MEDICALLY NEEDY: ALL GROUPS

The following service limitations apply to all medically needy recipients. Authorization by the state agency is required for exceptions to limitations described below.

4/1/91

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS
UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

All services provided for in Section 1905(a) of the Act which are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions are provided for EPSDT participants.

Amendment 93-02
Effective 1/1/93
Supersedes 91-35

Approval Date APR 22 1993

Revised Submission 3/29/93

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND

10/01/93 REHABILITATIVE SERVICES: Early Intervention Services (13.d)

Rehabilitative services include a range of coordinated rehabilitative or remedial medically necessary services provided to a child in order to identify, evaluate, correct, reduce, or prevent further deterioration of deficits in the child's mental or physical health.

Early intervention services are provided under the Individuals with Disabilities Education Act (IDEA), Part C, and are designed to ameliorate or prevent further developmental disabilities and physical and mental illnesses in children with developmental delays or established conditions that could result in developmental delays at as early an age as possible in order to optimize their functioning capacity. These services are designed to enhance, not duplicate, existing Title XIX mandatory or optional services; to ensure maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level.

Developmental delays are defined as a delay in the development in one or more of the following domains: cognitive, physical/motor, sensory (including vision and hearing), communication, social, emotional, or adaptive.

Early intervention services are provided based on the determination of medical need in any of the identified domains.

A developmental delay is a verified delay by use of two or more of the following: appropriate standardized instrument(s); observational assessment; parent report(s); developmental inventory; behavioral checklists; adaptive behavior scales; or professional judgment. When a standardized instrument is used, the following will be used to establish a developmental delay: a score of 1.5 standard deviation below the mean in at least one area of the identified domains, or a 25 percent delay on measures yielding scores in months in at least one of the identified domains.

Amendment 2004-010
Effective 07/01/2004
Supersedes 93-67
Approval 02/03/2005

Revised Submission _____

Early intervention services must be face-to-face encounters, medically necessary, within the scope of practice of the provider, and intended to maximize reduction of identified disabilities or deficits. Suspicious deficits, disabilities or developmental delays are identified and verified through comprehensive screening, assessments and evaluations. Sessions that address the identified delays must be a collaboration of identifying, planning and maintaining a regimen related to the child's functioning. Sessions may be provided in individual or group settings in the following locations: hospital, other clinical settings, home, day care center, or other locations identified as a natural environment for the child.

Provision of services where the family or caregivers are involved must be directed to meeting the identified child's medical treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

D. Eligible Providers

An eligible provider must enroll as a Medicaid individual provider or group provider that employs or contracts with staff who hold a valid and active license in full force and effect to practice in the state of Florida and have three hours of continuing education per calendar year, or be a non-healing arts certified Infants and Toddler Developmental Specialist (ITDS). The Florida Department of Health, Children's Medical Services Early Steps Program verifies the qualifications, training, experience and certification of the potential Medicaid enrollees, and recommends the provider for Medicaid participation.

In accordance with 42 CFR 431.51, all willing and qualified providers may participate in this program.

Eligible providers must meet the following requirements to enroll as a Medicaid Early Intervention Services provider:

19. Physician - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physicians and have a minimum of one year experience in early intervention.
20. Physician's assistant - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physicians and have a minimum of one year experience in early intervention.

Amendment 2004-010
Effective 07/01/2004
Supersedes 93-67
Approval 02/03/2005

Revised Submission _____

21. Nurse practitioner - Be licensed through the Florida Department of Health Medical Quality Assurance Board of Nursing and have a minimum of one year experience in early intervention. Meet requirements contained in 42 CFR 440.166.
22. Registered nurse (RN) - Be licensed through the Florida Department of Health Medical Assurance Board of Nursing and have a minimum of one year experience in early intervention.
23. Practical Nurse (LPN) - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Nursing and have a minimum of one year experience with early intervention.
24. Physical therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Physical Therapy Practice and have a minimum of one year experience in the area of early intervention. Meet requirements contained in 42 CFR 440.110.
25. Occupational therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Occupational Therapy Practice and have a minimum of one year experience in the area of Early Intervention. Meet requirements contained in 42 CFR 440.110.
26. Speech-language pathologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Occupational Therapy Practice and have a minimum of one year experience in the area of Early Intervention. Meet requirements contained in 42 CFR 440.110.
27. Audiologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Speech-language Pathology and Audiology with a minimum of one year experience in the area of early intervention. Meet the requirements contained in 42 CFR 440.110(c).
28. Respiratory therapist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Respiratory Care with a minimum of one year experience in the area of early intervention.
29. Clinical psychologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Psychology and have a minimum of one year experience in the area of early intervention.
30. School Psychologist - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Psychology and have a minimum of one year experience in the area of early intervention.
31. Clinical social worker - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. Minimum of one year experience in the area of early intervention.
32. Marriage and family counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical

Amendment 2004-010
 Effective 07/01/2004
 Supersedes 93-67
 Approval 02/03/2005

Revised Submission _____

Social Work, Marriage and Family Therapy, and Mental Health Counseling. Must have a master's level degree or higher and have a minimum of one year experience in the area of early intervention.

- 33. Mental health counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. Must have a master's level degree or higher and have a minimum of one year experience in the area of early intervention.
- 34. Registered dietician - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Dietetics and Nutrition and have a minimum of one year experience in the area of early intervention.
- 35. Nutrition counselor - Be licensed through the Florida Department of Health Medical Quality Assurance, Board of Dietetics and Nutrition and have a minimum of one year experience in the area of early intervention.
- 36. Infants and Toddlers Developmental Specialist (ITDS) - Have a bachelor's degree or higher from an accredited college or university in early childhood or early childhood/special education, child and family development, family life specialist, communication sciences, psychology or social work or equivalent degree based on transcript review. Must have a minimum of one year experience in early intervention or a minimum of five years documented experience may substitute for an out of field degree. The ITDS provides early intervention services under the direction of a licensed physician or other health care professional acting within their scope of practice. The licensed healing arts professionals on the Family Support Plan Team who provide the evaluation, the service planning assessment, the development of the IFSP and the development of the plan of care follow the child and direct and support the activities of the ITDS through consultation at team meetings or by accompanying the ITDS on visits with the child and family.

Experience requirements are set by the Department of Health, Early Steps Program. Early Steps defines one year of experience in early intervention as equaling 1600 hours of hands-on experience with 0-5 year old children with special needs or their families. A maximum of 400 hours hands-on work with 0 to 5 year old children with special needs or their families obtained as part of the educational requirement to obtain a degree can substitute for 25% of the 1 year experience. Certification of all experience is required upon

Amendment 2004-010
 Effective 07/01/2004
 Supersedes 93-67
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Revised Submission _____

enrollment from the Department of Health, Early Steps Program. Certification can consist of letters from former and current employers, letters from professors, or course syllabi describing internship experience and hours with transcripts showing the successful completion of the course.

E. Benefits and Limitations

Early intervention services are medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level. Early intervention services are provided to Medicaid-eligible children for whom all services are medically necessary.

Rehabilitative services include the following range of services, referred to as early intervention services:

1) Screening Services: a screening is a brief assessment of a child that is intended to identify the presence of a high probability of delayed or abnormal development which may require further evaluation and assessment. A screening must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law. The component(s) of the screening performed must be within the scope of practice of the provider. Screenings are performed by one early intervention professional and are limited to three per year per recipient.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

2) Interdisciplinary Psychosocial and Developmental Evaluation Services: This is either an initial or follow-up comprehensive, interdisciplinary psychosocial and developmental evaluation to determine a child's level of functioning in each of the following developmental areas: (1) gross motor; (2) fine motor;

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Supersedes 93-67
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Revised Submission _____

(3) communication; (4) self-help and self-care; (5) social and emotional development; and (6) cognitive skills. An evaluation is based on informed clinical opinion through objective testing and includes, at a minimum, a review of pertinent records related to the child's current health status and medical history; an evaluation of the child's level of functioning in each of the developmental areas; an assessment of the unique strengths and needs of the child; and identification of services appropriate to meet the needs of the child.

When used, a standardized test should be thorough, efficient, objectively scored, reliable, valid, culturally fair, and have a broad developmental focus. Tests are to be administered by providers.

The initial evaluation is limited to one per lifetime per recipient. Follow-up evaluations are limited to three per year per recipient. Evaluations must be recommended by a licensed healing arts professional or paraprofessional.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

4) Group, Individual, and Home Visiting Sessions: Sessions are face-to-face encounters of at least 30 minutes, not to exceed 60 minutes, with the child or the child's parent, family member or caregiver or both. The purpose of the session is to provide medically necessary services to alleviate or minimize the child's developmental disability, or the condition that could lead to the developmental disability or delay. Sessions must be provided by a Medicaid enrolled professional or paraprofessional early intervention provider within their scope of practice.

An individual session is held with one child or one of the child's parents, family member or caregiver or both.

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Supersedes 93-67
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Revised Submission _____

A group session is held with more than one child, more than one of the child's parents, family member or caregiver; or, more than one child and those children's parents, family members or caregivers. A minimum number of participants in a group is two. The recommended maximum for a group is four.

A home-visit session is an individualized session with one child or that child's parent(s), family member(s) or caregiver(s) or both in the child's home, child care facility or other location conducive to the natural environment of the child, and does not have a center-based or developmental day program.

Billable activities are those identified in the Medicaid Early Intervention Session(s) Plan of Care for the period authorized. Session services cannot duplicate or supplant existing Medicaid services. Services are designed to enhance development in physical/motor, communication, adaptive, cognitive, social or emotional and sensory domains, or to teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions.

Providers retain 100 percent of the payments provided for in Attachment 4.19-B.

Providers can be reimbursed for only one type of early intervention session (group, individual, or home-visit) per day, per child. A session cannot be split between providers, nor can more than one type of provider provide a session per day for the same child.

Exceptions to the service limitations will be granted based on medical necessity. Authorization to increase the limitation of frequency or time must be requested and approved prior to providing the service. Such authorization is limited to a 3-month period.

F. Early Intervention Services By Provider Type

Early intervention services are rehabilitative services that include a range of coordinated rehabilitative or remedial medically necessary services provided to a child in order to identify, evaluate, correct, reduce, or prevent further deterioration of deficits in the child's mental or physical health. Early intervention services, which include screening,

Amendment 2004-010
Effective 07/01/2004
Supersedes 93-67
Approval 02/03/2005

Revised Submission _____

evaluations and sessions, are designed to enhance, not duplicate, existing Title XIX mandatory or optional services; to ensure maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

The following services are provided by the appropriate provider type within his scope of practice, and when medically necessary, as part of an early intervention screening, evaluation or session. Services include:

- 10) Developmental - services under the direction of a licensed physician or other health care professional acting within their scope of practice. The licensed healing arts professionals on the Family Support Plan team provide the evaluation, the service planning assessment, the development of the Individualized Family Support Plan (IFSP) and the development of the plan of care, follow the child and direct and support the activities through consultation at team meetings, or by accompanying a provider on visits. These consultative services encompass identifying and rehabilitating a child's medical or other health-related condition and integrating developmental intervention strategies into the daily routines of a child and family to restore or maintain function or reduce dysfunction resulting from a mental or physical disability or developmental delay. Ensuring carryover of medically necessary developmental intervention strategies into all of the child's daily activities to increase the range of normal daily functioning and experience.
- 11) Medical - services for diagnostic or evaluation purposes, services to determine a child's developmental status and need for early intervention services.
- 12) Psychological - services are administering psychological and developmental tests, interpreting results, obtaining and integrating information about the child's behavior, child and family conditions related to learning, mental health and development, and planning and managing a program of psychological services, including psychological counseling, family counseling, consultation on child development, parent training and education programs.
- 13) Occupational Therapy - services to address the functional needs of a child related to adaptive development, adaptive behavior and

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 Supersedes 93-67
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play, and sensory, motor, and postural development to improve the child's functional ability to perform tasks, including identification, assessment, intervention, adaptation of the environment, and selection of assistive and orthotic devices.

- 14) Physical Therapy - services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems.
- 15) Speech/Language - services to identify children with communicative or oropharyngeal disorders and delays in communication skills development, referral for medical or other professional services and the provision of services necessary for their rehabilitation.
- 16) Nutritional - services that include conducting nutritional assessments, developing and monitoring appropriate plans to address the nutritional needs of the child, based on the findings of the nutritional needs of the child, based on the findings of the nutritional assessment, and making referrals to appropriate community resources to carry out nutritional goals.
- 17) Audiological - services to identify children with auditory impairment, using at risk criteria and appropriate audiologic evaluation procedures to determine the range, nature, and degree of hearing loss and communication functions. It includes referral for medical and other services necessary for rehabilitation, provision of auditory training and aural rehabilitation, and determination of the child's need for amplification and its selection, use and evaluation.
- 18) Respiratory Therapy - services to identify, evaluate and provide interventions to children with respiratory disorder which may result in a developmental delay in any of the identified domains.

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Approval 02/03/2005

Revised Submission _____

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER
21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND: (Continued)

10/1/90 15. REHABILITATIVE SERVICES: Exceptions to the service
(13d) limitations can be granted based on medical necessity.

a. Intensive therapeutic on-site services include the provision of therapeutic services, with the goal of preventing more restrictive, costly placement by teaching problem solving skills, behavior strategies, normalization activities and other treatment modalities as appropriate. On-site is defined as where the child is living, working or receiving schooling. Children residing in a public institution or who are under the control of the juvenile justice system are not eligible for Medicaid.

While it is recognized that involvement of family (including legal guardians) in the treatment of the child is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified child's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

Billable services are face-to-face encounters with the child and/or the child's family. Services must be rendered by a mental health professional with a minimum of a B.A. degree from an accredited university with emphasis in the areas of psychology, social work, health education or a related human services field.

Intensive therapeutic on-site services include:

- o Behavioral assessment of the child in order to define, delineate, evaluate and diagnose treatment needs. Assessment services include; psychosocial evaluation, psychiatric mental status exam, psychological testing, and developmental assessment of the child within the home, community, educational or vocational setting.
- o Development of a behavioral management program for the child designed to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder that interfere with the child's personal, familial, vocational and/or community adjustment.
- o Monitoring of the child's compliance with the behavioral management program.
- o Individual counseling or psychotherapy between the child and the mental health professional designed to maximize strengths and to reduce behavior problems and or functional deficits stemming from the existence of a mental disorder that interferes with the child's personal, familiar, vocational and/or community adjustment.
- o Family counseling or psychotherapy involving the child, his/her family and or significant others and a mental health professional designed to maximize strengths and to reduce behavior problems and or functional deficits stemming from the existence of a mental disorder that interfere with the child's personal, familial, vocational and/or community adjustment.
- o Other medically necessary therapeutic services specified by the psychiatrist in the child's plan of care.

Services are limited to one visit per day. Additional visits can be granted based on medical necessity.

Amendment 90-67
Effective 10/1/90
Supersedes 92-26
Approved 5-12-94

Revised Submission 2/20/92
Revised Submission 8/7/92
Revised Submission 2/3/94

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND: (Continued)

4/1/96 15. REHABILITATIVE SERVICES: (Continued)
(13d)

b. Home-based rehabilitative services are designed for the restoration or modification, and/or maintenance of social, personal adjustment, and basic living skills. These services shall be an effective intervention in assuring that a child with a psychiatric disability possesses those physical, emotional, and intellectual skills to live, learn and work in his or her own particular environment. Home-based is defined as the child's official place of residence. Children residing in a public institution, or who are under the control of the juvenile justice system, are not eligible for Medicaid.

While it is recognized that involvement of family (including legal guardians) in the treatment of the child is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the identified child's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified needs of the child are not covered by Medicaid.

Billable services are face-to-face encounters with the child and/or the child's family. Services must be rendered by an individual who is experienced in the needs of severely emotionally disturbed children, is capable of implementing services which address the child's needs identified in the care plan, demonstrate skills and abilities to deliver therapeutic services to severely emotionally disturbed children, complete an ADM approved pre-service training program and participate in annual training to improve skills. Providers may not be relatives of the recipient. Services are limited to those provided by or under the recommendation of a physician, psychiatrist or other licensed practitioner of the healing arts acting within the scope of his/her practice under State law.

Home-based rehabilitative services include:

- o One to one supervision of the child's therapeutic activities in accordance with his or her behavioral management program.
- o Skill training of the child for ~~development and/or~~ ^{HCPA P.I. CHASE 8-12-96} restoration of those basic living and social skills necessary to function in his or her own particular environment.
- o Assistance to the child and family in implementing behavioral goals identified through family counseling or treatment planning.

Services are limited to 56 hours per month. Additional hours can be approved based on medical necessity.

Amendment 96-03
Effective 4/1/96
Supersedes 95-16
Approved 8-12-96

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/98
(13d) REHABILITATIVE SERVICES: (Continued)
School-Based Therapy Services

Description

Florida Medicaid certified school match program allows school districts, charter, and private schools to receive reimbursement under the Florida Medicaid program for therapy services furnished in a school setting. These services are provided in accordance with 42 CFR 440.130(d).

Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring medically necessary therapy services in the school setting.

Who Can Provide

The following licensed practitioners rendering services through the school district, charter or private school, and in accordance with 42 Code of Federal Regulations 440.110:

- Occupational therapists or occupational therapy assistants licensed in accordance with Chapter 468, Florida Statutes under the supervision of a licensed occupational therapist.
- Physical therapists or physical therapy assistants who meet the requirements in Chapter 486, Florida Statutes under the supervision of a licensed physical therapist.
- Speech therapists or speech-language pathology assistants licensed in accordance with Chapter 468, Florida Statutes or Certified by the Department of Education under the supervision of a licensed speech therapist.

Allowable Benefits

Florida Medicaid covers the following school-based therapy services:

- Evaluations
- Individual and group treatment sessions

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/99
(13d)

REHABILITATIVE SERVICES (Continued)
School-Based Behavioral Services

Description

Florida Medicaid certified school match program allows school districts, charter, and private schools to receive reimbursement under the Florida Medicaid program for behavioral health services furnished in a school setting. These services are provided in accordance with 42 CFR 440.130(d).

Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring medically necessary behavioral services in the school setting.

Who Can Provide

The following licensed and/or certified practitioners rendering services through the school district, charter or private school:

- Behavior analysts or assistant behavior analysts certified by the Behavior Analyst Certification Board
- School counselors certified in accordance with Chapter 1012, Florida Statutes.
- Marriage and family therapists licensed in accordance with Chapter 491, Florida Statutes.
- Mental health counselors licensed in accordance with Chapter 491, Florida Statutes.
- Psychologists licensed in accordance with Chapter 490, Florida Statutes.
- Social workers licensed in accordance with Chapter 491, Florida Statutes.

Allowable Benefits

Florida Medicaid covers the following school-based behavioral services:

- Assessments
- Behavior analysis, including interpretations of information about the student behavior and conditions relating to functioning.
- Consultation, coordination of services, and follow-up referrals with other health care staff, other entities or agencies, parents, teachers, and family.
- Evaluations
- Individual counseling sessions
- Group counseling sessions [minimum of two recipients and a maximum of 10]

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER
21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

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Amendment 2016-031
Effective 10/28/16
Supersedes 99-16
Approved 10/02/17

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/01/97
(6d)

School-Based Nursing Services

Description

Florida Medicaid certified school match program allows school districts, charter, and private schools to receive reimbursement under the Florida Medicaid program for nursing services furnished in a school setting in accordance with 42 CFR 440.60.

Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring medically necessary nursing services in the school setting.

Who Can Provide

The following licensed and/or certified practitioners rendering services through the school district, charter or private school:

- Registered nurses (RN) licensed in accordance with Chapter 464, Florida Statutes.
- Licensed practical nurses (LPN) licensed in accordance with Chapter 464, Florida Statutes.
- School health aides working under the supervision of an RN, in accordance with Chapter 464, F.S., who have completed the following courses:
 - Cardiopulmonary resuscitation (CPR)
 - First aid
 - Medication administration
 - Patient specific training

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

7/1/98
(13d)

REHABILITATIVE SERVICES (Continued)
School-Based Nursing Services by County Health Departments

County Health Departments will only provide nursing services on the school campus and in the student's home that are not reimbursable under the clinic services program. Nursing services under the rehabilitative services program include the basic nursing care students require while they are in the school or in school home-bound programs.

Medication administration will include the dispensing of the medication and necessary documentation of oral, and/or inhalator medications. A licensed registered nurse (RN) and licensed practical nurse (LPN) may administer the medication within their scope of practice.

Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice, per 42 CFR 440.130. All requirements of 42 CFR 440.130 will be met.

Services may be rendered by or under the direction of a licensed registered nurse (RN) as allowed by state licensure laws, and must be within the scope of the professional practice act.

Licensed practical nurses (LPN) may render services as allowed by state licensure laws and under the professional practice act, if under the supervision of a registered nurse.

County Health Departments will be the paid-to-provider. All of the treating providers, both RNs and LPNs will be enrolled in the Medicaid program as treating providers.

Amendment 98-12
Effective 7/1/98
Supersedes NEW
Approved 9/4/98

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

REHABILITATIVE SERVICES

School-Based Behavioral Services by County Health Departments

County Health Departments will provide behavioral services that are not reimbursable under the clinic services program, only on the school campus and in the student's home. Behavioral services under the rehabilitative services program include the behavioral health students require while they are in the school or in school home-bound programs.

Behavioral services are diagnostic testing or active treatments to be rendered with the intent to reasonably improve the individual's physical or mental condition or functioning. Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice, per 42 CFR 440.130. All requirements of 42 CFR 440.130 will be met.

Behavioral services are intervention services that focus on treatment. Behavioral services may include testing and evaluation that apprise cognitive, emotional and social functioning and self-concept; interviews and behavioral evaluations including interpretations of information about the individual's behavior and conditions relating to functioning; therapy, including providing a program of behavioral services for the individual with diagnosed behavioral problems; unscheduled activities for the purpose of resolving an immediate crisis situation; and other medically necessary services within the scope of practice. Behavioral services may be provided in either an individual or group setting.

County Health Departments will be the Medicaid pay to provider of services provided in the school setting with treating providers either employed or individually contracted. Treating providers of behavioral services must have at a minimum a Master's degree in social work from an accredited college, and work under the supervision of a licensed clinical social worker (LCSW) as required by Florida Statutes in order to obtain the work experience necessary for licensure or certification. The state agency will require County Health Departments to verify that school-based treating behavioral services providers meet provider requirements. The state Medicaid agency will require an agreement with each County Health Department to this effect and will monitor this factor. Behavioral services providers should have experience in providing services in school settings to Medicaid eligible children and must establish linkages in order to coordinate and consult with school authorities, as well as families, to assess a child's needs and identify treatment options.

Employees of the Health Department providing behavioral health services in schools will not duplicate services provided by school district employees. Health Department staff will provide services only when the need of the student exceeds the level of staff employed by the school district or is not available from school district staff.

Health Department social workers (MSW and LCSW) will provide services to all Medicaid eligible students in the school setting who are in need of such services.

Amendment 2002-02
 Effective 7/1/02
 Supersedes NEW
 Approval Date JUN 06 2002
 Revised Submission May 30, 2002
 Revised Submission June 3, 2002

**EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS
OF AGE AND TREATMENT OF CONDITIONS FOUND:**

1. Screening examinations are recommended to be scheduled in accordance with the Bright Futures/American Academy of Pediatrics Periodicity Schedule. Additional screening examinations are also available upon referral from a healthcare, developmental or educational professional, when factors suggesting the need for EPSDT are presented, or upon the request of the parent/recipient.

Amendment 2016-012
Effective 1/01/16
Supersedes 93-02
Approval 05-04-16

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS
UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

4/1/91
(10)
(12b)

2. Dental Services. A direct dental referral is required for every child, 3 years of age and older, or earlier as medically indicated to adhere to the recommendation for preventive pediatric health care as recommended by the American Academy of Pediatrics and the Committee on Practice and Ambulatory Medicines. The periodicity schedule meets the requirements of Section 1905(r) of the Act. Following the initial dental referral, subsequent examinations by a dental professional are recommended every six months or more frequently as prescribed by a dentist or other authorized provider. Orthodontic services require prior authorization to be obtained for medical necessity.

Amendment 93-02
Effective 1/1/93
Supersedes 92-35

Approval Date APR 22 1993

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS
UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

10/1/95
(6b)

3. Optometric Services: A specific periodicity schedule has been established as mandated by OBRA 1989 for vision screenings in accordance with the recommendations of the appropriate medical consultants. The schedule for screenings adhere to the Recommendation for Preventative Pediatric Health Care as recommended by the American Academy of Pediatrics and the Committee on Practice and Ambulatory Medicines. The periodicity schedule meets the requirements of Section 1905(r) of the Act.

Amendment 95-20
Effective 10/1/95
Supersedes 93-02

Approval 1-23-96

REHABILITATIVE SERVICES:

Rehabilitative services are limited to mental health and substance abuse services that are provided for the maximum reduction of the recipient's mental health and substance abuse disability and restoration to the best possible functional level. Services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Services are limited to those which are medically necessary and are recommended by a licensed practitioner of the healing arts, psychiatrist, or other physician and included in a treatment plan. Exceptions to the service limitations can be granted based on medical necessity. Service limitations for EPSDT recipients are listed in the EPSDT section.

In keeping with the 2001-2002 General Appropriations Act, certain high cost mental health procedure codes are subject to prior authorization.

To be eligible to participate in this program, providers must:

- Have a current contract pursuant to the provision of Chapter 394, Florida Statutes, for the provision of community mental health or substance abuse services from the district or regional Department of Children and Families, Alcohol, Drug Abuse and Mental Health (ADM) program office; and
- Employ or have under contract a Medicaid-enrolled psychiatrist or other physician.

In addition to the above requirements:

- Alcohol prevention, treatment, or drug abuse treatment and prevention programs must hold a regular (i.e., not probationary or interim) license as defined in Chapter 397, F.S.
- Individuals seeking enrollment as providers of comprehensive behavioral health assessments must be reviewed and certified as meeting specific provider qualifications.
- Agencies seeking enrollment as providers of comprehensive behavioral health assessments or specialized therapeutic foster care services (Level I, Level II, and Crisis Intervention) must be reviewed and certified as meeting specific provider qualifications.

Amendment 2002-04
 Effective 1/1/02
 Supersedes 90-67
 Approval MAY 21 2002

Rehabilitative Services:

Community-based Substance Abuse Services

Community-based substance abuse rehabilitative services will be available to all Medicaid eligible individuals with substance abuse disorders who are medically determined to need rehabilitative services. These services must be delivered by an agency licensed by the state to deliver substance abuse services and under contract with a county to receive county tax dollars that are certified as the state share of reimbursement for these services. These services must be recommended by a physician or other practitioner of the healing arts within the scope of his/her practice under state regulation and furnished by or under the direction of a physician or other practitioner operating within the scope of applicable state regulations, to promote the maximum reduction of symptoms of substance abuse and/or restoration of a recipient to his/her best possible functional level. The services are as follows:

Comprehensive Community Support Services for Substance Abuse

These services are designed to assist clients to strengthen and/or regain skills, to develop the environmental support necessary to help clients thrive in the community, and to aide clients in meeting life goals the promote recovery and resiliency. Services include substance abuse education, family/parenting guidance, life skills, anger/stress management, and support counseling. Services do not include meetings of Narcotics Anonymous, Alcoholics Anonymous, or other twelve-step programs.

TN No.: 06-013
Effective Date: 02/10/07
Supersedes TN No.: New
Approval Date: 08/01/07

Comprehensive Community Support Services for Substance Abuse-Bachelors Degree Level

Comprehensive community support services are medically necessary clinical aftercare services that are directed toward individuals who have received and successfully completed substance abuse treatment within a correctional or other institutional setting or a community-based program, and need continued therapeutic services to maintain their recovery as they re-enter the community. The purpose of comprehensive community support services is to provide integrative therapeutic supports and aftercare in collaboration with available and relevant ancillary medical and behavioral support services in the community to promote the receipt and effectiveness of those services. These services are based on a recovery support services model that addresses interpersonal and coping skills in home, work, and school situations and facilitates medication monitoring and symptom monitoring through therapeutic service provision. Identifying barriers that impede the development of skills necessary for independent functioning in the community will also be an integral part of these services. These out-patient services may be provided in a variety of community-based settings that are licensed by the state to provide substance abuse services. Effective after care services are comprised of the following activities: supportive and psycho-educational counseling about substance abuse disorders; specific recovery support services such as guidance in locating housing, counseling to support employment; monitoring recipient progress toward meeting goals of the aftercare plan; coordinating any necessary services with other sources and subsequently making any referrals for medically necessary services. Services must be provided by a substance abuse counselor who has knowledge of existing support services within the community. Services shall be supervised by a licensed practitioner of the healing arts or a master's level C.A.P. Reimbursement for this service is limited to 60 units per state fiscal year per recipient. Each unit must be 30 minutes in duration.

Alcohol and/or Drug Intervention Service

Alcohol and/or Drug Intervention Service is provided for the purpose of early identification of substance abuse problems and rapid linkage to needed services. This service is used to detect alcohol or other drug problems and to provide a brief intervention to arrest the progression of such problems, thereby avoiding the need for more costly and intensive levels of treatment. The intervention service is delivered on an outpatient basis in community-based settings such as licensed substance abuse providers, schools, work sites, community centers, and homes. The goal is to provide the medically necessary clinical services to minimize and ameliorate substance abuse risk factors and behaviors early in the process as an alternative to a more restrictive level of treatment. The following activities are included under this service: clinical screening and evaluation; identification and provision of medically necessary treatment needs; referral to other clinically indicated services; and ensuring referral appointments are met. Services must be delivered by a substance abuse counselor under the supervision of a licensed practitioner of the healing arts or a master's level C.A.P. Reimbursement for this service is limited to 24 units of at least 30 minutes each, per state fiscal year per recipient.

TN No.: 06-013
 Effective Date: 02/10/07
 Supersedes TN No.: New
 Approval Date: 08/01/07

Behavior Analysis Services

Description

Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to restore appropriate behaviors by decreasing maladaptive behaviors.

Who Can Receive

Behavior analysis services are available for recipients under the age of 21 years for whom BA services are recommended by a licensed physician in accordance with 42 CFR 440.130(d) and are medically necessary for the restoration of the recipient to the best possible functional level.

Who Can Provide

Services must be performed by a practitioner who meets one of the following:

- Lead Analyst
 - Licensed in accordance with state law, with training and expertise in the field of behavior analysis; or
 - Board certified behavior analysts who are credentialed by the Behavior Analyst Certification Board®
- Board certified assistant behavior analysts who are credentialed by the Behavior Analyst Certification Board® and work under the supervision of a lead analyst
- Registered behavior technicians who are credentialed by the Behavior Analyst Certification Board® and work under the supervision of a lead analyst or board certified assistant behavior analyst

Allowable Benefits

- One behavioral assessment per recipient, per fiscal year.
 - The behavior assessment is used to identify specific factors associated with the occurrence of maladaptive behaviors, functional capacity, strengths and service needs used in the development of a behavior plan.
- Up to three behavior reassessments per recipient, per fiscal year.
- Up to 40 hours of behavior analysis intervention services, per week.
 - The implementation of BA interventions and ongoing monitoring of the recipient's progress towards goals in the behavior plan
 - Behavior analysis interventions may include but are not limited to discrete trial teaching, chaining, prompting, fading, and shaping

Behavior analysis services require prior authorization from the Agency for Health Care Administration (Agency) or the Agency's designee.

In accordance with section 1905(r)(5) of the Social Security Act, services that exceed coverage may be approved, if determined medically necessary.

Exclusions

- Any procedure or physical crisis management technique that involves the use of seclusion or manual, mechanical, or chemical restraint utilized to control behaviors.

Early and Periodic Screening and Diagnosis of recipients under the age of 21 Years and
Treatment of conditions found:

4. Description

Visual aid services provide visual aids to recipients to alleviate visual impairments.

Who Can Receive

Visual aid services are available to Florida Medicaid recipients under the age of 21 years who require medically necessary visual aid services.

Who Can Provide

Practitioners certified or licensed within their scope of practice.

Allowable Benefits

- Eyeglasses
Up to two pairs per 365 days

- Contact Lenses
For limited conditions and requires prior authorization by the Agency for Health Care Administration or its designee

- In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the Agency or its designee.

Amendment 2016-007
Effective 1/01/16
Supersedes 93-02
Approval Date 06-08-16

Early and Periodic Screening and Diagnosis of recipients under the age of 21 years, and
Treatment of conditions found:

5. 11c. Description

Hearing services are designed to provide screening, assessment, testing, or corrective services to recipients in order to detect and mitigate the impact of hearing loss in accordance with Title 42, Code of Federal Regulations, section 440.110 (c).

Who Can Receive

Hearing services are available to Florida Medicaid recipients under the age of 21 years who require medically necessary hearing services.

Who Can Provide

Practitioners certified or licensed within their scope of practice:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits

- The periodicity schedule for hearing services screening adheres to the Recommendations by the American Academy of Pediatrics and the Committee on Screening and Ambulatory Medicine. The periodicity schedule also meets the requirements of Section 1905(r) of the Act. Benefits include:
 - Diagnostic audiological tests
 - Corrective services, when clinical improvement can be reasonably expected.
 - One routine hearing assessment or reassessment every three years. This limit can be exceeded based upon medical necessity.
 - Newborn and infant hearing screening up to one screening for recipients under the age of 12 months
- In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the Agency for Health Care Administration or its designee.

Amendment 2016-006
Effective 5/05/16
Supersedes 95-20
Approval 04/06/17

Early and Periodic Screening and Diagnosis of recipients under the age of 21 years, and
Treatment of conditions found:

6. 12c. Description

Hearing devices are provided to recipients in order to mitigate the impact of hearing loss.

Who Can Receive

Hearing device services are available to Florida Medicaid recipients under the age of 21 years who require medically necessary hearing services.

Who Can Provide

In accordance with section 440.120, prosthetic devices must be prescribed by a physician or other licensed practitioner of the healing arts. Practitioners certified or licensed within their scope of practice include:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Hearing aid specialists licensed in accordance with Chapter 484, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits

Hearing aid devices are available for recipients under the age of 21 years as determined medically necessary by a licensed otolaryngologist, otologist or general physician. Benefits include:

- BAHA up to one per ear with prior authorization by the Agency for Health Care Administration (AHCA) or its designee
 - Cochlear implants up to one per ear with prior authorization by the AHCA or its designee
 - Repairs and replacements of implant external parts after the one year warranty period has expired
-
- In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the AHCA or its designee.

Amendment 2016-006
Effective 5/05/16
Supersedes 93-02
Approval 04/06/17

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS
UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

7/1/98
(6d)

Respiratory Services

Medicaid recipients under the age of 21 may receive medically necessary respiratory therapy services which are reimbursable to Medicaid enrolled providers. Services must be prescribed in writing by the recipient's primary care physician (or designated physician assistant or advanced registered nurse practitioner) or a designated MD specialist. Services must be provided by a registered respiratory therapist who is licensed by the state of Florida, has met the requirements of 42 CFR 440.60 and has been enrolled as a Medicaid provider. The registered respiratory therapist must administer treatment according to the primary care provider's specific approved written plan of care and written prescription. Florida allows all eligible licensed registered respiratory therapists to enroll as providers to ensure freedom of choice of providers in accordance with 42 CFR 440.70.

Reimbursement for one evaluation or re-evaluation per recipient is allowed every six months. Respiratory therapy visits must be a minimum of fifteen (15) minutes in duration with reimbursement available for a maximum of two individual treatment sessions per day. Exceptions to these limitations may be made based on medical necessity.

Therapy treatments are subject to prior authorization.

Amendment 03-23
Effective 10/1/03
Supersedes 98-14

Approval DEC 23 2003

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS
UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

Home Health Services

3/1/97
(7d)

Therapy services provided are occupational, physical, and speech. For these therapies, a maximum of two individual treatment sessions are allowed per recipient per day with each treatment session being a minimum of 15 minutes. Services must be prescribed in writing by the recipient's attending physician. The attending physician is the doctor in charge of the recipient's medical condition that causes the recipient to need home health services.

One evaluation or re-evaluation per recipient is allowed every six months. Exceptions to the service limitations can be granted based on medical necessity. Services must be provided through a licensed home health agency or a facility licensed by the state to provide medical rehabilitative services. Florida allows all eligible providers to enroll as Home Health Agencies, to ensure freedom of choice of providers in accordance with 42 CFR 440.70.

Amendment 97-05
Effective 3/1/97
Supersedes 96-06

Approval 9/22/97

Revised Submission 8/29/97

Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found

Home Health Nursing Visits

(7a) Description

Home health nursing services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health nursing services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health nursing services are available to recipients under the age of 21 years who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for up to four intermittent home health nursing visits, per day, when prior authorized by the Agency for Health Care Administration (Agency) or its designee.

The four visit limit is a combined limit for both home health nursing and home health aide services.

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary when prior authorized by the Agency or its designee.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facility for individuals with intellectual disabilities
 - Nursing facilities
 - Prescribed pediatric extended care centers

- Residential facilities or assisted living facilities when the services duplicate those provided by the facility

Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found

Home Health Aide Visits

(7b) Description

Home health aide services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health aide services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health aide services are available to recipients under the age of 21 years who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for up to four intermittent home health visits, per day, when prior authorized by the Agency for Health Care Administration (Agency) or its designee.

The four visit limit is a combined limit for both home health nursing and home health aide services.

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary when prior authorized by the Agency or its designee.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facility for individuals with intellectual disabilities
 - Nursing facilities

- Prescribed pediatric extended care centers
- Residential facilities or assisted living facilities when the services duplicate those provided by the facility

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER
21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

(24f) Description

9 Personal care services provide medically necessary assistance, in the home or the community, with activities of daily living (ADL) and age appropriate instrumental activities of daily living (IADL) to enable recipients to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability. Personal care services are provided in accordance with 42 Code of Federal Regulations 440.167.

Who Can Receive

Personal care services are available to recipients under the age of 21 years who require medically necessary personal care services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Independent personal care providers who:
 - Are 18 years or older.
 - Are trained in the areas of cardiopulmonary resuscitation, HIV/AIDS, and infection control.
 - Have at least one year of experience working in a medical, psychiatric, nursing or child care setting or working with recipients who have an intellectual disability. College, vocational, or technical training in medical, psychiatric, nursing, child care, or intellectual disabilities equal to 30 semester hours, 45 quarter hours, or 720 classroom hours can be substituted for the required experience.

Allowable Benefits

Personal care services are reimbursed for up to 24 hours per day, per recipient, in order to provide assistance with ADLs and age appropriate IADLS when the recipient meets the following criteria:

- Is under the care of a physician and has a physician's order for personal care services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community
- Has a medical condition or disability that substantially limits their ability to perform ADLs or IADLs and does not have a parent or legal guardian able to provide the required care

In accordance with section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a), services that exceed coverage may be approved, if determined medically necessary. The provider is required to obtain prior authorization from the Agency or its designee.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient. (Except when a recipient is enrolled in the Consumer-Directed Care Plus program)
- Services provided in any of the following locations:
 - Hospitals
 - Institutions for Mental Disease (IMDs)
 - Intermediate care facility for individuals with intellectual disabilities
 - Nursing facilities
 - Prescribed pediatric extended care centers
 - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS
UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

PRIVATE DUTY NURSING SERVICES

Description

Private duty nursing services provide care to recipients whose medical condition, illness, or injury requires the care to be delivered in the home or community setting. Private duty nursing services are provided in accordance with 42 Code of Federal Regulations 440.80.

Who Can Receive

Private duty nursing services are available to recipients under the age of 21 years who require medically necessary private duty nursing services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Independent licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Independent registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Private duty nursing services are authorized for up to 24 hours per recipient, per day and must be prior authorized by the Agency for Health Care Administration or its designee.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS
UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/98
(11)

Therapy Services

Services must be prescribed in writing by the recipient's primary care provider (or designated physician assistant or advanced registered nurse practitioner) or a designated MD specialist. One evaluation or re-evaluation per recipient is allowed every six months. Exceptions to the service limitations can be granted based on medical necessity. All therapists must meet the requirements of 42 CFR 440.110.

Medically necessary occupational, physical and speech therapy services may be provided for recipients under 21 years of age. Therapy sessions administered to recipients on an individual basis must be a minimum of 15 minutes in duration with reimbursement available for a maximum of two individual treatment sessions per day. Speech therapy may also be administered in group sessions, provided that the group contains a maximum of six children, for a minimum of thirty (30) minutes per group. Therapy sessions are subject to prior authorization.

Evaluations for Augmentative and Alternative Communication (AAC) systems must be conducted and documented by the speech therapist. An initial evaluation as well as a follow-up evaluation upon delivery of the system are required to ensure appropriateness of the unit. Re-evaluation of both the unit and the user is required every six months. One initial AAC evaluation is allowed every three (3) calendar years. The follow-up/re-evaluations are limited to two (2) per calendar year. Exceptions to these limitations may be made based on medical necessity.

Fitting/adjustment/training sessions for AAC systems are limited to eight (8) 30 minute sessions per year, per device. Exceptions to these limitations may be made based on medical necessity.

Amendment 03-23
Effective 10/1/03
Supersedes 97-21

Approval

~~DEC 23 2003~~

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS
UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/93
(12c)

12. Services for prosthetic and orthotic devices must be service authorized by the state agency and approved based on medical necessity. Prosthetic eyes are limited to one initial prosthetic eye for each eye per individual. Exceptions are granted based on medical necessity. Examples of medically necessary replacements are that the prosthetic eye is no longer the appropriate size or the eye has been inadvertently damaged, destroyed or stolen.

Amendment 93-03
Effective 1/1/93
Supersedes 93-02

Approval Date AUG 4 1993

Revised Submission 7/20/93

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS
UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

Home Health Services

3/1/97
(7c)

Medical supplies and durable medical equipment must be prescribed in writing by the recipient's primary care provider or a designated MD specialist and are limited to the items listed in the agency's provider handbook. Exceptions can be granted based on medical necessity.

Amendment 97-05
Effective 3/1/97
Supersedes 93-05

Approval 9/22/97

Revised Submission 8/29/97

EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS
UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

1/1/94

14. Chiropractic Services: Chiropractic services are limited to twenty-four visits within a calendar year. Exceptions to the service limitations can be granted based on medical necessity.

Amendment 94-01
Effective 1/1/94
Supersedes 93-02

Approval JUN 17 1994

1. INPATIENT HOSPITAL SERVICES OTHER THAN THOSE PROVIDED IN AN INSTITUTION FOR MENTAL DISEASE:

Description

Inpatient hospital services may be provided in accordance with 42, Code of Federal Regulations 440.10. Inpatient hospital services for all ages require authorization from the Agency or the Agency's designee, with the exception of emergency services.

Who Can Receive

Recipients enrolled on the date of service and requiring medically necessary inpatient hospital services.

Who Can Provide

Services must be performed by a facility that meets state requirements for licensure as an inpatient hospital.

Allowable Benefits

- Up to 365/6 days per fiscal year for recipients under the age of 21 years
- Up to 45 days per fiscal year for recipients age 21 years of age or older

Inpatient hospital services beyond the 45 day limit can be reimbursed with prior authorization when medically necessary, for emergency services, or for the treatment of tuberculosis.

Sterilization and abortion procedures, which meet federal requirements, can be reimbursed.

Amendment 2016-014
Effective 4/01/16
Supersedes 2011-015
Approval 01/05/17

OUTPATIENT HOSPITAL SERVICES: Pursuant to Florida Statutes, services are limited to a maximum of \$1,500 for non-EPSDT recipients 21 years of age and over per fiscal year. There is no limitation for EPSDT recipients. To best serve the needs of Florida's Medicaid population, the Agency has exempted the following services from the \$1500 limitation: emergencies, outpatient surgeries, and life sustaining treatments such as chemotherapy and dialysis.

Amendment: 05-001
Effective: 01/01/05
Supersedes: 2000-05
Approved: 05/20/05

7/1/92
(23e)

EMERGENCY HOSPITAL SERVICES: Same limitations as for
Outpatient or Inpatient Hospital Services.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval Date APR 22 1993

FAMILY PLANNING

4/1/2001
(4c)

An initial/annual family planning visit is limited to one per year and a supply visit is limited to one every month. Sterilizations are limited to recipients who meet the requirements of 42 CFR 441.253.

HIV testing and counseling are limited to four per year for recipients acknowledging HIV risks.

HIV testing and counseling are limited to two per lifetime for preventive measures.

Amendment 2001-05
Effective 4/1/2001
Supersedes 98-26

Approval JUN 27 2001

PHYSICIAN SERVICES

Description

Physician services are provided to maintain the recipient's health, prevent disease, and treat illness, in accordance with 42 CFR 440.

Who Can Receive

An eligible recipient, enrolled on the date of service, and requiring a medically necessary physician service.

Who Can Provide

Physicians licensed within their scope of practice to perform this service.

Allowable Benefits

- Health screenings for recipients under the age of 21 years in accordance with the American Academy of Pediatrics periodicity schedule.
- Office visits as medically necessary for recipients under the age of 21 years and pregnant recipients age 21 years and older.
- Up to two primary care office visits per month for recipients age 21 years and older.
- Up to one evaluation and management visit per month, per recipient in a custodial care or nursing care facility.
- Up to one adult health screening every 365 days for recipients age 21 years and older.

*Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity.

1/1/91
(6a)

PODIATRISTS: Limits visits outside the hospital to not more than one per recipient per day per podiatrist not to exceed two visits per month (except for emergencies) and one per recipient per month per podiatrist upon referral from the recipient's attending physician in long term care facilities (except for emergencies). One hospital visit per day per recipient per provider is allowed. A visit is not allowed on the same day as a surgical procedure unless it is indicated by an asterisk in the provider handbook. All elective surgical procedures require prior authorization or an EPSDT referral to determine medical necessity. Excludes routine foot care unless medically indicated (ex., allowed for diabetics), also excludes experimental and clinically unproven surgical procedures.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval Date APR 22 1993

10/1/97
6b)

Optometric Services

For non-EPSDT recipients twenty-one years of age and older, visual examinations are limited to two per year per recipient for the purpose of determining the refractive powers of the eyes. Exception authorization for any service limitation may be made by the state agency based on medical necessity. Service limitations for EPSDT recipients are listed in the EPSDT section.

Amendment 97-17
Effective 10/1/97
Supersedes 93-02

Approval 4/20/98

1/1/95
(6c)

CHIROPRACTIC SERVICES: Visits to a chiropractor are limited to twenty-four visits within a calendar year. Nursing home and ICF/DD residents require a referral from a physician (M.D. or D.O.). Service limitations for EPSDT recipients are listed in the EPSDT section.

Amendment 95-05
Effective 1/1/95
Supersedes 94-01

Approval 4/26/95

ADVANCED REGISTERED NURSE PRACTITIONER SERVICES

(6d) Description

Advanced registered nurse practitioner services are provided to maintain the recipient's health, prevent disease, and treat illness, in accordance with 42 CFR 440.60.

Who Can Receive

An eligible recipient enrolled on the date of service, and requiring a medically necessary medical service.

Who Can Provide

Advanced registered nurse practitioners licensed within their scope of practice to perform this service.

Allowable Benefits

- Health screenings for recipients under the age of 21 years in accordance with the American Academy of Pediatrics periodicity schedule.
- Office visits as medically necessary for recipients under the age of 21 years and pregnant recipients age 21 years and older.
- Up to two primary care office visits per month for recipients age 21 years and older.
- Up to one evaluation and management visit per month, per recipient in a custodial care or nursing care facility.
- Up to one adult health screening every 365 days for recipients age 21 years and older.

Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity.

Amendment 2016-022
Effective 8/15/16
Supersedes 2012-014
Approval 10-12-16

Home Health Nursing Visits

(7a) Description

Home health nursing services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health nursing services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health nursing services are available to recipients age 21 years and older who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for the following when prior authorized by the Agency for Health Care Administration or its designee:

- Up to four intermittent home health visits, per day, for pregnant recipients
- Up to three intermittent home health visits, per day, for non-pregnant recipients

The three and four visit limits are a combined limit for both home health nursing and home health aide services.

Service limitations for Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions (EPSDT) recipients are listed in the EPSDT section.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facility for individuals with intellectual disabilities
 - Nursing facilities
 - Prescribed pediatric extended care centers
 - Residential facilities or assisted living facilities when the services duplicate those provided by the facility

Home Health Aide Visits

(7b) Description

Home health aide services provide care to recipients whose medical conditions, illness, or injury require the care to be delivered in the recipient's place of residence or other community setting. Home health aide services are provided in accordance with Title 42, Code of Federal Regulations 440.70.

Who Can Receive

Home health aide services are available to recipients age 21 years and older who require medically necessary home health visit services.

Who Can Provide

- Home health agencies licensed in accordance with section 408.810, Florida Statutes (F.S.), and Rule Chapter 59A-8, Florida Administrative Code.
- Licensed practical nurses licensed in accordance with Chapter 464, F.S.
- Registered nurses licensed in accordance with Chapter 464, F.S.

Allowable Benefits

Florida Medicaid reimburses for the following when prior authorized by the Agency for Health Care Administration or its designee:

- Up to four intermittent home health visits, per day, for pregnant recipients
- Up to three intermittent home health visits, per day, for non-pregnant recipients

The three and four visit limits are a combined limit for both home health nursing and home health aide services.

Service limitations for Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions (EPSDT) recipients are listed in the EPSDT section.

Exclusions

Florida Medicaid does not reimburse for the following:

- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02, F.S., household members, or any person with custodial or legal responsibility for the recipient
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facility for individuals with intellectual disabilities
 - Nursing facilities

- Prescribed pediatric extended care centers
- Residential facilities or assisted living facilities when the services duplicate those provided by the facility

Coverage Template for Freestanding Birth Center Services

Attachment 3.1A: Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ↑ **No limitations** With limitations ↑ None licensed or approved

Florida Medicaid birth centers provide prenatal and delivery services for recipients expected to experience a medically low risk pregnancy and delivery.

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ↑ No limitations **With limitations (please describe below)**

↑ Please describe any limitations: Florida Medicaid limits prenatal visits to a maximum of 10 visits provided in a licensed birth center to a recipient expected to experience a low-risk pregnancy and delivery, however, additional visits may be provided based on medical necessity in a medically appropriate setting.

Please check all that apply:

(a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

(b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

↑ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: Florida Licensed Midwives

Amendment: 2011-005
Effective: July 1, 2011
Approved: 08-22-14
Supersedes: 93-61

10/1/93 CLINIC SERVICES: Ambulatory Surgical Centers

For ambulatory surgical centers, services are limited to those procedures which can be safely done outside of the inpatient hospital setting as determined by Medicare and the state agency policy.

Amendment 93-61
Effective 10/1/93
Supersedes NEW

Approval FEB 18 1994

1/1/93

CLINIC SERVICES: County Public Health Units

For county public health units, services are limited to one clinic encounter per recipient, per day, per provider for preventive or primary care.

Amendment 93-61
Effective 10/1/93
Supersedes NEW

Approval

FEB 18 1994

7/1/98 CLINIC SERVICES: Freestanding Dialysis Center Services

Services are limited to one hemodialysis treatment per recipient, per day, up to three times per week provided by a freestanding dialysis center.

Peritoneal dialysis treatments occur as medically indicated and all care is coordinated by the freestanding dialysis center.

All dialysis treatments include: supervision, management, and training of the dialysis treatment routine, durable and disposable medical supplies, equipment, laboratory tests, support services, parenteral drugs and applicable drug categories (including substitutions) provided by and at the freestanding dialysis center.

Amendment 2015-003
Effective 04/01/15
Supersedes 98-19
Approval 9/1/15

(10)
(12.b) DENTAL SERVICES: For non-EPSDT recipients twenty-one years of age and older, services that are provided in accordance with 42 CFR 440.100 and 440.120(b) are limited to:

a. Dentures. The dental services provided are limited to procedures related to dentures and those procedures necessary to seat the dentures. The recipient is limited to either a complete upper denture, a complete lower denture, or one complete set of dentures per lifetime. Replacement of broken or lost dentures is excluded from coverage. Repairs of dentures are covered services. Adjustments and relines are covered after three months for immediate dentures and six months for non-immediate dentures from the date service.

b. Partial Dentures. The dental services provided are limited to the fabrication, repair, reline and adjustment of a removable partial denture. The recipient is limited to either an upper partial, a lower partial, or one set of partials per lifetime. Replacement of a broken or lost partial is excluded from coverage. Adjustments and relines are covered up to six months after original seating of partial. Repairs of partial dentures are covered.

c. Oral and maxillofacial surgery for injury or disease when provided by a qualified oral surgeon (dentist).

d. Emergency dental services are medically necessary emergency procedures to relieve pain or infection. The services are limited to emergency oral examinations, necessary radiographs, extractions, and the incision and drainage of an abscess.

Dental services limitations for EPSDT recipients, provided in accordance with 42 CFR 441.56, are listed in the EPSDT section.

TN No.: 06-004
Supersedes
TN No.: 04-018

Approval Date: 09/05/06

Effective Date: 07/01/06

For non-Early and Periodic Screening and Diagnosis recipients 21 years of age and older:

11c. Description

Hearing services are designed to provide screening, assessment, testing, and corrective services to recipients in order to detect and mitigate the impact of hearing loss in accordance with Title 42, Code of Federal Regulations, section 440.110 (c).

Who Can Receive

Hearing services are available to Florida Medicaid recipients 21 years of age or older who require medically necessary hearing services.

Who Can Provide

Practitioners certified or licensed within their scope of practice:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits

- Diagnostic audiological tests
- Corrective services, when clinical improvement can be reasonably expected.
- One routine hearing assessment or reassessment every three years. This limit can be exceeded when medically necessary.

Service limitations for recipients under the age of 21 years are listed in the Early and Periodic Screening Diagnosis and Treatment section.

Amendment 2016-006
Supersedes 06-05
Effective Date: 5/05/16
Approved: 04/06/17

For non-Early and Periodic Screening and Diagnosis recipients 21 years of age and older:

12c. Description

Hearing devices are provided to recipients in order to mitigate the impact of hearing loss.

Who Can Receive

Hearing device services are available to Florida Medicaid recipients 21 years of age or older who require medically necessary hearing services.

Who Can Provide

In accordance with section 440.120, prosthetic devices must be prescribed by a physician or other licensed practitioner of the healing arts. Practitioners certified or licensed within their scope of practice include:

- Audiologists licensed in accordance with Chapter 468, F.S.
- Hearing aid specialists licensed in accordance with Chapter 484, F.S.
- Physicians licensed in accordance with Chapter 458 or 459, F.S., with a specialty in otolaryngology or otology
- Audiology assistants or provisionally licensed individuals directly supervised by a federally qualified and Florida-licensed audiologist

Allowable Benefits

- BAHA up to one per ear with prior authorization by the Agency for Health Care Administration (AHCA) or its designee
- Cochlear implants up to one per ear with prior authorization by the AHCA or its designee
- Repairs and replacements of implant external parts after the one year warranty period has expired.

Service limitations for recipients under 21 years are listed in the Early and Periodic Screening Diagnosis and Treatment section.

Amendment 2016-006
Supersedes 06-005
Effective Date: 5/05/16
Approved: 04/06/17

For non-Early and Periodic Screening and Diagnosis Recipients 21 years of age and older:

12d. Description - Eyeglasses

Visual aid services provide visual aids to recipients to alleviate visual impairments.

Who Can Receive

Visual aid services are available to Florida Medicaid recipients 21 years of age or older who require medically necessary visual aid services.

Who Can Provide

Practitioners certified or licensed within their scope of practice:

- Optometrist and certified optometrist licensed in accordance with Chapter 463, F.S.
- Ophthalmologist licensed in accordance with Chapter 458, F.S.
- Optician licensed in accordance with Chapter 484, F.S.

Allowable Benefits

- Eyeglasses
Up to one frame every two years
Up to two lenses every 365 days
- Additional eyeglass frames, lenses, pairs of glasses, and special order frames may be provided with prior authorization by the Agency for Health Care Administration (Agency) or its designee.
- Contact Lenses

For limited conditions and requires prior authorization by the Agency for Health Care Administration or its designee.

- Prosthetic eyes and services related to measuring, fitting, and dispensing.

Service limitations for EPSDT recipients are listed in the EPSDT section.

Amendment 2016-007
Effective 1/01/16
Supersedes 2009-027
Approval: 06/08/16

7/1/97

TRANSPORTATION: Excludes the provision of transportation by ambulance for ambulatory patients; ambulance services to a physician's private office; transportation to pharmacies; and transportation of nursing home patients to a physician's private office to fulfill utilization control requirements.

Transportation to and from school is allowed for students who are eligible under the provisions of Parts B and H of the Individuals with Disabilities Education Act (I.D.E.A.) and receive Medicaid reimbursable services listed in their Individual Education Plans (IEP) or Family Support Plans (FSP) at the school site on the date transportation is provided. Transportation service must be listed as a required service in the IEP or FSP.

Amendment 97-10
Effective 7/1/97
Supersedes 93-02

Approval 9/18/97

10/1/89 HOSPICE: Benefit periods are the same as those established by Medicare.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval Date APR 22 1993

7/1/98 OTHER PRACTITIONERS SERVICES

(6d) RESPIRATORY THERAPY: Services are available for non-EPSDT recipients 21 years of age and older in the outpatient and inpatient hospital settings and in nursing facilities. Refer to the EPSDT section for EPSDT limitations.

Amendment 98-14
Effective 7/1/98
Supersedes NEW

Approval 10/12/98

PERSONAL CARE SERVICES:

(23f) Description

Personal care services are not available for non-EPDST recipients 21 years of age and older. Service limitations for EPDST recipients are listed in the EPDST section.

10/1/90
(8)

PRIVATE DUTY NURSING SERVICES: No services are available for non-EPSDT recipients 21 years of age and older. Refer to the EPSDT section for EPSDT limitations.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval Date APR 22 1993

1/01/2003 THERAPIES

- (11a) Physical Therapy: Services are available for non-EPSDT recipients 21 years of age and older in the outpatient and inpatient hospital settings and in nursing facilities, and in community settings for the provision of wheelchair evaluations, re-evaluations, and fittings. Refer to the EPSDT section for EPSDT limitations.
- (11b) Occupational Therapy: Services are available in nursing facilities for non-EPSDT recipients 21 years of age and older, and in community settings for the provision of wheelchair evaluations, re-evaluations, and fittings. Refer to the EPSDT section for EPSDT limitations.
- (11c) Speech Therapy: Services are available in nursing facilities for non-EPSDT recipients 21 years of age and older. In addition, for non-EPSDT recipients 21 years of age and older, one initial evaluation for Augmentative and Alternative Communication (AAC) systems and eight (8) 30-minute fitting/adjustment/training sessions for AAC systems are available per person, per device, per year. Refer to the EPSDT section for EPSDT limitations.

Amendment 2003-03
Effective 1/01/2003
Supercedes 98-14
Approved 05/30/03

Nurse Midwives

7/1/2011

Nurse Midwives provide services to recipients with medically low risk pregnancies for prenatal, delivery and postpartum care, within their scope of practice under State law.

Amendment: 2011-005
Effective: 7/1/2011
Supersedes: 95-25
Approval: 08-22-14

EXTENDED SERVICES FOR PREGNANT WOMEN

4/1/93

The same services that are offered to any categorically needy recipient, as described in Attachment 3.1-A, are available to women for 60 days after the pregnancy ends. No additional coverage beyond what is provided to the general categorically needy recipient is provided and the group receiving services under this provision are subject to the same service limitations as the general categorically needy recipients as outlined in Attachment 3.1-A.

Ten prenatal obstetrical visits to low risk pregnant women and fourteen visits to high risk pregnant women are provided. Additional visits can be authorized if the Medicaid program medical consultant finds the additional visits medically necessary.

Amendment 93-21
Effective 4/1/93
Supersedes 93-02

Approval SEP 20 1993

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Effective 10/1/95

Supersedes 93-02
Amendment 2016-022
Effective 8/15/16
Supersedes 95-26
Approval 10-12-16

PRESCRIBED DRUGS:Covered Legend Drugs:

Covered outpatient drugs are those produced by any manufacturer that has entered into and complies with an agreement under Section 1927(a) of the Act, and which are prescribed for a medically accepted indication. Drugs must be prescribed and dispensed in accordance with medically accepted indications for uses and dosages.

Coverage for immunizations is limited to the following recipients who are not covered by Medicare Part D:

- Influenza and pneumococcal vaccine for institutionalized recipients; and
- Herpes Zoster (Shingles) vaccine for institutionalized recipients.

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B as provided by Section 1935(d)(1) of the Act.

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

As provided by Section 1927(d)(2) of the Act, certain outpatient drugs may be excluded from coverage. Those excluded are DESI drugs; experimental drugs; anorectics (unless prescribed for an indication other than obesity); non-legend drugs (except as specified below), aspirin, aluminum and calcium products used as phosphate binders, sodium chloride for specific medical indications; and any drugs for which the manufacturer has not entered into rebate agreements with the Department of Health and Human Services, the Veteran's Administration and the Public Health Service.

As provided by Section 1935(d)(2) of the ACT:

- The following excluded drugs are covered:**
- (a) agents when used for anorexia, weight loss, weight gain
 - None of the drugs under this drug class are covered*
 - (b) agents when used to promote fertility
 - None of the drugs under this drug class are covered*
 - (c) agents when used for cosmetic purposes or hair growth
 - None of the drugs under this drug class are covered*
 - (d) agents when used for the symptomatic relief cough and colds
 - Some drugs categories covered under the drug class*

Amendment 2022-0002
 Effective 1/1/2022
 Supersedes 2014-002
 Approved 04/26/2023

- Legend cough and cold preparations, including antitussives, decongestants, and expectorants are covered for recipients under the age of 21 years.
 - Legend or OTC single entity guaifenesin products are covered for recipients under the age of 21 years.
-
- (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride.
 - Some drug categories covered under the drug class*
 - Legend vitamin and mineral products are covered for dialysis patients.
 - (f) nonprescription drugs
 - Selective OTC drugs will be covered as listed on the State's website.
 - (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
 - None of the drugs under this drug class are covered*

Drug Rebate Agreement: The state is in compliance with Section 1927 of the Act. Based on the requirements for Section 1927 of the Act, the state has the following policies for drug rebate agreements:

- The drug file permits coverage of participating manufacturers' drugs.
- Compliance with the reporting requirements for state utilization information and restrictions to coverage.

Amendment 2022-0002
Effective 1/1/2022
Supersedes 2014-002
Approved 04/26/2023

- A supplemental rebate agreement, Version 05/20/2013, between the state and a drug manufacturer that is separate from the drug rebate agreements of Section 1927 is authorized by the Centers for Medicare and Medicaid Services. The agreement to be used between the State of Florida and drug manufacturers for supplemental rebates for drugs provided to the Medicaid population has been reviewed and authorized by the Centers for Medicare and Medicaid Services. The state reports rebates from separate agreements to the Secretary for Health and Human Services. The state will remit the federal portion of any cash state supplemental rebates collected.
- Manufacturers are allowed to audit utilization data.
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.
- Prior authorization programs provide for a 24-hour turn-around on prior authorization from receipt of a completed request, and at least a 72-hour supply in emergency situations.

Amendment 2013-007
Effective 08/01/2013
Supersedes 2013-001
Approved 9-10-13

13c **Preventive Services:**

10/1/09 Licensed Medicaid providers practicing within their scope of practice will administer the H1N1 influenza vaccine to adult recipients age 21 and over, following recommendations by the Centers for Disease Control and Prevention.

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Amendment 2016-022
Effective 8/15/16
Supersedes 95-26
Approval 10-12-16

Federally Qualified Health Center Services

Services provided in a federally qualified health center are limited to one medical, one dental, and one mental health visit per day, per recipient. Exceptions will be granted based on medical necessity. For example, a recipient seen at a federally qualified health center who subsequently experiences an accident or his condition worsens, may seek the necessary additional medical care from the federally qualified health center on the same day.

Amendment 2012-012
Supersedes 92-39
Effective 12/06/2012
Approval 03-11-13

Other Laboratory Services

The recipient must be referred by a physician or other practitioner of the healing arts and the services must be performed in a Clinical Laboratory Improvement Amendment of 1988 (CLIA) certified independent laboratory.

Amendment 92-40
Supersedes NEW
Effective 10/1/92
Approval JUL 30 1993

Other X-Ray Services

The service must be ordered by a physician or other practitioner of the healing arts and must be provided in either:

- (1) a physician's office, including an independent, private, diagnostic x-ray facility; or
- (2) if the recipient is homebound, at the recipients' residence, including an ICF/MR or nursing home.

Amendment 92-40
Supersedes NEW
Effective 10/1/92
Approval JUL 30 1993
Revised Submission 5/20/93

Licensed Midwives

7/1/2011

Licensed Midwives provide services to recipients with medically low risk pregnancies for prenatal, delivery and postpartum care, within their scope of practice under State law.

Amendment: 2011-005
Effective: 7/1/2011
Supersedes: 97-09
Approval: 08-22-14

PHYSICIAN ASSISTANT SERVICES

(6d) Description

Physician assistant services are provided to maintain the recipient's health, prevent disease, and treat illness, in accordance with 42 CFR 440.60.

Who Can Receive

An eligible recipient enrolled on the date of service, and requiring a medically necessary medical service.

Who Can Provide

Physician assistants licensed within their scope of practice to perform this service.

Allowable Benefits

- Health screenings for recipients under the age of 21 years in accordance with the American Academy of Pediatrics periodicity schedule.
- Office visits as medically necessary for recipients under the age of 21 years and pregnant recipients age 21 years and older.
- Up to two primary care office visits per month for recipients age 21 years and older.
- Up to one evaluation and management visit per month, per recipient in a custodial care or nursing care facility.
- Up to one adult health screening every 365 days for recipients age 21 years and older.

Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity.

Amendment 2016-022
Effective 8/15/16
Supersedes 2012-014
Approval 10-12-16

7/1/97
(6d)

REGISTERED NURSE FIRST ASSISTANT:

Assistant at surgery fees are limited to surgical codes that allow an assistant surgeon.

Amendment 97-08
Effective 7/1/97
Supersedes NEW
Approval 0/25/97

State/Territory: Florida**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED****MEDICALLY NEEDY GROUP(S)****30. Coverage of Routine Patient Cost in Qualifying Clinical Trials**

*The state needs to check each assurance below.

Provided: X

I. General Assurances:**Routine Patient Cost – Section 1905(gg)(1)**

X Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

X A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

X A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN: 22-0003
Supersedes TN: NEW

Approval Date: 04/28/2022
Effective Date: 01/01/2022