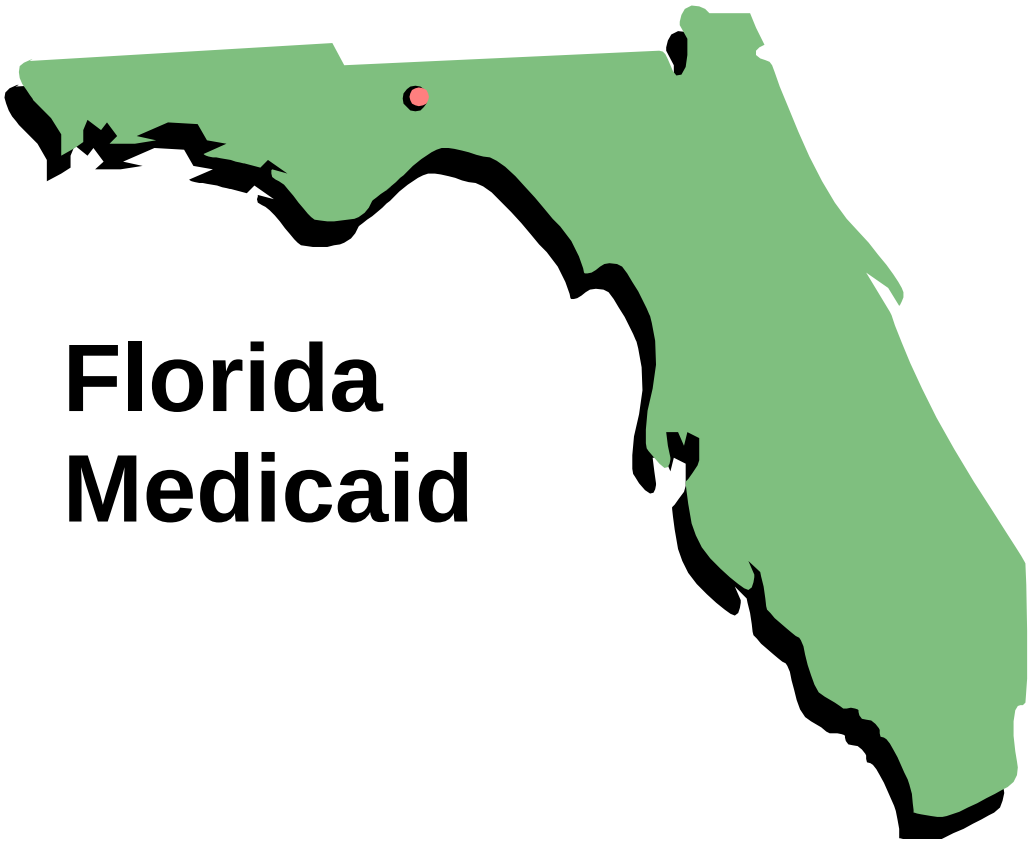

Florida Medicaid

Respiratory System Services Coverage Policy

Agency for Health Care Administration

June 2016

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1.0 Introduction

1.1 Description

Florida Medicaid provides evaluation, diagnostic, therapeutic, and surgical services for disorders of the respiratory system.

1.1.1 Florida Medicaid Policies

This policy is intended for use by providers that render respiratory system services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml,

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of respiratory system services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in AHCA's contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Respiratory system services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Parts 440 and 441
- Section 409.905, Florida Statutes (F.S.)
- Rule 59G-4.235, F.A.C.

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.4 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.5 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.6 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary respiratory services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, Florida Medicaid reimburses for services for recipients of all ages.

2.3 Coinsurance, Copayment, or Deductible
Recipients are responsible for the following copayment, unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For information on copayment requirements and exemptions, please refer to Florida Medicaid's copayment and coinsurance policy:

- $2.00 per practitioner office visit, per day
- $3.00 per federally qualified health center visit, per day
- $3.00 per rural health clinic visit, per day

3.0 Eligible Provider

3.1 General Criteria
Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

- Practitioners licensed within their scope of practice to perform this service
- County health departments administered by the Department of Health, in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Rural health clinics certified by Medicare

4.0 Coverage Information

4.1 General Criteria
Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid reimburses for the following services in accordance with the American Medical Association Current Procedural Terminology and the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

- Respiratory surgical services
- Pulmonary diagnostic testing and therapies
- Ventilator management
- Physician review and interpretation of home apnea monitoring for recipients under the age of two years who meet at least one of the following criteria:
  - Biological sibling of a sudden infant death syndrome victim
  - Birth weight of 1,500 grams (3.3 pounds) or less
  - Diagnosed with clinically significant apnea with breathing cessation for 20 seconds or longer, or an absence of breathing for any length of time accompanied by a decrease in heart rate (bradycardia)

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Physician review and interpretation of home apnea monitoring after three continuous months of normal results without continued authorization
- Physician review and interpretation services when the recipient has less than 20 hours of home apnea monitoring results in a 24 hour period
- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

6.2 Specific Criteria

Providers must maintain documentation of the number of hours and days that the recipient used the home apnea monitor.

7.0 Authorization

7.1 General Criteria
The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For more information on general authorization requirements, please refer to Florida Medicaid's authorization requirements policy.

7.2 Specific Criteria
Providers must obtain authorization from the quality improvement organization for home apnea monitoring review and interpretation services and to continue services after three continuous months of normal results.

8.0 Reimbursement

8.1 General Criteria
The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Claim Type
Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit
Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.3.1 Approved Modifiers
Providers must include the following modifiers, as appropriate, on the claim form:

- 26 Professional component performed by a different provider than the technical component.
- TC Technical component performed by a different provider than the professional component.

Providers may not include both the TC and 26 modifier for a single procedure on the claim form.

8.4 Diagnosis Code
Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate
For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit the Agency for Health Care Administration's Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.5.1 Global Surgery Package
Florida Medicaid reimbursement includes all necessary services normally furnished by a surgeon before, during, and after a procedure in accordance with the Centers for Medicare and Medicaid Services' global surgery period specifications.

For more information, see the CMS Web site at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

8.5.2 Enhanced Reimbursement Rate
Florida Medicaid reimburses pediatric surgery and urological specialty enrolled providers at the enhanced rate when indicated on the fee schedule.