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Florida Medicaid  
Neurology Services Coverage Policy
1.0 Introduction
Florida Medicaid neurology services provide for the diagnosis and treatment of diseases and disorders of the nervous system.

1.1 Florida Medicaid Policies
This policy is intended for use by providers that render neurology 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.


1.2 Statewide Medicaid Managed Care Plans
Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority
Neurology services are authorized by the following:
- Title XIX, Section 1861(r)(l) of the Social Security Act
- Title 42, Code of Federal Regulations (CFR), Parts 440 and 441
- Section 409.905, Florida Statutes (F.S.)

1.4 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 Coverage Policy.

1.4.1 Claim Reimbursement Policy
A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.4.2 Coverage and Limitations Handbook or Coverage Policy
A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

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

1.4.4 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.

1.4.5 Provider
The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.6 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 neurological services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance, Copayment, or Deductible
Recipients are responsible for the following copayment, in accordance with section 409.9081, F.S., 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 Copayments and Coinsurance Coverage 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 meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid neurology services.

3.2 Who Can Provide
Services must be rendered by one of the following:

- Practitioners licensed in accordance with Chapters 458, 459, or 464, F.S. and working within their scope of practice
- 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 covers 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 covers 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:

- Autonomic function testing
- Electrocochleogram
- Electrodiagnostics, including nerve conduction studies and electromyography
- Electroencephalograph for sleep studies and seizure activity
- Evoked potentials and reflex tests
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- Intrathecal baclofen therapy pump placement, removal, or revision
- Muscle and range of motion testing
- Muscle testing and guidance for chemodevervation
- Polysomnography and sleep studies indicated for the following:
  - Diagnosis of sleep related breathing disorders
  - Continuous Positive Airway Pressure titration in recipient’s sleep related breathing disorders
  - Documenting the presence of obstructive sleep apnea prior to surgical interventions
  - Assessment of treatment results in some cases, with a multiple sleep latency test in the evaluation of suspected narcolepsy
  - Evaluating sleep related behaviors that are injurious, and in certain atypical or unusual parasomnias
- Up to two nerve conduction velocity (NCV) studies for polyneuropathy in diabetes per year, per recipient
- Vagus nerve stimulator (VNS) placement, removal, or revision for intractable epilepsy

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 Coverage Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria
Services related to this policy are not covered 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 cover the following as part of this service benefit:
- Examination and NCV studies using portable hand-held devices
- Nerve conduction velocity screening tests performed for recipients with end-stage renal disease unless there is evidence of a new onset of peripheral nerve disease
- Services not listed on the fee schedule
- Telephone communications with recipients, their representative, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid’s Telemedicine Policy.

6.0 Documentation

6.1 General Criteria
For information on general documentation requirements, please refer to Florida Medicaid’s Recordkeeping and Documentation Requirements Coverage Policy.

6.2 Specific Criteria
Providers must document the polysomnography staging, recording, interpretation, and report in the recipient’s file.
7.0 Authorization

7.1 General Criteria
The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid’s Authorization Requirements Coverage Policy.

7.2 Specific Criteria
Providers must obtain authorization from the quality improvement organization for the intrathecal baclofen pump.

8.0 Reimbursement

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

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.

8.4 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

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.


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.