

# Florida Medicaid Fee Schedule Overview

Bureau of Medicaid Policy

Agency for Health Care Administration

March 20, 2018

2:00 – 3:00 pm



# Disclaimer

- The information provided in this presentation is only intended to be general summary information to the public. It is not intended to take the place of existing policy, rule, state, or federal regulation.



# Fee Schedule Training Overview

- Summary
- Basics
- 2018 Updates
- Claims Submission
- Use
- Covered Services and Billing Codes
- Rate Setting and Updates
  - Timeline
  - Process
- National Correct Coding Initiative

*Please note: slides from this presentation will be posted in the Additional Reference Information section of the Agency's Primary and Preventive Care Policy Web site:*  
[http://ahca.myflorida.com/Medicaid/Policy\\_and\\_Quality/Policy/behavioral\\_health\\_coverage/primary\\_care\\_policy/index.shtml](http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/behavioral_health_coverage/primary_care_policy/index.shtml)



# Fee Schedule Summary



# Summary

- States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines.
- Federal law requires states to provide certain “mandatory” benefits and allows states the choice of covering other “optional” benefits.
- Florida Medicaid covers services as listed in Section 409.905 and 409.906, Florida Statutes (F.S.).



# Summary

- Rule [59G-4.002](#) Florida Administrative Code (F.A.C.): Provider Reimbursement Schedules and Billing Codes
  - This rule applies to providers rendering Florida Medicaid services to recipients in the fee-for-service delivery system.



# Summary

- Florida Medicaid fee schedules are available on the Agency's Web site.
  - These can be located at:  
[http://ahca.myflorida.com/medicaid/review/fee\\_schedules.shtml](http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml).
- The fees listed are only applicable in the fee-for-service delivery system.



# Summary

- Codes that appear on fee schedules include
  - Current Procedural Terminology (CPT)
  - Common Dental Terminology (CDT)
  - Healthcare Common Procedure Coding System (HCPCS)
  - Revenue Codes





# Fee Schedule Basics



# Fee Schedules

- Fee schedules must be used in conjunction with:
  - Federal Regulation
  - Florida Statutes
  - Agency rules
  - Agency policies



# Fee Schedules: Fee-For-Service

- Provider fee schedules are a comprehensive list of codes published by Florida Medicaid to inform providers of the reimbursement rate in the fee-for-service delivery system for specific services performed.
- Billing code lists inform the providers of the billing codes that Florida Medicaid accepts for specific covered services.



# Fee Schedules: Statewide Medicaid Managed Care

- Statewide Medical Managed Care (SMMC, health plans) plans have the flexibility to:
  - Provide reimbursement for alternate codes and additional services.
  - Negotiate mutually agreed upon reimbursement rates with its network of contracted providers.
- Negotiated rates can be different than those listed on the fee schedule.
  - In no instance may the health plan impose limitations or exclusions more stringent than those specified in the contract.
  - Health plans may exceed specific coverage criteria included in the coverage policies and fee schedules and any specific coverage exclusions that are specified in the contract.



# Fee Schedules

- Updated Fee Schedules
  - Fee schedules are updated annually.
  - Services and rates are reimbursed through the fee-for-service delivery system.
- Promulgated Fee Schedules
  - Florida Medicaid updated fee schedules are promulgated into Administrative Rule.
  - The Managed Care Plan shall comply with all current promulgated Florida Medicaid Coverage and Limitations handbooks (Handbooks) and Florida Medicaid Coverage Policies as noticed in the Florida Administrative Register (FAR), and incorporated by reference in rules relating to the provision of services, except where the provision of the Contract alter the requirements set forth in the Handbooks and Medicaid fee schedules.



# Fee Schedules

- Providers must use fee schedules in conjunction with coverage policies to view:
  - Reimbursement rates
  - Prior authorization requirements (indicated for certain services)
  - Special modifiers
  - Facility fees
  - Professional component fees
  - Technical component fees



# The 2018 Updates

## All Fee Schedules

- Annual fee-for-service fee schedule, billing code, and rate updates for calendar year 2018

## Practitioner Fee Schedule

- Streamlined implementation of Medicare's facility fee
- The Incident to Services policy is now titled the Advanced Registered Nurse Practitioner (ARNP) and Physician Assistant (PA) Reimbursement Rates policy. The policy has been revised and is posted on the 2018 Practitioner Fee Schedule.

## Laboratory Fee Schedules

- Separation of the Physician and Outpatient Laboratory Fee Schedule.
  - Outpatient laboratory services are now reimbursed using the Enhanced Ambulatory Patient Grouping (EAPG) methodology.
  - The “Physician and Outpatient Laboratory Fee Schedule” will be renamed into the “Practitioner Laboratory Fee Schedule” and the “Outpatient Laboratory Fee Schedule”.



# The 2018 Updates, continued

- Laboratory Fee Schedules
  - In compliance with Section 1903(i)(7) of the Social Security Act, State Medicaid programs must reimburse for clinical diagnostic laboratory services at a rate that does not exceed the current Medicare rate.
  - Reduction of the fee-for-service reimbursement rate for the laboratory codes listed on the next slide, in compliance with Section 1903(i)(7) of the Social Security Act.





# The 2018 Updates, continued

CPT Code	Description
80047	METABOLIC PANEL IONIZED
81294	MLH1 GENE DUP/DELETE VARIANT
81295	MSH2 GENE FULL SEQ
81297	MSH2 GENE DUP/DELETE VARIANT
81298	MSH6 GENE FULL SEQ
81433	HRDTRY BRST CA-RLATD DSORDRS
81434	HEREDITARY RETINAL DISORDERS
81437	HEREDTRY NURONDCRN TUM DSRDR
81438	HEREDTRY NURONDCRN TUM DSRDR
81442	NOONAN SPECTRUM DISORDERS
81535	ONCOLOGY GYNECOLOGIC
86356	MONONUCLEAR CELL ANTIGEN
86850	RBC ANTIBODY SCREEN
87536	HIV-1 QUANT&REVRSE TRNSCRPJ
87625	HPV TYPES 16 & 18 ONLY
87900	PHENOTYPE INFECT AGENT DRUG
87901	PHENOTYPE INFECT AGENT DRUG
87903	PHENOTYPE INFECT AGENT DRUG
87904	PHENOTYPE INFECT AGENT DRUG



# The 2018 Updates, continued

- The fee schedules for Durable Medical Equipment and Medical Supply Services for all Medicaid recipients and for Medicaid recipients under the age of 21 years have been combined into one fee schedule. An age column now specifies which age categories are eligible for each service. This column can be sorted by age.
- Updates to the Prescribed Pediatric Extended Care Services fee schedule daily rates are inclusive of Therapy Services.



# Claims Submission



# Claims Submission

Florida Medicaid has two coverage policies to assist with claim form completion, they are:

- Medicaid Providers Who Bill on the CMS-1500
- Medicaid Providers Who Bill on the UB-04

These coverage policies can be located on the Florida Medicaid Web site that is provided on the final slide of this presentation.



# Claims Submission

- Florida Medicaid has a Provider Services Contact Center. Provider Contact Center Specialists are dedicated to responding professionally and accurately to provider inquiries.
- Medicaid field offices, in conjunction with the field services staff, offers a variety of monthly training sessions for Medicaid providers. Please visit the [Recipient and Provider Services](#) page for training details and region information.



# Claims Submission

- **Medicaid providers may call for assistance at the following phone number: 1-800-289-7799.**
- **Provider Services Contact Center – Option 7: available 7am – 6pm ET, Monday through Friday**
- **Provider Enrollment – Option 4: available 8am – 5pm ET, Monday through Friday.**
- **[Field Services](#) - Option 7: available 7am – 6pm ET, Monday through Friday.**



# Florida Medicaid 2018 Fee Schedules



# Florida Medicaid 2018 Fee Schedules

- Ambulatory Surgical Center (ASC) Services
- Assistive Care Services
- Behavior Analysis
- Behavioral Health Overlay Services
- Birth Center
- Child Health Services Targeted Case Management Services
- Community-Based Substance Abuse County Match Services
- Community Behavioral Health Services
- County Health Department Certified Match Program





# Florida Medicaid 2018 Fee Schedules

- Dental
- Durable Medical Equipment and Medical Supply Services for All Medicaid Recipients
- Early Intervention Services
- Emergency Transportation Services
- Hearing Services
- Home Health Visit Services
- Immunization
- Independent Laboratory
- Injectable Medication Oncology



# Florida Medicaid Fee Schedules

- Licensed Midwife
- Medicaid Certified School Match Program
- Medical Foster Care Services
- Mental Health Targeted Case Management Services
- Occupational Therapy Services
- Outpatient Laboratory Services
- Personal Care Services
- Physical Therapy Services
- Physician Pediatric Surgery
- Practitioner
- Practitioner Laboratory
- Prescribed Drug



# Florida Medicaid Fee Schedules

- Prescribed Pediatric Extended Care Services
- Private Duty Nursing Services
- Radiology
- Regional Perinatal Intensive Care Center (RPICC) Services Neonatal
- Regional Perinatal Intensive Care Center (RPICC) Services Obstetrical
- Respiratory Therapy
- Specialized Therapeutic Services
- Speech-language Pathology Services
- Targeted Case Management for Children at Risk of Abuse and Neglect Services
- Visual services



# Billing Codes

- County Health Department
- Federally Qualified Health Center
- Hospice
- Hospital Outpatient Services
- Intermediate Care Facility for Individuals with Intellectual Disabilities Services
- Nursing Facility Services
- Rural Health Clinic
- Statewide Inpatient Psychiatric Program Services



# Florida Medicaid Fee Schedules and Billing Codes

- Florida Medicaid fee schedules, billing codes, and coverage policies are located on the Agency's Web site at:  
<http://ahca.myflorida.com/medicaid/review/index.shtml>.
- The Florida Medicaid fee schedules, billing codes, *and* coverage policies should be resourced for covered services.



# Practitioner Fee Schedule Review



# Practitioner Fee Schedule Use

- Practitioners licensed within their scope of practice to perform services may use the Practitioner Fee Schedule.
  - Statute, licensure, and professional boards govern each practitioner’s scope of practice/standard of care.
  - The Agency does not regulate practitioner standards of care nor licensure.



# Practitioner Fee Schedule

## *Updated 1/1/2018*

- A legend is provided on the fee schedule to provide the definition of the titles and acronyms seen on the fee schedule.





# PRACTITIONER FEE SCHEDULE

**Effective January 1, 2018**

Note Number	Title	Details
1	<b>Legend</b>	<ul style="list-style-type: none"> <li>• Procedure: indicates the service level code reimbursed in the fee-for-service delivery system within the practitioner’s scope of practice.</li> <li>• Modifier (Mod): indicates pricing modifiers that have alerted the code by some circumstance without significantly changing the base definition. These include:               <ul style="list-style-type: none"> <li>EP: Service provided as part of EPSDT program</li> <li>FP: Family planning program service</li> <li>TG: Healthy Start Prenatal Risk Screening completed during the first trimester</li> <li>TH: Obstetrical treatment/services, prenatal or postpartum</li> </ul> </li> <li>• Fee Schedule Increase (FSI): indicates the base Florida Medicaid rate with a 4% increase included for all ages and provider types (independent of increases detailed below).</li> <li>• Facility: indicates the reimbursement rate for a practitioner if a procedure is performed in one of the following places of service: inpatient hospital (21), outpatient hospital (22), emergency room hospital (23), or ambulatory surgical center (24), according to Medicare’s designation.</li> <li>• PCI: indicates the professional component increase for physician work portion of a test.</li> <li>• TCI: indicates the technical component increase for the technical portion (i.e. staff and equipment costs) of a test.</li> <li>• PA: indicates the need for a prior authorization of the service through the Agency’s Quality Improvement Organization vendor.</li> <li>• Asterisk (*): Indicates reimbursement for a high risk delivery when associated with a high risk diagnosis code.</li> </ul>



# Practitioner Fee Schedule

## Updated 1/1/18

- Following the legend the second section of the Practitioner Fee Schedule explains the 4% and 24% rate increases for recipients

2	<p><b>Pediatric Rate Increases for Recipients (ages 0-20 years)</b></p>	<ul style="list-style-type: none"> <li>• 4% increase for all FSI, Facility, PCI, and TCI rates for all services.  <i>Example: For code 99201, the rate is <math>\\$30.35 \times 1.04 = \\$31.56</math> (FSI, Facility, PCI, or TCI) <math>\times 1.04 =</math> rate with a 4% pediatric increase.</i></li> <li>• For codes 99381-99384, 99385 EP, 99391-99394, and 99395 EP the base fee includes the 4% pediatric increase.</li> <li>• 24% increase for all FSI, Facility, PCI, and TCI rates for all services with physician specialty types: 02, 03, 04, 05, 08, 10, 14, 15, 17, 21, 22, 23, 29, 30, 31, 36, 37, 38, 39, 43, 46, 51, 53, 55, 57, 58, 60, and 62.  <i>Example: For code 99201, the rate is <math>\\$30.35 \times 1.04 \times 1.24 = \\$39.13</math> (specialty rate) (FSI, Facility, PCI, or TCI) <math>\times 1.04 \times 1.24 =</math> pediatric rate with a 24% increase.</i></li> </ul>
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# Practitioner Fee Schedule

## *Updated 1/1/2018*

- The third section of the Practitioner Fee Schedule addresses the Rate Increase for Pediatric Physicians.

3	<b>Rate Increase for Pediatric Physicians</b>	<ul style="list-style-type: none"><li>• A 10.2% increase for all FSI and Facility rates for specific services (CPT codes 99201-99496) with physician specialty types: 01, 19, 23, 35, 36, 37, 38, 39, 43, 49, 59, 101, and 102.</li></ul> <p><i>Example: For code 99201, the rate is <math>\\$30.35 \times 1.102 = \\$33.45</math></i></p> <p><i>(FSI, Facility, PCI, or TCI) <math>\times 1.04 \times 1.102 =</math> pediatric rate with a 10.2% increase.</i></p>
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# Practitioner Fee Schedule

## *Updated 1/1/2018*

- The fourth section of the Practitioner Fee Schedule demonstrates the method for calculating all the rate increase that have been mentioned (4%, 10.2% and 24%).

4	<b>Calculating All Rate Increases</b>	<ul style="list-style-type: none"><li>• When all criteria above are met, the 4%, 24%, and 10.2% increases are applicable.</li></ul> <p><i>To calculate the rate with all applicable increases, multiply the FSI, Facility, PCI, or TCI rate by 1.04, then multiply by 1.24, and then multiply by 1.102.</i></p> <p><i>Example: For code 99201 the rate is <math>\\$30.35 \times 1.04 \times 1.24 \times 1.102 = \\$43.13</math></i> <i>(FSI, Facility, PCI, or TCI) <math>\times 1.04 \times 1.24 \times 1.102 =</math> rate with 4%, 24%, and 10.2% increases.</i></p>
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# Practitioner Fee Schedule

## *Updated 1/1/2018*

- The fifth section of the Practitioner Fee Schedule addresses the Primary Care Evaluation and Management Rate Increase.

5	<b>Primary Care Evaluation and Management (E&amp;M) Rate Increase</b>	<ul style="list-style-type: none"><li>• Specific E&amp;M services (99212 – 99214) provided to recipients ages 0-19 by provider types 25 and 26 are reimbursed at set rates, and receive the 10.2% increase for the following specialties: 01, 19, 23, 35, 36, 37, 38, 39, 43, 49, 59, 101, and 102. <i>These set rates are: 99212= 1 unit at \$26.45, 99213 = 1 unit at \$32.56, and 99214 = 1 unit at \$48.27.</i></li></ul>
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# Practitioner Fee Schedule

## *Updated 1/1/2018*

- Section six lists the services that are not eligible for the rate increases.

6	<b>Services not Eligible for Rate Increases</b>	<ul style="list-style-type: none"><li>• Reimbursement increases detailed above do not apply to the following services: regional perinatal intensive care center services, injectable medications/immunization/vaccinations, supplies, devices, and laboratory/pathology services.</li></ul>
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# Practitioner Fee Schedule

## *Updated 1/1/2018*

- Section seven addresses assistant at surgery reimbursement.

7	<b>Assistant at Surgery Reimbursement Rates</b>	<ul style="list-style-type: none"><li>• When the assistant at surgery is a physician, the assistant physician is reimbursed at 16%.</li><li>• If not a physician, the assistant at surgery is reimbursed at 12.8%.</li></ul>
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# Practitioner Fee Schedule

## *Updated 1/1/2018*

- Section eight is the 2018 Advanced Registered Nurse Practitioner (ARNP) and Physician Assistant (PA) Reimbursement Rates policy that replaced the 2017 Incident to Services policy.

8	<b>Advanced Registered Nurse Practitioner (ARNP) and Physician Assistant (PA) Reimbursement Rates</b>	<ul style="list-style-type: none"> <li>• Services provided by an ARNP or a PA within their scope of practice may be billed under a physician's Medicaid provider number when the physician is in the building and able to render assistance as needed. These services are reimbursed at the physician allowable amount.</li> <li>• Services provided within the ARNP's and PA's scope of practice that are performed when the physician is not in the building, must be billed under the rendering ARNP's or PA's Medicaid provider number and are reimbursed at 80% of the allowable amount.</li> </ul>
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# Practitioner Fee Schedule

## *Updated 1/1/2018*

- The ninth section of the Practitioner Fee Schedule is the anesthesia reimbursement rule.

9	<b>Anesthesia Reimbursement Rates</b>	<ul style="list-style-type: none"><li>• Anesthesia time is reported in total minutes and reimbursed through the below calculation. Qualified non-physician providers, within their scope of practice, are reimbursed at 80%.</li></ul> <p><i>(Anesthesia FSI, Facility, PCI, or TCI rate) + (time/15 x \$14.50) = reimbursement rate.</i></p>
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# Fee-For-Service Rate Setting



# Fee-For-Service Rate Setting and Update Process

- Medicaid Program Finance (MPF) sets all rates on fee schedules
- Process takes place annually in December



# Why are Codes Added or Deleted?

- Reasons codes may be added or deleted from a fee schedule include:
  - Additions:
    - ✓ Annual release of new codes
    - ✓ Medically necessary as approved by the generally accepted medical professional standards (GAPMS) process
  - Deletions:
    - ✓ Annual discontinuation of codes
    - ✓ Temporary codes become permanent



# Reimbursement Rates

- The Agency considers the following in the rate setting process:
  - Utilization
  - Medicare pricing
  - Other state Medicaid pricing
  - Resource based, relative value scale (RBRVS) published by CMS
  - Relative Value Units (RVUs)
    - Provider time
    - Materials
    - Other costs
  - Florida Legislature appropriated additional funding



# National Correct Coding Initiative (NCCI)



# What is NCCI?

- CMS's National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B and Medicaid claims.
  - For information on edits for the [Medicare NCCI](#) program, please visit this Web site.
  - Pursuant to applicable provisions of the Social Security Act, ss. 1903(r)(1)(B)(iv).



# NCCI in Medicaid

- The Affordable Care Act of 2010 required CMS to notify states by September 1, 2010 of the NCCI methodologies that were compatible with Medicaid.
- [State Medicaid Director Letter #10-017](#) notified states that all five Medicare NCCI methodologies were compatible with Medicaid.
- The Affordable Care Act required state Medicaid programs to incorporate compatible NCCI methodologies in their systems for processing Medicaid claims by October 1, 2010.





# Types of NCCI Edits in Medicaid

- The [National Correct Coding Initiative \(NCCI\)](#) contains two types of edits:
  1. NCCI procedure-to-procedure (PTP) edits that define pairs of HCPCS/CPT codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.
  2. Medically Unlikely Edits (MUEs) define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.



# NCCI Methodologies in Medicaid

- The Medicaid NCCI program consists of six methodologies:
  1. PTP edits for practitioner and ambulatory surgical center (ASC) services.
  2. PTP edits for outpatient services in hospitals (including emergency department, observation, and hospital laboratory services).
  3. PTP edits for durable medical equipment.
  4. MUEs for practitioner and ASC services.
  5. MUEs for outpatient services in hospitals.
  6. MUEs for durable medical equipment.
- Medicaid NCCI methodologies apply to Medicaid fee-for-service and managed care claims except for allowable NCCI edit exclusions in accordance with [42 CFR 433.116](#) and [45 CFR 95](#).



# NCCI Methodologies in Medicaid

- Medicaid NCCI methodologies apply to Medicaid fee-for-service and managed care claims.
  - Per the [SMMC Contract, Attachment II, Core Contract Provision](#), the Managed Care Plan shall incorporate into its claim processing and claims payment system the NCCI editing programs for the Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes to promote correct coding and control coding errors, except for allowable NCCI edits exclusions in accordance with 42 CFR 433.116 and 45 CFR 95.



# Medicaid NCCI Edit Files

- Florida Medicaid primarily follows NCCI edits.
- The complete updated Medicaid NCCI edit files are posted to CMS's Web site at the beginning of each calendar quarter.
- These files completely replace the Medicaid NCCI edit files from previous calendar quarters.
  - The presence of a HCPCS / CPT code in a PTP edit or of an MUE value for a HCPCS / CPT code does not necessarily indicate that the code is covered by any state Medicaid program or by all state Medicaid programs.



# Contact Us

## Florida Medicaid Web site

- <http://ahca.myflorida.com/Medicaid/index.shtml>
- Complaint hub and other tools can be located here

### Welcome to Medicaid!

Medicaid is the medical assistance program that provides access to health care for low-income families and individuals. Medicaid also assists the elderly and people with disabilities with the costs of nursing facility care and other medical and long-term care expenses.

In Florida, the Agency for Health Care Administration (Agency) is responsible for Medicaid. The Agency successfully completed the implementation of the [Statewide Medicaid Managed Care \(SMMC\) program](#) in 2014. Under the SMMC program, most Medicaid recipients are enrolled in a health plan. Nationally accredited health plans were selected through a competitive procurement for participation in the program.

The Division of Medicaid's website is designed to align with our functional organizational structure.

Some examples of where key information can be found under the new structure are below:

Looking for information on:	Go to:
Behavior Analysis Services Information	Bureau of Medicaid Policy
Health Plan Contracts and Information	Statewide Medicaid Managed Care

**Beth Kidder**  
Deputy Secretary for Medicaid

2727 Mahan Drive  
Mail Stop #8  
Tallahassee, FL 32308  
Phone: (850) 412-4000

Report a Complaint 

Claims Dispute Resolution Program 

Submit Questions 

Recipient Resources 



Florida Medicaid Dental  
Dental Care for Your Health

