Florida Medicaid Fee Schedule Overview

Bureau of Medicaid Policy
Agency for Health Care Administration
Fall 2017
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
• Use
• Covered Services and Billing Codes
• Rate Setting and Update Process
  – Timeline
  – Process
• Question/Answer Period
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.
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 website.
  – These can be located at: 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
  – Common Dental Terminology (CDT)
  – Healthcare Common Procedure Coding System (HCPCs)
  – Revenue Codes
Fee Schedule Use
Fee Schedule Use

• Fee schedules must be used in conjunction with:
  – Federal Regulation
  – Florida Statutes
  – Agency rules
  – Agency policies
Fee Schedule Use: Fee-For-Service

- Provider Reimbursement and Billing Code 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.
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 above and specific coverage exclusions specified in the contract.
Fee Schedule Use

• Updated Fee Schedules
  – Fee schedules are updated annually.
  – Services and rates may be reimbursed through the updated fee schedule in the fee-for-service delivery system.

• Promulgated Fee Schedules
  – Florida Medicaid updated fee schedules are promulgated into Administrative Rule.
  – Health plans shall comply with all current promulgated Florida Medicaid Coverage Policies (Policies) as noticed in the Florida Administrative Register (FAR), and incorporated by reference in rules relating to the provision of services, except where the provisions of the Contract alter the requirements set forth in the Policies and Medicaid fee schedules.
Fee Schedule Use

- 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
Covered Services
Covered Services

Currently Florida Medicaid Fee Schedules include:

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

- Dental
- Durable medical equipment and medical supply services for all Medicaid recipients
- Durable medical equipment and medical supply services for Medicaid recipients under the age of 21 years
- Early intervention services
- Emergency transportation services
- Hearing services
- Home health visit services
- Immunization
- Independent laboratory
Covered Services

- Injectable medications non-oncology
- Injectable medications oncology
- Licensed midwife
- Medicaid certified school match program
- Medical foster care services
- Mental health targeted case management services
- Occupational therapy services
- Personal care services
- Physical therapy services
- Physician and outpatient laboratory
- Physician pediatric surgery
Covered Services

- Practitioner
- Prescribed pediatric extended care services
- Private duty nursing services
- Radiology
- Regional perinatal intensive care center (RPICC) neonatal services
- Regional perinatal intensive care center (RPICC) obstetrical services
- Respiratory therapy services
- Specialized therapeutic services
- Speech-language pathology services
- Targeted case management for children at risk of abuse and neglect services
- Visual services
Covered Services

Currently Billing Codes Fee Schedules include:

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

- Fee schedules and coverage policies for covered services are located on the Agency’s website at: [http://ahca.myflorida.com/medicaid/review/index.shtml](http://ahca.myflorida.com/medicaid/review/index.shtml).

- Fee schedules *and* coverage policies should be used for covered services.

Immunization Administration
Immunization Administration
Ages 0 – 20 Years

• Effective October 1, 2017, Florida Medicaid providers will be required to submit:
  – The vaccine product CPT code \textbf{-and-}
  – The vaccine administration CPT code

• If more than one vaccine is administered during the same visit, each vaccine product code and an administration code must be submitted
Immunization Administration Codes
Ages 0 – 20 Years

• 90460
  – Immunization administration through 18 years of age via any route of administration with counseling by physician or other qualified health care professional first or only component of each vaccine or toxoid administered.

• 90471
  – Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections) one vaccine single or combination vaccine/toxoid.

• 90472
  – Each additional vaccine (single or combination vaccine/toxoid). List separately in addition to code for primary procedure.

• 90473
  – Immunization administration by intranasal or oral route one vaccine single or combination vaccine/toxoid.

• 90474
  – Each additional vaccine single or combination vaccine/toxoid. List separately in addition to code for primary procedure.
Providers who receive vaccine products through the Vaccine for Children program can seek reimbursement for the vaccine administration from Florida Medicaid.

- Both the vaccine product CPT code and the vaccine administration CPT code must be submitted
  - Vaccine product code is reimbursed at $0.00
  - Vaccine administration will be reimbursed in accordance with Rule 59G-4.002, F.A.C.
Immunization Administration
Ages 0 – 18 Years
Vaccine for Children Program

• The Vaccines for Children (VFC) Program is a federal program administered and funded by the Centers for Disease Control and Prevention (CDC) through the National Center for Immunization and Respiratory Diseases (NCIRD).
  – The VFC Program purchases the vaccines and supplies them to enrolled VFC Program providers at no cost for children ages 0 – 18 years.
  – Enrolled VFC Program providers are able to order vaccines through their state VFC Program and receive routine vaccines at no cost.
Immunization Administration  
Ages 0 – 18 Years  
Vaccine for Children Program

• Effective March 27, 2015 the VFC provider initial enrollment process will be completed via email.
  – If you would like to enroll in the VFC program, please send email to FloridaVFC@FLHealth.gov.
  • You can also reach them via phone at 877-888-7468.
  – You will be contacted by a VFC representative at the Florida Department of Health with instructions for initial enrollment.
  – Additional information can be found at:  
Vaccine Administration

• Updated policy effective October 1, 2017
  – Fee-for-service delivery system only

• Provider alert sent June 22, 2017
  – Alerts can be accessed on the Agency’s website at:
    http://www.ahca.myflorida.com/medicaid/alerts/alerts.shtml
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.
Fee Schedule Example: Practitioner

*Updated 1/1/17, Posted March 2017*

**PRACTITIONER FEE SCHEDULE**

*Effective January 1, 2017*

Anesthesia Reimbursement Method: Calculate your reimbursement by dividing the total minutes of anesthesia by 15. Multiply this number by the conversion factor of $14.50. Add this to the fee listed below for the procedure code (00120 = $72.49). Example: 100 minutes of anesthesia for code 00120 = $159.49. (100 min. divided by 15 = 6.67, rounded down to 6, 6 x $14.50 = $87.00, $87.00 + $72.49 = total anesthesia fee of $159.49.)

(Qualified non-physician providers, within their scope of practice, are reimbursed at 80%. Example: $159.49 x .80 = $127.59.)
Fee Schedule Example: Practitioner

Updated 1/1/17, Posted March 2017

For services provided to children under 21, there is a 4% increase over the adult fee. In addition to the 4% increase, the following physician specialty types receive a 24% increase for services provided to children under 21: 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, 62. When the criteria are met and the 4% and 24% are both applicable, to calculate the specialty fee, multiply the base fee by 1.04, as noted above for children, and then multiply that result by 1.24. Example: For code 99201, the fee is $28.08 X 1.04 = $29.20 X 1.24 = $36.21 (specialty fee).
For CPT codes in the range of 99201-99496, an additional 10.2% increase will apply for services provided by the following physician specialty types: 01, 19, 23, 35, 36, 37, 38, 39, 43, 49, 59, 101, 102. When all criteria in each section are met, and the 4%, 24% and 10.2% are applicable, to calculate the specialty fee for those certain pediatrician specialty codes, multiply the base fee by 1.04, then multiply that result by 1.24, and then multiply that result by 1.102. Example: For code 99201, the fee is $28.08 \times 1.04 = $29.20 \times 1.24 = $36.21 \times 1.102 = $39.91 \text{ (pediatrician specialty fee)}. For codes 99381-99384, 99385 EP, 99391-99394, and 99395 EP the base fee includes the 4% pediatric increase. The following rates are for primary care evaluation and management services provided by provider type 25 or 26 to recipients ages 00-19: 99212 = 1 unit at $26.45, 99213 = 1 unit at $32.56, and 99214 = 1 unit at $48.27. The only increase applied to the primary care evaluation and management services codes is the 10.2%, and it is only applied to those specialties indicated in this section as eligible for the 10.2%.
Dear Managed Care Plan,

The purpose of this email is to alert health plans of an update that was made to the 2017 Practitioner Fee Schedule in March 2017.

The 2017 Practitioner Fee Schedule was posted to the Agency’s website in February 2017. This initial version of the fee schedule included the enhanced reimbursement rate for Common Procedural Terminology (CPT) codes 99212, 99213, and 99214 for recipients ages 0 – 19 in the document header. This information was listed incorrectly.

The 2017 Practitioner Fee Schedule was corrected and posted to the Agency’s website in March 2017. This version of the fee schedule corrected the enhanced reimbursement rate calculations for CPT codes 99212, 99213, and 99214 for recipients ages 0 -19 in the document header and it reads as follows (with emphasis on the highlighted verbiage).

For CPT codes in the range of 99201-99496, an additional 10.2% increase will apply for services provided by the following physician specialty types: 01, 19, 23, 35, 36, 37, 38, 39, 43, 49, 59, 101, 102’. When all criteria in each section are met, and the 4%, 24% and 10.2% are applicable, to calculate the specialty fee for those certain pediatrician specialty codes, multiply the base fee by 1.04, then multiply that result by 1.24, and then multiply that result by 1.102. Example: For code 99201, the fee is $28.08 X 1.04 = $29.20 X 1.24 = $36.21 X 1.102 = $39.91 (pediatrician specialty fee). For codes 99381-99384, 99385 EP, 99391-99394, and 99395 EP the base fee includes the 4% pediatric increase. The following rates are for primary care evaluation and management services provided by provider type 25 or 26 to recipients ages 00-19. 99212= 1 unit at $26.45, 99213 = 1 unit at $32.56, and 99214 = 1 unit at $48.27. The only increase applied to the primary care evaluation and management services codes is the 10.2%, and it is only applied to those specialties indicated in this section as eligible for the 10.2%.

The Agency has received several complaints from physicians/physician practices regarding the reimbursement rates received from plans for these three CPT codes. These three CPT codes are also included in the Managed Medical Assistance Physician Incentive Program. Plans may need to review payments made to physicians to ensure they align with the rates (including any adjustments for fee increases) posted on the 2017 Practitioner Fee Schedule if the plan’s contract with a provider (physician) is based upon the Medicaid fee schedule.

Should you have any questions, please contact your Agency contract manager.
When the assistant at surgery is a physician, the assistant physician is reimbursed at 16%. If not a physician, the assistant at surgery is reimbursed at 12.8%.

Advanced Registered Nurse Practitioners, and Physician Assistant rates are reimbursed at 80%.
## PRACTITIONER FEE SCHEDULE

**Effective January 1, 2017**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Mod</th>
<th>FSI</th>
<th>Facility</th>
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<tbody>
<tr>
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<tr>
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<td>86.99</td>
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<tr>
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<td></td>
<td>72.49</td>
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</tbody>
</table>
Fee Schedule Example: Practitioner  
*Updated 1/1/17, Posted March 2017*

- Columns on the Practitioner Fee Schedule include:
  1. Procedure – code
     - The procedure code representing service performed
  2. Mod – modifier
     - Special modifiers other than modifiers required by the Centers for Medicare and Medicaid Services (CMS), [CMS.gov](https://www.cms.gov)
  3. FSI – fee schedule increase
     - The FSI rate is defined as the base fee plus an additional four percent for services to Medicaid recipients. In the fee-for-service delivery system, the following providers are reimbursed at the FSI rate: advanced registered nurse practitioner, chiropractic, hearing, optometric, physician, physician assistant, podiatry, registered nurse first assistant, and visual.
Columns on the Practitioner Fee Schedule include:

4. Facility – amount reimbursed to the provider when the procedure is performed in the below places of service:
   • 21 Inpatient,
   • 22 Outpatient
   • 23 Emergency Room
   • 24 Ambulatory Surgical Center

   - Practitioners receive lower rates when services are rendered in a facility because the facility incurs overhead/equipment costs
   - Services that have a facility fee are based upon Medicare's determination of services that can be provided in a facility.
Fee Schedule Example: Practitioner
*Updated 1/1/17, Posted March 2017*

4. Facility fee continued
   – Facility fees were included in fee schedules in 2013, 2014, and 2015.
   – The facility rate column was not included on the 2016 Practitioner Fee Schedule due to the facility rate being coded in Florida Medicaid Managed Information System (FLMMIS) as the PCI rate.
   – As Florida Medicaid moves towards aligning coding with the CMS billing requirements, the Agency added the facility rate column to the 2017 Practitioner Fee Schedule.
Fee Schedule Example: Practitioner
Updated 1/1/17, Posted March 2017

• Columns on the Practitioner Fee Schedule include:
  5. PCI – professional component increase
     • The PCI identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test.
  6. TCI – technical component increase
     • The TCI identifies stand-alone codes that describe the technical component (such as staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only.
Columns on the Practitioner Fee Schedule include:

7. PA – prior authorization
   - The PA identifies procedures that must be prior authorized through the Agency in the fee-for-service delivery system.
     - Additional information on the Agency’s prior authorization and quality improvement contracts in the fee-for-service delivery system can be located at: http://ahca.myflorida.com/Medicaid/Utilization_Review/index.shtml
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:
    ✓ Addition of mandatory covered codes by CMS
    ✓ Medically necessary as approved by the generally accepted medical standards (GAPMS) process
  – Deletions:
    ✓ Removal of mandatory covered code by CMS
    ✓ 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 website.
  - 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 website 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.
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:

<table>
<thead>
<tr>
<th>Looking for information on:</th>
<th>Go to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Analysis Services Information</td>
<td>Bureau of Medicaid Policy</td>
</tr>
<tr>
<td>Health Plan Contracts and Information</td>
<td>Statewide Medicaid Managed Care</td>
</tr>
</tbody>
</table>

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Report a Complaint
Claims Dispute Resolution Program
Submit Questions
Recipient Resources

Florida Medicaid Dental
Dental Care for Your Health