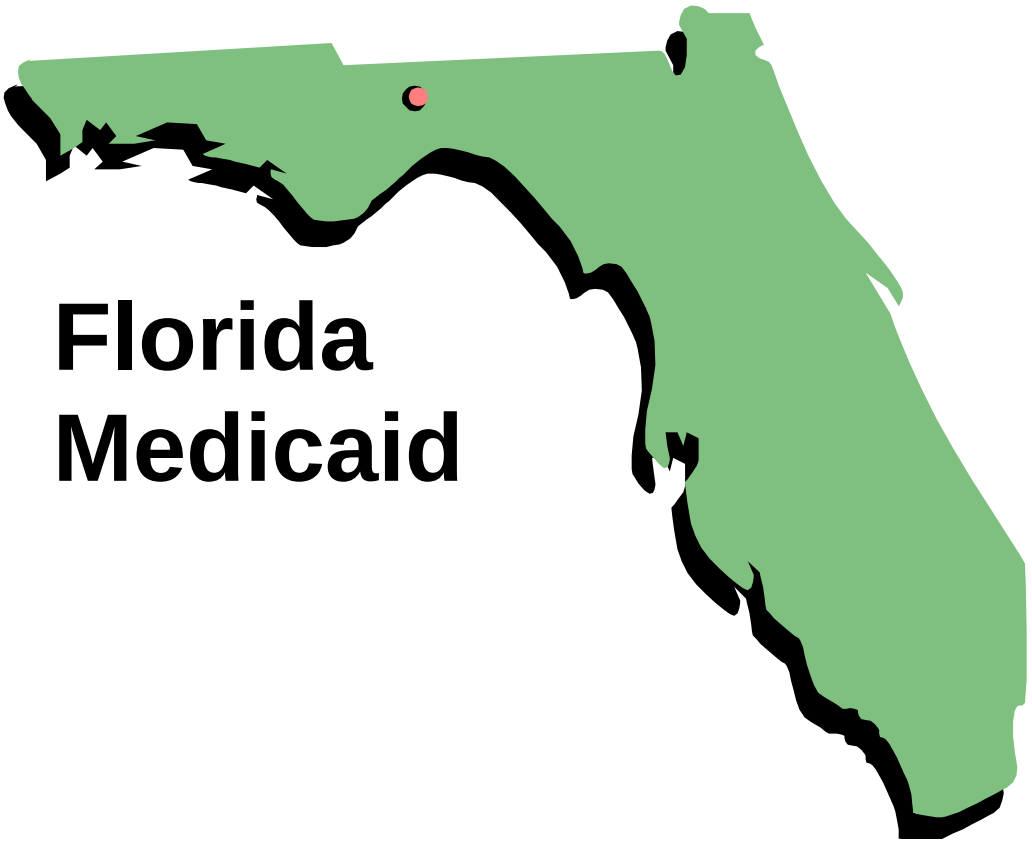

Florida Medicaid

PRACTITIONER SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

April 2014

AHCA

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

PRACTITIONER SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
UPDATE LOG

How to Use the Update Log

Introduction

The update log provides a history of the handbook updates. Each Florida Medicaid handbook contains an update log.

Obtaining the Handbook Update

When a handbook is updated, the provider will be notified. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Medicaid providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Services Contact Center at 1-800-289-7799.

Explanation of the Update Log

Providers can use the update log below to determine if updates to the handbook have been received.

Update describes the change that was made.

Effective Date is the date that the update is effective.

UPDATE	EFFECTIVE DATE
New Handbook	December 2012
Revised Handbook	April 2014

PRACTITIONER SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
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Chapter and Topic **Page**

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter outlines the three types of Florida Medicaid policy handbooks that all enrolled providers must comply with in order to obtain reimbursement. This chapter also describes the format used for the handbooks and instructs the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid program.
- Coverage and limitations handbooks explain covered services, their limits, who is eligible to receive them, and any corresponding fee schedules. Fee schedules can be incorporated within the handbook or separately.
- Reimbursement handbooks describe how to complete and file claims for reimbursement from Medicaid.

The current Florida Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Federal and State Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act
- Title 42 of the Code of Federal Regulations
- Chapter 409, Florida Statutes
- Rule Division 59G, Florida Administrative Code

In This Chapter

This chapter contains:

Handbook Use

Purpose	The purpose of the Medicaid handbooks is to educate the Medicaid provider about policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters, or other documentation.
Provider	Term used to describe any entity, facility, person, or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	Term used to describe an individual enrolled in Florida Medicaid.
Provider General Handbook	Information that applies to all providers regarding the Florida Medicaid program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who renders more than one type of Medicaid service will have more than one coverage and limitations handbook for which they must comply.
Reimbursement Handbook	Most reimbursement handbooks are named for the type of claim form submitted.

Characteristics of the Handbook

Format	The format of the handbook represents a reader-friendly way of displaying material.
Label	Labels are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Chapter Topics	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.
Note	Note is used to refer the reader to other important documents or policies contained outside of this handbook.
Page Numbers	Pages are numbered consecutively within each chapter throughout the handbook. The chapter number appears as the first digit before the page number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an "Update" and "Effective Date."
Handbook Update Classifications	The Medicaid handbooks will be updated as needed. Updates are classified as either a: • Replacement handbook – Major revisions resulting in a rewrite of the existing handbook, without any underlines and strikethroughs throughout the rulemaking process. • Revised handbook – Minor revisions resulting in modification of the existing handbook identified during the rulemaking process by underlines and strikethroughs.
Handbook Effective Date	The effective date of a handbook is the month and year that will appear on the final published handbook. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New information or information moved from one place to another within the handbook will be identified by an underline on draft versions of the handbook during the development and proposed stages of the rulemaking process <u>(e.g., new information)</u>.
Identifying Deleted Information	Deleted information will be identified by a line through the middle of the selected text on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., ~~deleted information~~).
Final Published Handbook	The adopted and published version of the handbook will not have underlines (indicating insertions) and text with strikethroughs (indicating deletions).

CHAPTER 1
QUALIFICATIONS, ENROLLMENT, AND REQUIREMENTS

Overview

Introduction

This chapter describes Florida Medicaid's practitioner services, the specific authority regulating these services, and provider qualifications, enrollment, and requirements.

Legal Authority

Practitioner services are authorized by Title 42, Code of Federal Regulations (CFR), sections 440.50, 440.230, 447.304, and 440.60. The state authority for the licensing of providers is Chapters 458, 459, and 464, Florida Statutes (F.S.). Florida Medicaid's practitioner services is authorized by section 409.905, F.S., and Rule 59G-4.205, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

Purpose and Definitions

Medicaid Provider Handbooks	This handbook is intended for use by practitioners that render services to eligible Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains information about specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid program. Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. All of the Florida Medicaid provider handbooks are incorporated by reference in Rule Division 59G, F.A.C.
Practitioner	Practitioner, or provider, for the purposes of this handbook, refers to physicians, advanced registered nurse practitioners (ARNP), physician assistants (PA), registered nurse first assistants (RNFA), and anesthesiology assistants (AA) where appropriate according to the individual's scope of practice.
Physician	Physician, for the purposes of this handbook, refers to doctors of medicine or osteopathic medicine who hold a valid and active license in full force and effect pursuant to the provisions of Chapter 458 or 459, F.S., and are eligible to enroll and participate as physicians in the Medicaid program.
Resident Physician	A resident physician is one who has earned the medical doctor or doctor of osteopathic degree, or equivalent, and is engaged in an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved program of graduate medical education. These programs are designed to increase the knowledge of the clinical disciplines of medicine, surgery, or any other special fields that provide advance training in preparation for the practice of a specialty or subspecialty. Residents are described as postgraduate year 1 to 8 (PGY1-PGY8), as applicable.
Advanced Registered Nurse Practitioner (ARNP)	A registered nurse certified by the Florida Board of Nursing as an ARNP and who holds a valid and active license in full force and effect pursuant to Chapter 464, F.S. The ARNP works in collaboration with practitioners, designated by statute, according to protocol to provide diagnostic and interventional patient care. The general provisions stated in this handbook apply to all Medicaid-enrolled ARNPs. ARNPs who practice in a particular specialty must also comply with the additional provisions listed according to that specialty in this handbook.

Purpose and Definitions, continued

Physician Assistant (PA)	A health care professional who is a graduate of an approved program and certified by the National Commission on Certification of PAs. The PA provides diagnostic and therapeutic patient care, delegated by the supervising physician, in accordance with Chapters 458 and 459, F.S., and applicable F.A.C. rules.
Mobile Units	A fully operational vehicle, unit, or trailer that travels to different locations for the provision of services and is not a stationary unit.
Anesthesiologist Assistant (AA)	A graduate of an approved program who is licensed to perform medical services in accordance with sections 458.3475 and 459.023, F.S.
Registered Nurse First Assistant (RNFA)	A licensed registered nurse who is certified in perioperative nursing, and holds a certification from a recognized program, as defined in section 464.027, F.S. The role of an RNFA is to provide pre-, intra-, and post-operative nursing care to surgical patients.

Qualifications

General

To enroll as a Medicaid provider, a practitioner must be licensed as one of the following:

- Medical physician within the scope of the practice of medicine as defined in Chapter 458, F.S.;
- Osteopathic physician within the scope of the practice of osteopathic medicine as defined in Chapter 459, F.S.;
- Medical or osteopathic physician licensed in the state in which the service is provided;
- Physician with a Medical Faculty Certificate issued by the Florida Board of Medicine as outlined in section 458.3145, F.S.;
- ARNP licensed as an advanced registered nurse practitioner within the scope of practice of nursing as defined in Chapter 464, F.S.;
- PA licensed as a physician assistant within the scope of practice as defined in Chapter 458 or 459, F.S.;
- AA licensed as an anesthesiologist assistant in accordance with sections 458.3475 and 459.023, F.S.;
- RNFA licensed as a registered nurse with certification as a registered nurse first assistant as defined in Chapter 464, F.S.

Note: See the Florida Medicaid Provider General Handbook for information on out-of-state providers and services.

Qualifications, continued

Members of the Public Health Service and Armed Forces

Practitioners who perform services in Florida, but are not licensed in Florida, may enroll as Medicaid providers if they are commissioned medical officers of the Public Health Service or Armed Forces of the United States, on active duty, and acting within the scope of their public health service or military responsibilities.

Physician Specialty

If the physician is a specialist and wants to be recognized as such by Medicaid, the physician must declare a specialty code on his provider enrollment file with the Medicaid fiscal agent for reimbursement of certain services. To document the validity of the specialty, the physician must submit proof of post-graduate training to the Medicaid fiscal agent.

Note: For information and instructions on submitting required documentation for specialty verification providers may call the Medicaid fiscal agent's Provider Enrollment department at 1-800-289-7799 (Option 4) or visit the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Enrollment, and then Enrollment Forms.

ARNP Specialty

Reimbursement for anesthesia services, obstetrical services, and psychiatric services are limited to ARNPs who have completed an educational program in the appropriate specialty, and are authorized to provide these services by section 464, F.S., and protocols filed with the Florida Board of Nursing.

The specialty code must be on the ARNP's provider enrollment file with the Medicaid fiscal agent for proper reimbursement of certain services.

To add an ARNP specialty code to the provider's file, either call the Medicaid fiscal agent's Provider Enrollment department at 1-800-289-7799 (Option 4) or visit the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, Enrollment, and then select Enrollment Forms.

Collaborative Agreement

To enroll as a Medicaid provider, an ARNP or PA must submit a collaborative agreement form signed by the ARNP or PA and a Florida licensed physician that documents the professional relationship between the ARNP or PA and the physician. ARNPs may have an agreement with a dentist also.

If an ARNP or PA refers a recipient to the collaborating physician and the collaborating physician is not a Medicaid provider, the ARNP or PA must advise the recipient that the provider is not enrolled in Medicaid and that the recipient may be billed for the services that the physician renders. The ARNP or PA must have available a list of Medicaid-enrolled providers from the area Medicaid office for referral to Medicaid-enrolled physicians. A list can be requested from the Medicaid fiscal agent by calling 1-800-289-7799, or from the Web site at www.mymedicaid-florida.com.

Enrollment

General

Practitioners must meet the general Medicaid provider enrollment requirements that are contained in the Florida Medicaid Provider General Handbook. In addition, practitioners must follow the specific enrollment requirements that are listed in this handbook.

AA, ARNP, PA, or RNFA in a Physician Group

If an AA, ARNP, PA, or RNFA is employed by or contracts with a physician who can enroll as a Medicaid provider, the physician must enroll as a group provider and the AA, ARNP, PA or RNFA must enroll as an individual treating provider within the group.

If the ARNP or PA owns the group practice, then the ARNP or PA must enroll as the group provider, and the other members of the group, including physicians, must enroll as individual treating providers belonging to the group.

Physician Group Providers Located in Independent Diagnostic Testing Facilities (IDTF)

Two or more Medicaid-enrolled providers whose practice is incorporated under the same tax identification number and located within an IDTF, as defined by 42 CFR 410.33, must enroll as a Medicaid group practice. In order to receive reimbursement from Medicaid, each member of the group must also enroll as an individual treating provider within the group.

- The IDTF must be Florida licensed as a healthcare clinic.
- Practices located in an IDTF must be certified by Medicare.
- The supervising physician at the IDTF must be a Medicaid-enrolled radiologist and the Medicaid provider number must be linked to the IDTF group number.

Locum Tenens Providers

A locum tenens provider is one who substitutes on a temporary basis for another provider while the permanent provider is indisposed. A locum tenens provider must meet all of the general Medicaid provider enrollment requirements that are contained in this handbook and in the Florida Medicaid Provider General Handbook. The locum tenens provider must enroll in Medicaid as an individual treating provider before services may be reimbursed.

Site Visit Requirements

Physician groups that are more than 50 percent non-physician owned and located in a free-standing clinic or office must have a site visit for both their initial application as well as any additional locations prior to approval.

Physician provider applicants are subject to random on-site inspections in accordance with section 409.907(7), F.S.

Enrollment, continued

Mobile Units	Mobile unit providers must contract only with County Health Departments (CHD), Federally Qualified Health Centers (FQHC) or mobile clinics affiliated with academic medical institutions accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation (COCA). Rural Health Clinic (RHC) mobile units must be certified by Medicare as a mobile RHC in accordance with the Code of Federal Regulations, Title 42. Medicaid will reimburse CHD, FQHCs, and RHCs for mobile unit services. Mobile unit services must be provided and billed in compliance with this handbook and the applicable CHD, FQHC, or RHC Coverage and Limitations Handbooks. The Florida Medicaid handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information For Providers, then Provider Support and then Provider Handbooks.
Other Licensed Health Care Practitioners	If a physician employs or contracts with a non-physician health care practitioner, the non-physician practitioner must be enrolled in Medicaid to receive reimbursement and to provide services to Medicaid recipients.
Individual Provider Responsibility Within a Group Practice	An individual treating provider, who is a member of a group, must be enrolled and obtain an individual Medicaid provider ID number before performing services for Medicaid recipients. It is the responsibility of the individual treating provider to notify the Medicaid fiscal agent of all group practices with which he is affiliated. Any individual treating provider who is terminating a relationship with a group practice must notify the Medicaid fiscal agent in writing of this termination in order to update his provider file.

Requirements

General	In addition to the general provider requirements and responsibilities that are contained in the Florida Medicaid Provider General Handbook, providers are also responsible for complying with the provisions contained in this section.

Requirements, continued

National Correct Coding Initiative (NCCI) Guidelines	Procedure code reimbursement is subject to NCCI and Medically Unlikely Edit (MUE) guidelines. Providers should refer to the CMS NCCI Web site at www.cms.gov/MedicaidNCCICoding/ for correct coding guidelines and specific applicable code combinations.
Personal Supervision	Services provided by an ARNP or a PA under the personal supervision of a physician may be billed by the physician instead of the ARNP or PA. Teaching physicians who seek reimbursement for oversight of patient care by a resident must personally supervise all services performed by the resident. Personal supervision pursuant to Rule 59G-1.010(276), F.A.C., means that the services are furnished while the supervising practitioner is in the building and that the supervising practitioner signs and dates the medical records (chart) within 24 hours of the provision of the service. Exceptions are deliveries, psychiatric services, and Child Health Check-Up screenings. The ARNP or PA who provides these services must bill using their own Medicaid ID number as the rendering provider number.
RNFA Supervision	The RNFA must adhere to the supervision guidelines set forth by the Board of Nursing. All services provided by a RNFA must be under the direct supervision of the physician.
AA Supervision	The AA must adhere to the supervision guidelines set forth in Chapters 458 and 459, F.S. and requires onsite, personal supervision by an anesthesiologist in the office or suite where the procedure is being performed.
Psychiatric Services Provided In Community Behavioral Health Services	A psychiatrist employed or contracted by a Medicaid-enrolled community behavioral health (formerly named community mental health) provider as a treating physician must bill all the services he provides for that community behavioral health provider under the community behavioral health provider's number. All services must be provided in accordance with the policies contained in the Community Behavioral Health Services Coverage and Limitations Handbook.

Requirements, continued

Residents in Teaching Facilities and Practitioners Employed by Facilities	Residents and practitioners whose salaries are considered in the hospital's cost report may not bill Medicaid on a fee-for-service basis. All Federal laws, Florida Statutes, and Florida Administrative Code rules applicable to the Florida Medicaid Program and any physician specialty program reimbursed by Medicaid apply to residency programs.
Students in Clinical Teaching Institutions	Students in Florida medical institutions may document in the medical record and participate in key components of a billable service. The medical record entry must be dated and cosigned by the billing physician.
Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC)	Providers enrolled under RHC or FQHC group provider numbers and who are providing services in the RHC or FQHC must bill all the services they provide in accordance with policies outlined in the RHC or FQHC coverage and limitations handbook.
Requirement for Medical Records	See the Florida Medicaid Provider General Handbook for the record keeping requirements.
Providers Contracted with Medicaid Managed Care Plans	The service-specific Medicaid coverage and limitations handbooks provide the minimum requirements for all providers. This includes providers who contract with Florida Medicaid managed care plans (e.g., provider service networks and health maintenance organizations). Providers shall comply with all of the requirements outlined in this handbook, unless otherwise specified in their contract with the managed care plan. The provision of services to recipients enrolled in a Medicaid managed care plan shall not be subject to more stringent criteria or limits than specified in this handbook.

CHAPTER 2
COVERED, LIMITED, AND EXCLUDED SERVICES

Overview

Introduction

This chapter provides service coverage, limitations, and exclusions information. It also describes who can provide and receive services and any applicable service requirements.

In This Chapter

This chapter contains:

Overview, continued

In This Chapter, continued

This chapter contains:

General Coverage Requirements

Medical Necessity

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.

Rule 59G-1.010 (166), F.A.C. defines "medically necessary" or "medical necessity" as follows:

"[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs.

General Coverage Requirements, continued

Medical Necessity, continued

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
4. Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

"(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services, does not, in itself, make such care, goods or services medically necessary or a covered service."

Exceptions to the Limits (Special Services) Process

As required by federal law, Florida Medicaid provides services to eligible children 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 Social Security Act, codified in Title 42 of the United Sates Code 1396d(a).

Services requested for children under the age of 21 years in excess of limitations described within this handbook or the associated fee schedule may be approved, if medically necessary, through the prior authorization process described in the Florida Medicaid Provider General Handbook.

Covered Services

Only those services designated in this chapter and listed in the individual Practitioner Services Fee Schedules are reimbursed by Medicaid.

Note: The Practitioner Services Fee Schedules are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and then select Fee Schedules. Fee schedules are incorporated by reference in Rule 59G-4.002, F.A.C.

Limitations

Certain services are designated with limitations by diagnosis or other limitations in the appendices in this handbook.

Medicaid does not reimburse services furnished to Florida Medicaid recipients when they are out of the country.

Medicaid does not reimburse services related to acupuncture.

Other limitations specified in this handbook also apply.

General Coverage Requirements, continued

Practitioner Limitations	Unless a provider type is specified within the policy, the service may be provided by any practitioner type covered by this handbook. If a provider type is listed within the policy, only the listed provider type can provide the service.
Duplicate Services	Medicaid will not reimburse two or more of the following provider types for the same procedure, same recipient, and same date of service: • Advanced registered nurse practitioner (ARNP) • Chiropractor • County health department • Federally qualified health center • Licensed midwife • Physician • Physician assistant (PA) • Podiatrist • Registered nurse first assistant (RNFA) • Rural health clinic • District schools
Service Limitations	Certain procedure codes have service frequency, diagnoses, or practitioner based limitations. These limitations are indicated within this handbook or the applicable fee schedules.
Urinalysis, Hemoglobin, and Hematocrit	Manual and dipstick urine, hemoglobin, and hematocrit tests performed as part of a visit are not reimbursed in addition to the visit. The provider may not bill for them as separate procedures.
Scope of Practice	Medicaid does not reimburse for services that are outside the rendering practitioner's scope of practice.
Procedure Codes and Fees	See the individual practitioner's fee schedule for the procedure codes and fees. The fee schedules are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Provider, then Provider Support and then Fee Schedules.

Adult Health Screening Services

Description

An adult health screening is performed by a practitioner to assess the health status of a Medicaid recipient age 21 years and older. It is used to detect and prevent disease, disability, and other health conditions, or monitor their progressions.

This service is not reimbursed for recipients residing in an intermediate care facility for the developmentally disabled (ICF/DD) as these services are covered by the ICF/DD per diem.

Adult Health Screening Procedure Codes

Medicaid reimburses adult health screening services for recipients age 21 years and older with any of the following procedure codes and no modifier:

- 99385 for new patient screenings age 21–39 years
- 99386 for new patient screenings age 40–64 years
- 99387 for new patient screenings age 65 years and older
- 99395 for established patient screenings age 21–39 years
- 99396 for established patient screenings age 40–64 years
- 99397 for established patient screenings age 65 years and older

Screening Service Limitations

Medicaid will reimburse for one adult health screening every 365 days.

Required Service Components

A practitioner who provides adult health screenings must be able to provide or refer and coordinate the provision of all required screening components. The required components must be documented in the recipient's medical record. Required components include the following:

- Health history, including any pertinent psychiatric history
- Physical examination, including mental status exam
- Visual acuity testing
- Hearing screen
- For females, breast exam at least every three years starting at age 20 years and then every year starting at age 40 years
- Laboratory procedures
- Documentation of discussion and education regarding prostate cancer screening with males starting at age 50 years, and at age 45 years for those considered at higher risk
- Referral for or provision of treatment when health problems or deficiencies are diagnosed

Descriptions of these components are provided on the following pages.

Adult Health Screening Services, continued

Health History	At a minimum, the following items must be documented in the recipient's medical record: • Present history, including pertinent psychiatric history • Past history • Family history • Dietary history • Nutritional assessment • Use of alcohol, drugs, and tobacco • List of all known risk factors
Physical Examination	At a minimum, the following items must be documented in the recipient's medical record: • Measurements of height, weight, blood pressure, and pulse • Physical inspection to include assessment of general appearance, skin, eyes, ears, nose, throat, teeth, thyroid, heart, lungs, abdomen, breasts, extremities, and genitalia
Visual Acuity Testing	At a minimum, visual acuity testing must document a recipient's ability to see at 20 feet.
Hearing Screen	At a minimum, a hearing screen must document a recipient's ability to hear by air conduction.
Required Laboratory Procedures	At a minimum, the following laboratory procedures are required and are included in the reimbursement of an adult health screening: • Urinalysis dipstick for blood, sugar, and acetone • Hemoglobin or hematocrit
Recommended Service Components	The following screening components are recommended: • Papanicolaou (PAP) test • Mammography screening referral • Colorectal screening • Screening for prostate cancer • Body mass index measurement Descriptions of these components are provided on the following pages.

Adult Health Screening Services, continued

Cervical Cancer Screening	Medicaid reimburses for medically necessary cervical cancer screening, including Papinicoulaou (PAP screening) and human papilloma virus screening.
Recommended Mammography Screening Referral	Referral for routine screening mammography is recommended by the American Cancer Society for all females age 40 years and older. Mammography screening is limited to one a year. A diagnostic mammogram that is used to evaluate or monitor an abnormal finding is allowed more than once a year, and may be performed on women younger than 40 years of age. Mobile mammography services must be performed by a Food and Drug Administration (FDA) approved mammography unit that is affiliated with a hospital or physician's office. Medicaid does not reimburse independent mobile diagnostic units.
Colon Cancer Screening	Medicaid reimburses colon cancer screening procedures and for symptoms that indicate medical necessity.
Recommended Laboratory Procedures	The following laboratory procedures are recommended, when indicated: • Tuberculin skin test • Prostate specific antigen (PSA) for male recipients age 50 years and older, or beginning at age 45 years for males with a higher risk for prostate cancer • Testing for sexually transmitted infections The tuberculin skin test can be reimbursed in addition to the adult health screening. Medicaid does not reimburse practitioners for venipuncture, collection, handling, or transportation of specimens. This is considered part of the evaluation and management service or global fee-for-service.

Allergy Services

Description	Allergy services include those diagnostic and therapeutic procedures relating to atopic reactions.
Required Service Components	Required service components include all of the following: • Health history • Physical exam • Testing • Immunotherapy, if indicated
Health History	A health history must be included in the Medicaid recipient's health record and should contain all of the following: • Current medications • Known allergies • Health behavior • History of all illnesses • Family, seasonal, environmental, and situational history
Allergy Exam	A comprehensive allergy exam includes all of the following: • The clinical course of the reaction • Eosinophilia evaluation—blood or secretion • Direct skin testing with clinical evidence for atopy • Radioallergosorbent testing if direct skin testing is not possible
Allergy Testing	If allergy tests are performed, they must be based on the history, physical findings, and the practitioner's clinical judgment.
Immunotherapy	When indicated, allergy services may include allergen injection and antihistamine therapy for the suppression of atopic reactions.
Office Visit	Evaluation and management visit codes may be reimbursed in addition to allergen immunotherapy only if other identifiable services are provided and documented during the same visit.

Allergy Services, continued

Allergen Therapy	Provision of allergen preparation, and injection services are reimbursed separately. Medicaid does not reimburse complete service codes that allow for combined billing of preparation and injection. Preparation of the allergen and administration of the first injection may be reimbursed by billing a preparation procedure code and an injection procedure code. Subsequent injections may be reimbursed with an injection procedure code only.
Allergen Preparation Services	Preparation of single dose vials, procedure code 95144, may be reimbursed only when an allergist is preparing extract to be injected by another practitioner. Preparation of a multiple dose vial may be reimbursed only once per treatment cycle using procedure codes 95145-95170. Procedure code 95144 or 95165 is used only for allergen preparation for other than biting or stinging insects.
Allergen Injection Services	Allergen injections may be reimbursed using procedure codes 95115 or 95117.

Anesthesia Services

Description	Anesthesia services are the management of general and regional anesthesia. The purpose of these services is to render a person insensible to pain and emotional stress during surgical, obstetrical and medical procedures. Anesthesia services also include the evaluation and management of problems in pain relief.
Provider Specialty Code Requirement	Anesthesia procedure codes in the range of 00100-01999 are only reimbursed for: • Physicians with a valid specialty code of anesthesiology (03). • Certified registered nurse anesthetists (CRNA) with a valid specialty code (084). • Anesthesiologist assistants (AA) with a valid specialty code (130) under the personal supervision of a physician with a valid specialty code (03) on the provider file with the Medicaid fiscal agent.

Anesthesia Services, continued

Anesthesiologist Assistants (AA)

An AA may bill Medicaid using their individual Medicaid provider number. The reimbursement is 80 percent of the physician fee and pediatric specialty fee increases do not apply.

When the AA is employed and salaried by a medical facility and the salary is reflected in the hospital cost report, for Medicaid reimbursement purposes, the AA may not receive direct reimbursement from Medicaid. Only the anesthesiologist may be reimbursed for supervision.

Certified Registered Nurse Anesthetist (CRNA)

Florida Medicaid reimburses anesthesia services provided by a Medicaid-enrolled CRNA licensed under Chapter 464, F.S.

A CRNA employed by an anesthesiologist may bill using their individual Medicaid provider number. The reimbursement is 80 percent of the physician fee.

When the CRNA is employed and salaried by a medical facility and the salary is reflected in the hospital cost report, for Medicaid reimbursement purposes, the CRNA may not receive direct reimbursement from Medicaid. Only the anesthesiologist may be reimbursed for supervision.

Anesthesia Time

Anesthesia time begins when the anesthesiologist, CRNA, or AA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist, CRNA, or AA is no longer in personal attendance.

Anesthesia Calculation

The calculation for reimbursement of anesthesia services is:

Anesthesia Base Rate + (time/15 x $ conversion factor) = maximum reimbursement.

- The Anesthesia Base Rate is listed on the Physician Anesthesia and ARNP fee schedule.
- Time is reported in total minutes, not units. During claim processing, the total time is divided by 15 minute increments and rounded down to the nearest whole unit.
- Time less than 15 minutes is rounded up to one 15 minute increment and will pay base fee.

When two or more procedures are performed during one surgical period, use only the major anesthesia procedure code related to the primary diagnosis, reason for surgery, and total anesthesia time in minutes on the claim form.

Anesthesia Services, continued

Service Components

All of the following service components are included in the anesthesia fee and cannot be billed separately:

- Pre-operative care, care during the surgery, and post-operative care
- Administration of fluids or blood
- System total body hypothermia
- Nasogastric intubation and decompression
- The following monitoring services:
  - ECG
  - Transesophageal echocardiograms (TEE) for monitoring purposes
  - Temperature, pulse, and blood pressure
  - Oximetry, blood gases, capnography, and mass spectrometry

Hemodynamic Monitoring During Anesthesia

Precise and accurate documentation of hemodynamic monitoring procedures or services performed in addition to general anesthesia service provided is required for proper reimbursement.

Site of insertion, number of separately inserted lines, and their locations must be documented for reimbursement purposes.

Multiple port catheters are not separately reimbursed by the number of functions they are capable of performing. The reimbursement is for the major procedure of each insertion site.

Other Procedures Allowed with Anesthesia

Any of the following procedures may be billed in addition to the anesthesia procedure code when performed in conjunction with anesthesia services when clearly documented on the anesthesia record:

- Cutdown
- Arterial catheterization
- Central venous catheter
- Swan-Ganz catheter insertion

Modifiers

Only modifiers 78, QK, and QS are currently valid for anesthesia services.

Unplanned Return Trip to Operating Room

When the patient returns to the operating room on the same day and the anesthesia provider is the same, the second anesthesia service must be billed with a modifier 78.

If the anesthesia provider is different, a modifier 78 is not required even if the services are for the same day and the same recipient.

Anesthesia Services, continued

Hospital Consultations	Medicaid reimburses hospital consultations to an anesthesiologist for medical issues or anesthesia issues related to pain control. Reimbursement for a hospital consultation is limited to one consultation per "inpatient" hospital admission. The consultation must be related to a medical issue or pain not controlled by the attending physician or surgeon. A referral from the attending physician or surgeon is required for reimbursement of the consultation. Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for billing instructions for consultation procedures.
Service Limitations	Anesthesia services are covered only if the corresponding surgical procedure is eligible for coverage by Medicaid. Anesthesia administered during multiple surgeries is reimbursable under one major anesthesia procedure code for the total anesthesia time, in minutes, inclusive of all procedures. Epidural anesthesia for a vaginal delivery or a cesarean delivery is limited to a total of 6 hours (360 minutes) of reimbursable time. Billing for anesthesia time in excess of the 6 hour reimbursable limit will not result in additional reimbursement.
Service Exclusions	Analysis of arterial blood gases, 82800-82810, is not covered when performed in addition to anesthesia. Central venous access procedures are not covered when performed in conjunction with Swan-Ganz insertion, 93503, unless documented at separate distinct sites. A transesophageal echocardiogram (TEE) for monitoring purposes, CPT 93318, is not covered during the intra-operative period. For further TEE information see the Cardiovascular Services section of this handbook. Medicaid does not reimburse the anesthesiologist for management of intravenous patient controlled analgesia (PCA). Carbon dioxide, expired gas determinations, pulse oximetry, and other routine monitoring components of anesthesia services are not reimbursable separately.

Anesthesia Services, continued

Service Exclusions, continued

Consultations and anesthesia services, procedure codes 00100-01999, are not reimbursable to the same practitioner on the same date of service for the same recipient.

Routine post-operative pain management, except for continuous epidural, is not reimbursable to the anesthesia provider.

Medicaid does not reimburse injectable medication services during the intra-operative period. Intra-operative services are a usual and necessary part of a surgical procedure. Examples are local anesthetic, digital block, or topical anesthesia. These services are included in the payment for a global surgery and are not reimbursable in addition to the surgical procedure(s) 10000-69999.

Abortion, Hysterectomy and Sterilization

In order for Medicaid to reimburse for anesthesia services rendered during an abortion, hysterectomy or sterilization, the practitioner requesting reimbursement must submit the appropriate form from the following documents before payment is made:

- Abortion Certification
- Hysterectomy Acknowledgment
- Exception to Hysterectomy Acknowledgment Requirement
- Sterilization Consent

The anesthesia provider must obtain a copy of the appropriately completed form from the surgeon providing the service.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for instructions on these forms.

Supervision of AA and CRNA

Florida Statutes require that anesthesiologists directly supervise services provided by an AA. The supervising anesthesiologist may bill as the rendering provider for services performed by Medicaid-enrolled AAs under their direct supervision.

If the provider chooses to bill the claim with the AA as the rendering provider, the supervising anesthesiologist may bill for supervision of the AA by billing the anesthesia code with a QK modifier.

An anesthesiologist may supervise a maximum of four CRNAs or AAs providing general anesthesia at one time. Medicaid reimburses the anesthesiologist 20 percent of the anesthesia fee for supervising the CRNA or AA.

Anesthesia Services, continued

Supervision of AA and CRNA continued	To be reimbursed for an anesthesiologist's supervision of a CRNA service, the anesthesiologist must bill with a modifier QK. If a CRNA is employed and salaried by a medical facility and the salary is reflected in the hospital cost report, for Medicaid reimbursement purposes, the CRNA may not bill for direct reimbursement from Medicaid. The anesthesiologist may be reimbursed for supervision of the CRNA in this circumstance and may bill Medicaid if not contracted or salaried by the facility. Medicaid does not reimburse for supervision of procedures outside the anesthesia range 00100-01999. Medicaid does not reimburse anesthesiology supervision of CRNAs performing monitored anesthesia care or moderate sedation. A surgeon, dentist, or any physician without a specialty in anesthesia cannot be reimbursed for providing an anesthesia service or supervising a CRNA.
Non-Labor Epidural Anesthesia	Procedure code 62311 or 62319 is used to bill for the insertion and single or continuous injection of the epidural catheter. Medicaid does not reimburse time increments for these procedures. These procedure codes are not reimbursable with any general anesthesia or obstetrical anesthesia on the same day. Only the major anesthesia procedure code is reimbursable with total time increments. Pain management by epidural catheter on the days after the catheter insertion is reimbursable using procedure code 01996 with no time increments.
Obstetrical Anesthesia Billing	Labor management by epidural anesthesia is billed using procedure code 01967. This procedure code is used to bill continuous epidural analgesia for labor and vaginal delivery. Should the labor progress to a vaginal delivery, no other anesthesia code is allowed. If labor management by epidural anesthesia progresses to a cesarean delivery, bill procedure code 01967, and anesthesia time, and the add-on procedure code 01968 with 1 minute only. Medicaid does not reimburse additional time for the add-on procedure code but reimburses the base rate fee for this procedure code.

Anesthesia Services, continued

Obstetrical Anesthesia Billing, continued

The above billing also applies to procedure code 01969 (add-on code) following neuraxial labor epidural analgesia.

Labor management by epidural anesthesia for vaginal or cesarean delivery is limited to a maximum of six hours (360 minutes) of anesthesia time.

Pain management by epidural catheter on the days after the catheter insertion may be reimbursed using procedure code 01996 with no time increments.

Continuous labor epidural for delivery is reimbursed; however, if the recipient returns to the operating room later during the same hospitalization for a tubal ligation, the separate epidural for the tubal ligation is not reimbursable.

Medically Necessary Labor Epidurals

Anesthesiology providers may not refuse to provide a labor epidural to a Medicaid recipient or ask for remuneration in cash for the procedure at the time the woman is in labor. Labor and delivery are considered emergency services. As such, all medically necessary services to control pain are considered emergency services.

The decision to have a labor epidural must be decided between the recipient and her anesthesiology provider in consultation with the obstetrician. No means of coercion, dissuasion, or refusal by an anesthesia provider to provide medically necessary pain relief to a recipient in labor shall be utilized in making this decision.

Monitored Anesthesia Care (MAC)

MAC must be requested by the attending practitioner, made known to the patient, and performed in accordance with the institution's accepted procedures.

In some institutions, physicians other than anesthesiologists are credentialed or otherwise qualified to provide MAC for certain diagnostic or therapeutic procedures. Medicaid will reimburse physicians other than anesthesiologists for provision of MAC billed with the following anesthesia CPT codes: 00635, 00740, 00810, 01922, 01935, and 01936.

To be reimbursed for MAC, the anesthesiologist, other qualified physician, or anesthetist must meet all of the following requirements:

- Perform a pre-anesthetic examination and evaluation.
- Prescribe the required anesthesia.
- Personally participate in or have medical direction of the entire plan of care.

Anesthesia Services, continued

Monitored Anesthesia Care (MAC), continued

- Be continuously physically present when personally participating in the case.
- Be in close proximity to allow for availability for diagnosis and treatment of emergencies when medically directing a case.
- Observe all institutional regulations pertaining to anesthesia services.
- Furnish all services considered as standard accepted medical practice by anesthesiology providers.

MAC Reimbursement

Medicaid reimburses MAC at the same rate as general or regional anesthesia. To receive reimbursement, the provider must add a QS modifier to the appropriate procedure code.

Moderate Sedation

Moderate sedation must be ordered by the attending physician and not be considered an integral part of the medical procedure performed for the recipient. Documentation of the agent used and route of administration must be maintained in the medical record.

Moderate sedation does not include minimal sedation (anxiolysis). The administration of oral medications, when used to reduce anxiety or tension cannot be billed as moderate sedation. Moderate sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. If airway intervention is required, it is considered monitored anesthesia care and should be billed with the anesthesia codes (00100-01999).

Moderate sedation requires continuous face-to-face attendance and monitoring of vital signs. Documentation of continual monitoring of oxygen saturation, heart rate, and blood pressure, agent used and route of drug administration must be maintained in the medical record.

ARNPs and CRNAs with a specialty type code (84) for anesthesiology may be reimbursed for moderate sedation.

Cardiovascular Services

Description	Cardiovascular services include those diagnostic and therapeutic services performed for the diagnosis or alleviation of disorders of the heart and its extending vascular system.
Stress Testing and Pharmacologic Agents	Stress tests performed by the physician and interpreted in the office are billed using procedure code 93015. When utilizing pharmacologic agents during a stress test, performed in the office setting only, bill the pharmacologic agent using the appropriate injectable medication code listed on the Physician Injectable Services fee schedule. Introduction of a needle or any other form of intracatheter device is not reimbursable in addition to any injectable medication.
Non-invasive Vascular Studies	Non-invasive vascular studies include all of the following: • Direct supervision of the studies • Physician interpretation and report of study results • Analysis of data, including bi-directional vascular flow or imaging when provided Medicaid does not reimburse a separate technical component for vascular studies performed in the physician office.
Required Service Component	Any device used in vascular studies must produce a hard copy output or produce a record that permits analysis of bi-directional vascular flow.
Doppler Device	The use of a hand-held Doppler or other Doppler device that does not produce a hard copy output or produce a record for analysis is considered to be part of the physical exam of the vascular system and cannot be reimbursed separately.

Cardiovascular Services, continued

Cardiac Catheterization Reimbursement

Reimbursement to physicians for cardiac catheterization includes all of the following components:

- Physician's service including pre-assessment
- Introduction, positioning and repositioning of catheter(s)
- Recording of intracardiac and intravascular pressures
- Obtaining blood samples for measurements of blood gases and dye (or other) dilution curves
- Cardiac output measurements with or without electrode catheter placement
- Final evaluation and report
- Selective catheter placement to determine patency of veins and arteries for harvesting prior to cardiovascular surgery

Injection procedures and other special studies performed in conjunction with cardiac catheterizations are reimbursed separately.

Billing for cardiac catheterization procedure codes rendered in the inpatient hospital, outpatient hospital, and ambulatory surgical center require use of modifier 26 for PC pricing.

Electrocardio-grams (EKG)

Interpretations by the physician of 12-lead EKGs are reimbursable in addition to a visit.

Medicaid does not reimburse for rhythm strip interpretation.

Reimbursement for interpretation and report, procedure code 93010, can be made only to the physician who signs and dates the EKG.

Echocardiography

Echocardiography includes obtaining ultrasonic signals from the heart and great arteries, with two-dimensional image and Doppler ultrasonic signal documentation; interpreting such signals; and reporting such findings.

Physician reimbursement for echocardiograms is limited to once per 30 day period.

When an additional echocardiogram is medically necessary, the provider must bill for the additional service with a modifier 22 and submit medical documentation that supports the need for an additional echocardiogram within thirty days.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for information on entering modifiers on the claim form.

Cardiovascular Services, continued

Transesophageal Echocardiogram (TEE)

Medicaid will reimburse the practitioner for TEEs when the physician provides all components of the procedure code as described in the CPT codebook. Documentation of all studies must be signed by the physician and maintained in the medical record.

Interpretation and report of a TEE must be for diagnostic purposes and not for the sole purpose of monitoring during surgery.

When a pre-operative TEE is performed on the same date of service as a post-operative TEE, bill the procedure code with 2 units of service on the same claim line.

TEEs are limited to a maximum of two per date of service when performed by the physician pre-operatively and post-operatively to evaluate cardiac surgery patients.

Prolonged Physician Attendance

Prolonged physician evaluation and management may be reimbursed in addition to a TEE under conditions that require extensive evaluation and management services.

Documentation for the medical necessity of prolonged physician attendance is required in the medical record.

Extracorporeal Membrane Oxygenation (ECMO) Neonates

ECMO is to be used as a temporary bedside lifesaving procedure. Medicaid will reimburse the physician for insertion of the cannula, initial 24 hours and each additional 24 hours needed.

ECMO is considered medically necessary in neonates who meet all of the following criteria:

- Gestational age of at least 34 weeks
- Birth weight of 2,000 grams or greater
- Age less than 10 days
- Diagnosis of one or more of the following:
  - Hyaline membrane disease
  - Meconium aspiration
  - Persistent fetal circulation
  - Congenital diaphragmatic hernia
  - Possible cardiac anomaly
  - Respiratory distress syndrome
  - Refractory neonatal septic shock

ECMO for neonates is considered experimental and investigational when all of the above criteria are not met.

Medicaid does not reimburse separately for ECMO decannulation.

Cardiovascular Services, continued

ECMO Children and Adults

ECMO is to be used as a temporary bedside lifesaving procedure. Medicaid will reimburse the physician for insertion of the cannula, initial 24 hours and each additional 24 hours needed.

ECMO is considered medically necessary in children and adults who meet any of the following criteria:

- Adult respiratory distress syndrome (ARDS)
- Non-necrotizing pneumonias (both bacterial and viral)
- Pulmonary contusion
- Refractory pediatric septic shock
- Other reversible causes or respiratory or cardiac failure that are unresponsive to all other measures
- Following heart surgery to ease transition from cardiopulmonary bypass to ventilation
- As a short-term (i.e. hours to a few days) bridge to heart transplant

ECMO for children and adults is considered experimental and investigational for all other indications.

Medicaid does not reimburse separately for ECMO decannulation.

Service Exclusions

Medicaid does not reimburse for mobile cardiovascular services. This includes the physician's professional component of cardiovascular studies when the study is performed by a mobile cardiovascular provider.

Medicaid does not reimburse for procedure codes that provide diagnostic data that are duplicative of another more comprehensive procedure code performed on the same date of service.

Chemotherapy Services

Description

Chemotherapy is a drug therapy that refers to any of the following:

- Use of antibiotics by killing micro-organisms (antibacterial chemotherapy).
- Use of cytostatic drugs to kill cancerous cells (cytostatic chemotherapy).
- The treatment of autoimmune diseases such as multiple sclerosis, Lupus, and rheumatoid arthritis.
- The suppression of transplant rejections (immunosuppression).

Chemotherapy Services, continued

Service Coverage	Chemotherapy administration, refilling and maintenance of either portable or implantable pump, chemotherapy injection, and provision of injectable chemotherapy agent are covered services. See section on Injectable Medication Services in this chapter for additional information.
Billing Chemotherapy Medications	Chemotherapy medications purchased and administered in the office are reimbursed using the appropriate HCPCS drug code and HCPCS billing units. Submission of a valid National Drug Code (NDC), metric unit, and metric quantity are also required. HCPCS drug codes for chemotherapy medications include J-codes; some C-codes; and some Q-codes. C-codes and Q-codes may be activated for Medicaid claims in order to speed claim processing, and avoid manual medical review. However, the non-specific drug code (J9999) is required for Medicare B billing and subsequent crossover to Medicaid. If a HCPCS drug code is not available for a specific chemotherapy medication, bill with procedure code J9999. Submission of a valid National Drug Code (NDC), metric unit, and metric quantity are also required. Code J9999 requires that the provider submit medical documentation with the claim indicating the drug, medical indication, dosage, route of administration and the initials of the health care provider administering the drug to the recipient. Without all of these components, the claim will be denied. Reimbursement for chemotherapy medications is determined according to the same pricing methodology used by pharmacy services. Note: See the Florida Medicaid Prescribed Drug Services Coverage and Limitations Handbook. Reimbursement is the lesser of the average wholesale price (AWP) less 15.4 percent or wholesale acquisition cost (WAC) plus 5.75 percent.
Visits and Chemotherapy	Procedure codes for chemotherapy services are reimbursed in addition to a recipient office visit. Either may occur independently on any date of service, or they may occur sequentially on the same day.
Agent Preparation	Chemotherapy agent preparation is included in the service for administration of the agent.

Chemotherapy Services, continued

Regional and Parenteral	Regional chemotherapy perfusion is reimbursed using codes for arterial infusion. Separate codes for each parenteral method of administration employed may be reimbursed when chemotherapy is administered by different techniques.
Peripherally Inserted Central Catheter (PICC)	Placement of a PICC (peripherally inserted central catheter) must be billed using the appropriate code from the CPT codebook. These codes are reimbursable in addition to an office visit that is rendered on the same day of service.
Service Limitations	See Medically Accepted Indications and Service Limitations in the Injectable Medication Services section in this chapter for additional information.

Cochlear Implant Services

Description	Cochlear implant services provide restoration of auditory capacity to Medicaid-eligible recipients with hearing loss that is not improved with the use of hearing aids. Please refer to the Florida Medicaid Hearing Services Coverage and Limitations Handbook for information on Cochlear Implants.

Consultation Services

Description	A consultation is an evaluation provided by a practitioner whose opinion or advice regarding evaluation and management of a recipient's specific problem is requested by another healthcare provider. A consultation initiated by a recipient or the recipient's family and not requested by a practitioner is not reimbursable as a consultation. It is reimbursed using the procedure codes for office visits, as appropriate.

Consultation Services, continued

Consultation that Becomes a Referral	If subsequent to the completion of a consultation, the provider assumes responsibility for management of a portion or all of the recipient's care, the provider may not bill for the follow-up consultation codes as defined by the CPT codebook. In the hospital setting, the practitioner receiving the recipient for partial or complete transfer of care must use the appropriate inpatient hospital consultation code for the initial encounter followed by subsequent hospital care codes. In the office setting, the appropriate established patient evaluation and management code must be used.
Documentation Requirements	At a minimum, the following components must be recorded in the recipient's medical record: • Request and need for consultation from the attending or requesting healthcare provider • Consultant's opinion and any services ordered or performed • Written report provided to the attending or requesting healthcare provider
Hospital Inpatient Consultation Visits	Medicaid reimburses for one initial consultation, per hospitalization, per recipient, per specialty. If a partial or complete transfer of care ensues following the initial hospital consultation, all follow-up visits are considered subsequent hospital visits.
Office or Hospital Outpatient Consultation Visits	Medicaid reimbursement is limited to one initial consult visit, per physician specialty, per 365 days, for a non-hospitalized recipient. If a partial or complete transfer of care ensues following the initial office or outpatient consultation visit, all follow-up visits are considered subsequent evaluation and management services. If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician, an evaluation and management code should be used.
MediPass Recipients	If a patient is a MediPass or Provider Service Network (PSN) recipient, the provider must obtain a referral number from the MediPass or PSN primary care provider (PCP) and enter it on the claim form for payment of the service. Note: See the Florida Medicaid Provider General Handbook for information on MediPass.

Consultation Services, continued

Non-reimbursable Consultation Visits

Medicaid does not reimburse for a consultation visit in addition to an office, home, or hospital visit on the same day of service, for the same recipient, by the same provider.

Medicaid does not reimburse for consultation visits rendered in nursing or custodial care facilities.

Medicaid does not reimburse consultation visits for a second opinion.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for proper billing instructions for consultation procedure codes.

Critical Care Services

Description

Critical care is the care and monitoring of an unstable, critically ill, or injured patient in a variety of medical emergencies that requires constant attention and can only be provided by a physician. The care of such patients involves decision-making of high complexity to assess, manipulate, and support central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, unpredictable post-operatively complications, overwhelming infection, or other vital system functions to treat single or multiple vital system organ system failure or to prevent further deterioration. It may require extensive interpretation of multiple databases and the application of advanced technology to manage the patient. Critical care may be provided on multiple days when the condition requires the level of physician attention described above.

Examples can include cardiac arrest, shock, severe bleeding, respiratory failure, and post-operative complications that are not an expected complication of the initial illness, injury, diagnosis or surgical procedure.

Critical care is usually, but not always, provided in a critical care area such as the coronary care (CCU), intensive care (ICU), respiratory care, or emergency care unit. However, critical care services may be provided in any location in unusual circumstances.

Reimbursement

Reimbursement for critical care codes is limited to situations in which the physician is providing constant attention to the unstable critically ill patient. Services that do not meet this requirement, even if provided in a critical care area, must not be billed using critical care codes. Hospital care evaluation and management codes must be used to report these services. All other program and CPT codebook guidelines apply.

Critical Care Services, continued

Critical Care Time

The critical care codes are used to report the total duration of time spent by a physician providing constant attention to an unstable patient, even if the time spent by the physician providing critical care services on that date is not continuous. Billing procedure code 99291 for critical care is appropriate only once per date per physician, even if the time spent by the physician is not continuous on that date.

If the total time providing critical care is 30 minutes or less do not report critical care. Report the appropriate level of evaluation and management procedure code.

Procedure code 99291 is billed to report up to the first 30–74 minutes of critical care service per day. This procedure code may only be billed once per day by an individual physician or physician of the same specialty within a physician group. Additional critical care time increments must be billed using procedure code 99292 as shown in the chart below.

Reimbursement for critical care services exceeding 194 minutes or more than four units of 99292 on the same date of service requires submission of documentation with the claim that supports the medical necessity for extended critical care and need for constant physician attention.

Critical Care Time Reporting

The following chart is used to appropriately bill for time spent performing critical care services. The chart is adapted directly from the Common Procedural Terminology (CPT) by the American Medical Association:

Total Duration of Critical Care	Codes
Less than 30 minutes	Appropriate E&M codes
30–74 minutes	99291 X 1
75–104 minutes	99291 X 1 and 99292 X 1
105–134 minutes	99291 X 1 and 99292 X 2
135–164 minutes	99291 X 1 and 99292 X 3
165–194 minutes	99291 X 1 and 99292 X 4
195 minutes or longer	99291 X 1 and 99292 X ____ *

*Medical documentation needed.

Critical Care Services, continued

Limitations

Critical care is the direct delivery by a physician of medical care for the critically ill or critically injured patient. For reporting by professionals, the following services are included in critical care when performed during the critical period by the physician providing critical care:

- Interpretation of cardiac output measurements
- Interpretation of chest x-rays
- Pulse oximetry
- Blood gases and data stored in computers
- Gastric intubation
- Temporary transcutaneous pacing
- Ventilator management
- Vascular access procedures

Separately Reportable Services

Time spent performing separately reportable procedures or services should not be included in time reported as critical care time.

Guidelines for Reporting Critical Care Codes

In order to reliably and consistently determine that delivery of critical care services rather than other evaluation and management services is medically necessary, the following medical review criteria must be met in addition to the definition of critical care services:

- Clinical condition criterion—There is a high probability of sudden, clinically significant or life threatening deterioration in the patient's condition, which requires the highest level of physician preparedness to intervene urgently; and
- Treatment criterion—Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent personal assessment and treatment by the physician. Withdrawal of or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition.

Critical Care in a Teaching Facility

Critical care services are time-based services. Critical care services in a teaching hospital may only be billed using the time that the teaching physician was in attendance and rendering service related to the individual patient's care. When a bill is submitted for a procedure code determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made.

Critical Care Services, continued

Critical Care in a Teaching Facility, continued	Because critical care is reported using time as the basis, the teaching physician's progress note must contain documentation of the total time involved providing critical care services. Document the date and total time spent with the patient on all notes. If the time and date are not legible and documented, the service may be subject to denial. When calculating time of a critical care service in a teaching hospital, all of the following must be considered: • Time spent teaching residents or medical students may not be counted toward the critical care service time. • Teaching physician must be present for the period of time for which the claim is made. • Teaching physician must not bill time spent by the resident in the absence of the teaching physician.
Limitation on Place of Service	Critical care is expected in the hospital setting and is only reimbursable by Medicaid when the critically ill or injured patient is either admitted to the inpatient hospital or is anticipated as an admission to the inpatient hospital for continued critical care.
Non-Critical Care	When a recipient is still located in the critical care area of the facility, but is no longer critically ill, the provider must bill subsequent hospital visits instead of critical care.
Prolonged and Stand-By Services	Physician stand-by service and prolonged service cannot be reimbursed in addition to critical care.
Procedure Codes and Fees	For pediatric and neonatal critical care services, see the Pediatric Critical Care Services and Neonatal Critical Care Services sections in this chapter.

Custodial Care Facility Services

Description	Custodial care facility services are evaluation and management services that are provided to a recipient in a facility that provides room, board, and other personal assistance services, generally on a long-term basis. It includes domiciliary, rest home, or custodial care facilities such as: • Assisted Living Facilities (ALF) • Adult Family Care Homes (AFCH) • Extended Congregate Care Facilities (ECC) • Continuing Care Retirement Communities (CCRC)
Annual Comprehensive Nursing Facility Assessment	Medicaid reimburses for an annual comprehensive nursing facility assessment every 365 days. This procedure code may not be billed in addition to the monthly nursing facility evaluation and management codes.
Service Frequency	Evaluation and management services for chronic care management are limited to one medically necessary visit per month, per provider, per recipient.
Acute Care Events	Episodic care visits to manage acute events can be reimbursed if the attending practitioner is required to visit the patient to make an alteration in the patient's treatment plan. The provider must bill with a 22 modifier, and submit a report documenting the care provided. Claims are reviewed for medical necessity. Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for information on entering modifiers on the claim form.
Facility Visit	A custodial care facility visit is not reimbursed in addition to another evaluation and management visit for the same day, same provider, and same recipient.
Excluded Services	Medicaid does not reimburse for consultation services rendered in a custodial care facility. Services provided in an office or room located in a custodial care facility may not be billed as office evaluation and management visits. Psychiatric services, including pharmacological management, rendered in a custodial care facility cannot be reimbursed.

Dialysis Services

Description	Dialysis services are those provided for the artificial and mechanical removal of toxic materials and the maintenance of fluid, electrolyte, and acid-base balance in cases of impaired or absent kidney function.
Service Requirements	Medicaid reimburses for dialysis services rendered by or under the direct supervision of a physician not salaried by the dialysis center or hospital. Physician management and ongoing care of a dialysis recipient, exclusive of other medical conditions, are reimbursed as part of the dialysis service. Reimbursement is not available for the supervision of the dialysis procedure. Reimbursement is not available for supervising medical directors who monitor patient care at free-standing dialysis centers.
Billing of Monthly or Less than Monthly Dialysis Codes	If a physician provides monthly or less than monthly, dialysis procedures for the routine maintenance of a dialysis recipient, the medical record documentation must be maintained at the facility where the actual dialysis service is performed. The physician bills the monthly, or less than monthly, dialysis procedure codes using the place of service where he performed the service of routine maintenance, not the place of service where the actual dialysis service was performed.
Inpatient Dialysis and Visits	Medicaid will reimburse for dialysis services in the inpatient hospital setting in addition to one initial inpatient hospital consultation or one outpatient hospital consultation, as appropriate, and one discharge day management procedure code per recipient, per hospitalization. The hemodialysis procedures, including evaluation and management services related to the recipient's renal disease on the day of the hemodialysis procedure, may be reimbursed only when provided in the inpatient hospital setting. These procedure codes are for the direct face-to-face supervision of a dialysis recipient. They are not reimbursable in addition to daily hospital visits.
Services Included	Services related to the recipient's end stage renal disease that are rendered on the day when the dialysis is performed are included in the dialysis procedure.

Dialysis Services, continued

Service Limits and Exclusions	Dialysis services are considered a visit and cannot be reimbursed in addition to certain evaluation and management codes.
Non-Covered Services	Dialysis training and hemoperfusion are not covered services.

Durable Medical Equipment Services

Durable Medical Equipment (DME)	Providers must bill DME services in accordance with the policy outlined in this section and with the policy in the DME and Medical Supply Services Coverage and Limitations Handbook. Medicaid will not reimburse providers for DME services that are billed with unlisted CPT or HCPCS codes unless the unlisted DME billing has been approved and priced by Medicaid. Providers with an orthopedic specialty may bill Medicaid for DME using the DME codes listed in the Physician DME fee schedule when the DME is provided in the office setting. Any Medicaid covered DME not listed in the Physician DME fee schedule must be provided by an enrolled DME provider. Note: The Physician DME fee schedule is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules.

Evaluation and Management Services

Description	Evaluation and management services are face-to-face encounters with the recipient or the recipient's family provided in the inpatient or outpatient hospital, recipient's home, or practitioner's office. An exception to the face-to-face encounter may occur when a physician consultation occurs via a telecommunications system in accordance with this handbook.
New Patient Visit	A new patient is one who has not received any professional services from a practitioner within the past three years.

Evaluation and Management Services, continued

Established Patient Visit	An established patient is one who has received professional services from a practitioner, or another practitioner of the same specialty who belongs to the same provider group, within the past three years.
On-Call	On-call coverage and treatment of established patients for other practitioners must be billed with established patient visits.
Office Visits	Office visits can be reimbursed for services provided in a practitioner's office, an outpatient facility, or ambulatory facility.
Home Visits	Home visits can be reimbursed for a medically necessary visit in the private residence of the recipient. Custodial care facility and nursing facility visits are not considered home visits and must be billed in accordance with the policies stated in the Custodial Care Facility Services and Nursing Facility Services sections in this chapter.
Hospital Visits	Hospital visits to an inpatient recipient are reimbursable for only the following services: • Evaluation and management visit • Non-surgical service Hospital visits to an inpatient recipient are not reimbursed, when the visit relates to a procedure not covered by Medicaid. Reimbursement is not made to the ARNP or PA and the physician for the same service, same recipient, and same date of service.
Billing for an Additional Hospital Visit	Medicaid will reimburse for a visit that is for a significant, separately identifiable service above and beyond the usual pre- and post-operative care associated with the surgical procedure that was performed. To be reimbursed for this visit, the provider must bill with a modifier 25. To be reimbursed for an evaluation and management visit that is performed during the post-operative period for a reason unrelated to the original procedure, the provider must bill with a modifier 24.
Pediatric Primary Care Visits	Providers receive additional reimbursement for procedure codes 99212, 99213, and 99214 provided to eligible recipients 0–19 years of age.

Evaluation and Management Services, continued

Physician Standby Visits

Physician standby services are reimbursed for cesarean section standby only.

A physician standby service (procedure code 99360) is reimbursable in addition to the history and exam of the normal newborn infant (code 99460) only if:

- Criteria for standby were met (30 minutes or more).
- Delivery was by cesarean section.

Physician standby service (procedure code 99360) is not reimbursable in addition to attendance at delivery (procedure code 99464).

Prolonged Services

Prolonged practitioner service procedure codes will be reimbursed only when all of the following criteria are met:

- Practitioner has furnished and billed an evaluation and management code.
- Time counted toward payment for prolonged evaluation and management services includes only direct face-to-face contact between the practitioner and the patient whether the service was continuous or not.

The medical record must document all of the following information:

- Content of the evaluation and management service
- Duration and content of prolonged services that the practitioner personally furnished after the typical time of the evaluation and management service is exceeded by at least 30 minutes

The time counted toward the use of prolonged practitioner service codes is limited to the sum of all direct practitioner-patient face-to-face time beginning only after the time required to perform the content of the billed evaluation and management service is exceeded by at least 30 minutes.

Prolonged practitioner services in the inpatient setting are not billable with critical care codes, pediatric critical care codes, or anesthesia services.

Do not bill prolonged practitioner service codes instead of visit codes.

Evaluation and Management Services, continued

Emergency Care Visits	Emergency care evaluation and management services may be reimbursed to private practitioners or hospital-based practitioners who are not salaried by a facility when the services are provided in the emergency facility of a hospital. Some emergency care evaluation and management services may be reimbursed to an ARNP when the services are provided in the emergency facility of a hospital. If a MediPass recipient presents at the emergency room with a condition that the emergency room practitioner determines does not meet the definition of an emergency as defined in section 409.901(10), F.S., a provider whose salary is not included in the hospital's cost report may bill for a screening, evaluation, and examination utilizing procedure code 99281.
Visit After Hours	When emergency services are provided in a provider's office at times other than regularly published office hours, Medicaid may reimburse for services requested after hours (procedure code 99050) in addition to the appropriate level of office visit. These services cannot be billed when the provider and staff "plan" to be at the office ready and available to address patients who may require care, even though previously unscheduled. The provider must determine that the services need immediate attention.
Hospital Observation Services	Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff. They are services that are reasonable and necessary to evaluate an outpatient's condition, or determine the need for a possible admission to the hospital as an inpatient. Such services are covered when provided by the written order of a practitioner directing admission to observation services. Services for routine post-operative monitoring during a normal recovery period cannot be billed as observation services. Medicaid reimburses for one observation service per day, per recipient.

Evaluation and Management Services, continued

Newborn Visit Frequency in the Hospital	Medicaid reimburses for a history and examination of the normal newborn with the appropriate "V" diagnosis code once in the recipient's lifetime. Medicaid reimburses up to two subsequent hospital care visits for the evaluation and management of a normal newborn after the initial visit. Medicaid does not reimburse for visit services for a normal newborn that remains in the hospital after three days. Medicaid does not reimburse for CPT codes specific to discharge day management for a normal newborn. Medicaid does not reimburse for a newborn visit and Child Health Check-Up screening for the same provider, same recipient, and same day of service.
Attendance at Delivery of Newborn	Medicaid reimburses for attendance of a physician at delivery (99464) for initial stabilization of a newborn (when requested by the delivering physician) with the appropriate illness diagnosis code. Procedure code 99464 can be reimbursed in addition to 99460. Appropriate diagnosis codes for each procedure code are required. Procedure code 99464 cannot be reimbursed with physician standby services (99360). Procedure code 99464 cannot be reimbursed with procedure code 99465.
Infusion Therapy Services	To be reimbursed for prolonged intravenous infusion, the presence of a qualified professional, as defined in CPT codebook, is required Medicaid does not reimburse for insertion of intracatheters, heparin locks, or other methods for delivering intravenous infusions in addition to the prolonged intravenous infusion therapy procedure codes.
Visit Reimbursement Limitations	Office, home, hospital, and emergency room visits are limited to one visit, per recipient, per day, per specialty, except for emergency services. Visits for general services (for example, family practice) are limited to two per month for non-pregnant adults. Visits to the same recipient by more than one specialty provider on the same day are reimbursable. Office or home visits for supervision of chronic illness are limited to one visit a month, per recipient, per specialty.

Evaluation and Management Services, continued

Visit on the Same Day as Surgery

Medicaid does not reimburse an evaluation and management visit on the same day as surgery unless one of the following requirements are met:

- Evaluation and management service results in the initial decision to perform surgery. The decision to perform surgery services should be billed by appending a modifier 25 to the evaluation and management procedure code.
- Evaluation and management service is a significant, separately identifiable visit beyond the usual pre- and post-operative care associated with the surgery.
- CPT surgical code is exempt from visit surgery rules.

Medicaid will not reimburse for routine evaluation and management follow-up visits related to surgery with a modifier 25.

Non-reimbursable Visits

Medicaid does not reimburse visits for second opinions. The only exception to this limitation is for consultations by board-certified psychiatrists under the specific circumstances outlined in the Psychiatric Services section in this chapter.

Family Planning Services

Description

Family planning services are covered for Medicaid-eligible persons of childbearing age who desire family planning services and supplies. The services are for the purpose of enabling persons to voluntarily plan family size or plan the length of time between births.

Note: For sterilization procedures, see Surgery Services in this chapter.

Family Planning Procedure Codes

Services specific to family planning are reimbursed with CPT procedure codes for preventive medicine and require the use of the modifier FP.

Description	Procedure Code	Modifier
New Patient Family Planning Visit	99384-99386	FP
Established Patient Family Planning Visit	99394-99396	FP
Family Planning Counseling Visit	99403	FP
Family Planning Supply Visit	99211	FP

These services are not reimbursable when billed using any other evaluation and management procedure code.

Family Planning Services, continued

Services for Minors

Medicaid does not reimburse for family planning services for a minor (under age 18 years) unless the minor:

- Has written consent of parent or legal guardian.
- Is married.
- Is a parent.
- Is pregnant.
- Will suffer from probable health hazards if such services are not provided as determined by the practitioner, based on sexual activity or other medical reasons.

The provider must document the reason for providing family planning services to the minor in the recipient's medical record.

New Visit Components

Only one new family planning visit, per recipient, per provider or provider group can be reimbursed.

At a minimum, all of the following components must be provided and documented in the recipient's medical record:

- Health history
- Pre-examination education session
- Physical examination
- Required laboratory tests
- Selection of contraceptive method, provision of supplies
- Post-examination interview

Established Visit Components

At a minimum, all of the following components must be provided during an established family planning visit and documented in the recipient's medical record:

- Updates to the original data in the patient record
- Physical examination
- Addressing renewal needs of contraceptive method
- Post-examination interview

Refer to Adult Health Screening Services in this chapter for recommendations on the cervical cancer screening component for this established visit.

Established family planning visit reimbursements are limited to one every 365 days.

Family Planning Services, continued

Laboratory Tests

Medicaid will reimburse for the following laboratory tests for a new or established family planning visit, when indicated:

- Hemoglobin or hematocrit
- Urinalysis
- Screening for sexually transmitted diseases
- Rubella titer
- Tuberculin skin test

The tuberculin skin test may be reimbursed separately in addition to the family planning service. The rubella titer and sexually transmitted disease screens are billed by the pathologist or independent laboratory providing the service.

Counseling Visit

The purpose of a counseling visit is to discuss the family planning method chosen or to discuss other available methods. Counseling visits should include information on natural family planning methods.

All of the following components must be provided and documented in the recipient's medical record:

- All information necessary to increase the recipient's understanding of and motivation for family planning.
- Provision of supplies for the contraceptive method, if indicated.
- Identification of any problems with current birth control method.

A counseling visit and supply visit are not reimbursable for the same date of service, same recipient, same provider, or provider group.

Supply Visit

The purpose of a supply visit is to assess the recipient and provide family planning supplies such as birth control pills or condoms.

All of the following minimum components must be provided and documented in the recipient's medical record:

- Check of weight and blood pressure
- Check for any side effect of medications
- Provision of supplies or prescriptions for the contraceptive method

Supply visit reimbursements are limited to once per month.
All prescriptions for family planning supplies are reimbursed through the Medicaid Prescribed Drug Services program.

Family Planning Services, continued

HIV Counseling	The purpose of HIV counseling services is to determine a Medicaid family planning recipient's risk factor associated with HIV and to provide necessary prevention education and to make referrals as needed. HIV counseling is reimbursable using procedure codes 99401 or 99402 when HIV testing is indicated. Medicaid will reimburse for a counseling session performed prior to obtaining the specimen for HIV screening and again when blood screening test results are available. HIV counseling must clearly relate to a family planning visit on the same date of service or within the previous 12 months. A family planning diagnosis code (V25.01 through V25.9) must be entered on the claims submitted for procedure codes 99401 and 99402.
HIV Counseling Limits	HIV counseling sessions may be billed in addition to a family planning visit or an evaluation and management visit when all components of both visits are performed. HIV counseling sessions are limited to four per year, per recipient who acknowledges HIV risks. They are limited to two per lifetime, per recipient for preventive counseling.
HIV Counseling Documentation	Medical record documentation must identify risk factors as appropriate or state, "no acknowledged risk." Documentation for post-test HIV counseling sessions must minimally contain referrals as appropriate to programs.
Intrauterine Device (IUD)	Insertion and removal of an IUD is reimbursable in addition to a family planning new or l established visit or an evaluation and management visit if all components of an evaluation and management visit are met and documented in addition to the IUD service. Reimbursement for the IUD device is covered using the IUD specific HCPCS code. IUDs qualify under the federal drug rebate program, so these claims require a valid NDC number. The NDC number can be found on the product that is being administered to the recipient. Medicaid utilizes the 11 digit format, and this may require insertion of leading zeros if they do not appear on the package. Procedure code 99070 is not an appropriate code and cannot be reimbursed for an IUD.

Family Planning Services, continued

Injectable and Implantable Contraception	Services associated with the decision to use long-acting injectable or implantable contraceptives are covered using the appropriate family planning code. Reimbursement for the medication is covered using the appropriate HCPCS code and valid NDC number. The NDC number can be found on the product that is being administered to the recipient. Medicaid utilizes the 11 digit format, and this may require insertion of leading zeros if they do not appear on the package, for example: 00001-0234-05. Note: Refer to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for billing guidelines.
Diaphragms and Cervical Caps	Provision of diaphragms and cervical caps is by prescription and reimbursed through the Medicaid Prescribed Drug Services program. The diaphragm or cervical cap fitting can be reimbursed to the provider. Note: See the Medicaid Prescribed Drugs Services Handbook for more information.
Pregnancy Testing	A pregnancy test may be indicated prior to the use of a particular contraceptive method. Pregnancy testing may be reimbursed if all components of the service are provided. Specimens for pregnancy testing sent to an independent lab may be reimbursed to the laboratory. The provider may not bill for the collection of the specimen.
Service Limits and Exclusions	Family planning procedure codes are not reimbursable on the same date of service to the same recipient with any evaluation and management procedure codes. Medicaid does not reimburse for infertility evaluation and treatment.

Fluoride Varnish Policy

Fluoride Varnish Reimbursement for Non-Dentists

Medicaid reimburses practitioners for the application of fluoride varnish to the teeth of Medicaid-eligible children age 0 to 4 years of age. Fluoride varnish procedures must include counseling with the child's primary caregiver on proper nutrition and the need to see a dentist.

Fluoride varnish may be applied every 90 days up to 4 times a year to a child's teeth showing signs of white spot lesions using diagnosis code 521.01. The appropriate code for billing fluoride varnish procedures is 99499 SC.

The health care professional should refer the child to a dentist in order to establish a dental home. If a dental provider is not available in the area, the health care professional should notify the area Medicaid office that the child needs to see a dentist for an evaluation.

A list of dental providers for each area is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Under the Area Offices section, select Area Office Map, then choose the county that the child lives in, and then under Area Office Information, select Medicaid Dental Providers.

Physicians practicing in county health departments, federally qualified health centers and rural health centers may apply fluoride varnish to eligible Medicaid children. Fluoride varnish procedures should be billed using the facility group provider number. The treating provider number must be entered in item 24J on the CMS-1500 claim form.

Immunization Services

Description

Immunization services provide vaccines to induce a state of being immune to or being protected from a disease. Medicaid reimburses these services for recipients from birth through 20 years of age.

Eligible Recipients

Medicaid-eligible recipients from birth through 18 years of age are eligible to receive free vaccines through the federal Vaccine For Children (VFC) Program. The provider is reimbursed only for the administration of the vaccine. The vaccine is free to the provider through the VFC program, Department of Health.

Medicaid-eligible recipients 19 through 20 years of age may receive vaccines through their health care provider. These vaccines are not free to the provider and are reimbursed by Medicaid. Reimbursement includes the administration fee and the cost of the vaccine.

Medicaid does not reimburse for immunization services for recipients who are 21 years of age and older.

Vaccines for Recipients Birth Through 18 Years

For eligible recipients from birth through 18 years of age, vaccines and combination vaccines providing protection against all of the following diseases are available free to the VFC-enrolled provider through the VFC program:

- Diphtheria, Tetanus and Pertussis (DTaP)
- Haemophilus Influenzae Type b (HIB)
- Hepatitis B (pediatric and adult)
- Meningococcal Conjugate (MCV4)
- Pneumococcal (PCV 7)
- Polio (IPV)
- Measles, Mumps, and Rubella (MMR)
- Tetanus and Diphtheria (Td) (Adult)
- Influenza
- Varicella
- Human Papillomavirus (HPV)
- Rotavirus

Any of the following vaccines are available by request or for high-risk areas only through the VFC program:

- Hepatitis A
- Diphtheria and Tetanus (DT) (Pediatric)
- Pneumococcal Polysaccharide (PPV)
- Meningococcal Polysaccharide (MPSV4)

Immunization Services, continued

Vaccines for Recipients 19 Through 20 Years	For eligible recipients ages 19–20 years, vaccines and combination vaccines providing protection against all of the following diseases are reimbursable: • Hepatitis A • Hepatitis B • Human Papillomavirus (HPV) • Influenza • Measles, Mumps, and Rubella (MMR) • Meningococcal Conjugate (MCV 4) • Meningococcal Polysaccharide (MPSV4) • Pneumococcal Polysaccharide (PPV) • Tetanus and Diphtheria (Td) • Varicella
Vaccine for Children Program (VFC)	Providers must enroll in the VFC program to receive free vaccines for 0–18 year olds through the VFC program. Information regarding the Vaccine for Children (VFC) Program is available by calling the State of Florida Department of Health, Bureau of Immunization, at 800-4-VFC-KID or 800-483-2543.
Administration Fee Reimbursement	Medicaid reimburses an administration fee to physicians, ARNPs and PAs providing free vaccines through the VFC Program to Medicaid-eligible recipients from birth through 18 years of age. Providers should bill the CPT code specific to the vaccine administered and not the administration code.
Reimbursement for Non-VFC Vaccines	Medicaid may reimburse the cost of the vaccine and an administration fee for Medicaid-eligible recipients 0–18 years of age who receive vaccines not available through the VFC Program.
Vaccine Reimbursement	Medicaid reimbursement for providing vaccines to Medicaid-eligible recipients 19–20 years of age includes both the vaccine and an administration fee. The provider must bill with the appropriate HCPCS procedure code assigned to the vaccine and a modifier HA when appropriate. CPT codes 90632, 90660, and 90746 do not require the HA modifier.
Child Health Check-Up	A Child Health Check-Up screening is reimbursable in addition to reimbursement for immunizations.

Immunization Services, continued

Evaluation and Management (E&M) Services	E&M services are reimbursable in addition to the administration fee for vaccines, provided the visit is for a separate and identifiable service and the services are documented in the medical record.

Independent Diagnostic Testing Facility Services

Description	An independent diagnostic testing facility (IDTF) is defined as a fixed location that is independent of a hospital or physician's office as defined by 42 CFR 410.33. For radiologic diagnostic testing facilities, Florida Medicaid will reimburse for services that are furnished in an IDTF by physicians with group practices located in the IDTF, or are supervised by an enrolled Medicaid physician, licensed in Florida. The IDTF must comply with prior authorization requirements for advanced diagnostic imaging.

Injectable Medication Services

Description	Injectable medication services provide for injection of medication into the body.
Billing Non-Chemotherapy Drugs	Injectable (non-chemotherapy) medications purchased and administered in the office are reimbursed using the appropriate HCPCS Drug Code and HCPCS billing units. Submission of a valid NDC, metric unit, and metric quantity are also required. HCPCS drug codes include J-codes, and certain A-codes, C-codes, Q-codes, and S-codes. C-codes, Q-codes, and S-codes may be activated for Medicaid claims in order to speed claim processing and avoid manual medical review. If a HCPCS drug code is not available non-chemotherapy drugs, bill procedure code J3490. Submission of a valid NDC, metric unit, and metric quantity are also required. See the requirement below. Code J3490 requires that the provider submit medical documentation with the claim indicating the drug, medical indication, dosage, route of administration, and the initials of the health care professional administering the drug. Without all of these components documented, the claim will be denied.

Injectable Medication Services, continued

Billing Non-Chemotherapy Drugs, continued	These claims must be submitted to the fiscal agent. Fee-for-service claims are entered into the claims system for the Agency for Health Care Administration (AHCA) review and pricing. Please include the name of the drug on the CMS-1500 form, so that the AHCA reviewer can quickly identify the drug being billed and expedite processing of the claim. Reimbursement for non-chemotherapy medications is determined according to the same pricing methodology used by Medicaid pharmacy services. The non-specific drug codes (J3490, J3590) will still be required for Medicare B billing and subsequent crossover to Medicaid. Note: See the Florida Medicaid Prescribed Drug Services Coverage and Limitations Handbook.
Non-FDA Approved Medications	Medicaid does not reimburse for non-FDA approved medications. Medicaid does not reimburse procedures that are experimental or when non-FDA approved medications are included in the procedures.
Evaluation and Management (E&M) Services	The cost of the injectable medication, if it is covered under Florida Medicaid, is reimbursable in addition to an E&M service. E&M services are reimbursable in addition to the administration of an injectable medication, provided the visit is for a separate and identifiable service and the services are documented in the medical record.
Federal Rebate Agreement	Medicaid will only reimburse drugs for which the manufacturer has a federal rebate agreement per Sec. 1927 [42 U.S.C. 1396r-8]. The current list of manufacturers who have drug rebate agreements is available on AHCA's Web site at www.ahca.myflorida.com. From the Site Menu, under Division of Medicaid, select Pharmacy Services.
Chelation Therapy	Medicaid only reimburses medically necessary chelation therapy for recipients with known diagnosis of toxic substances. Laboratory documentation of the toxic substance must be maintained in the recipient's medical record.

Injectable Medication Services, continued

Medically Accepted Indications

To be reimbursed by Medicaid, a drug must be medically necessary and either:

- Prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia in accordance with Section 1927(k)(6) of the Social Security Act.
- Prior authorized by a qualified clinical specialist approved by the Agency.

The Agency may exclude or otherwise restrict coverage of a drug in accordance with Section 1927 of the Social Security Act.

Outpatient-administered drugs fall under the jurisdiction of the Pharmaceutical and Therapeutics Committee and their recommendations, and Agency decisions associated with the Preferred Drug List (PDL). See the Florida Medicaid Prescribed Drug Services Coverage and Limitations Handbook for discussion of PDL.

Note: See the Prescribed Drug Services Coverage and Limitations Handbook.

Service Limitations

Medicaid does not reimburse for investigational or experimental drugs as defined in Rule 59G-1.010, F.A.C.

Investigational use, for the purposes of Medicaid reimbursement, is defined as the use of a drug, whether an FDA approved drug or not, when that drug is used as an approved product in the context of a clinical study protocol, or the use of a product for an indication that is not supported by the current body of medical literature.

Medicaid does not cover any aspect of clinical trials, including radiology follow-up scans, laboratory procedures and any other medical testing, if the drugs are provided free of charge to the recipient.

National Drug Code (NDC) Requirement

The National Drug Code (NDC) is required on all claims for drugs, including Medicare-Medicaid crossover claims. The NDC is required on the CMS-1500 claim form with the N4 qualifier on the appropriate electronic field. Claims received without the NDC will result in a denial. Submission of a valid NDC, metric unit, and metric quantity are required. The NDC number can be found on the product that is being administered to the patient. Medicaid utilizes the 11 digit format, and this may require insertion of leading zeros if they do not appear on the package (i.e., 00001-0234-05).

Note: Please see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for instructions on entering the NDC on the claim.

Injectable Medication Services, continued

National Drug Code Crosswalk	The HCPCS to NDC crosswalk is published and updated quarterly by the Centers for Medicare and Medicaid (CMS). The crosswalk is accessible via the CMS Web site at www.cahabagba.com or at the following web address, www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02. Not all drugs listed on the CMS crosswalk are eligible for reimbursement by Florida Medicaid.
Drug Wastage	Medicaid will reimburse for wastage of the unused portion of a single use vial, when the dosage and wastage is clearly documented in the medical record. Medicaid will not reimburse medication wastage without proper documentation. Medicaid will not reimburse for wastage for multi-dose vials.
Prior Authorization Requirements for IVIG	Intravenous Immune Globulin (IVIG) requires prior authorization. IVIG prior authorizations are managed through the Bureau of Pharmacy Services. The pharmacy clinical criteria for IVIG and the necessary prior authorization form can be found on the AHCA Web site at www.ahca.myflorida.com. From the Site Menu under the Division of Medicaid, select Pharmacy Services, next select Florida Medicaid Preferred Drug Program, and then Prior Authorization Requirements and Forms.
Botulinum Toxins	Botulinum toxins are reimbursed on a per unit basis.
Evaluation and Management in Addition to Botulinum Toxin	Intramuscular and subcutaneous injections are not reimbursable in addition to an evaluation and management procedure code. Evaluation and management services are reimbursable in addition to the botulinum toxin treatment, provided that the visit is for a separate and identifiable service, and the services are documented in the medical record.
Injection of Botulinum Toxins	Injections must be reported one time per procedure, even if multiple injections are performed in sites along a single muscle or if several muscles in a functional muscle group are injected. Bilateral procedures will be considered for reimbursement when the documentation clearly indicates bilateral anatomical sites (i.e., right arm, left arm).

Injectable Medication Services, continued

Electromyography (EMG) with Injectable Contrast Dye	Use of CPT codes 95869 or 95870 (limited EMG studies) may be considered for EMG guidance if the injection site is difficult to determine. Only one procedure per visit will be reimbursed based on sufficient, clear and concise medical documentation. A routine electromyography (EMG) is not covered. For consideration of coverage, the physician must document in the medical notes that he had difficulty in determining the proper injections site(s) for botulinum toxin.
Excluded Services	Medicaid does not reimburse injectable medication services for intra-operative services. Intra-operative services are a usual and necessary part of a surgical procedure. Examples are local anesthetic, digital block, or topical anesthesia. These services are included in the payment for a global surgery and are not reimbursable in addition to the surgical procedure(s) 10000-69999.
Medicare Crossover Claims for J3490, J3590, and J9999	Medicare crossover claims for J-codes J3490, J3590, and J9999 are submitted from Medicare directly to the fiscal agent and are automatically paid by the system. Crossover claims for unclassified drugs do not come to AHCA for review and pricing.

Intrathecal Baclofen Therapy

Procedure Description	Intrathecal baclofen therapy (ITB) is used to manage severe spasticity of spinal cord or cerebral origin. The drug baclofen is infused through a surgically placed neuraxial catheter to a subcutaneously implanted infusion pump designed specifically for the administration of baclofen into the intrathecal space for continued therapy.
Indications for ITB Eligibility	The following criteria must be met before placing a recipient on ITB therapy: • As indicated by at least a six week trial, the recipient cannot be maintained on non-invasive methods of spasm control, such as oral anti-spasmodic drugs (baclofen). These methods fail to control the spasticity adequately or produce intolerable side effects. • Prior to implantation of the pump, the recipient has to respond favorably to a trial intrathecal dose of the anti-spasmodic drug baclofen. • The recipient must have a positive response to a test bolus (by barbotage over not less than one minute) of intrathecal baclofen by spinal catheter or lumbar puncture before initiating long term therapy. • The intrathecal baclofen must be administered via an implantable pump that has been approved by the FDA specifically for the administration of baclofen into the intrathecal space for continued therapy.

Intrathecal Baclofen Therapy, continued

HCPCS Codes Covered by Medicaid for ITB Therapy

Medicaid covers ITB therapy for qualified candidates when the implantation service is rendered in the outpatient hospital setting only. The HCPCS codes below are designated to cover the ITB device. The hospital provider will use either of these codes to bill Medicaid for the device. The hospital must have a valid prior authorization number:

- E0783 Infusion pump system, implantable, programmable (includes all components, e.g., catheter, connectors, etc.)
- E0786 Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)

Note: E0786 (replacement pump) will be allowed no sooner than every 5 years.

Prior Authorization Required for ITB

Prior authorization from the Medicaid QIO is required before reimbursement of the ITB device can be made to the outpatient hospital provider.

The process for obtaining prior authorization is as follows: The physician recommending the ITB treatment for a qualifying recipient must request prior authorization from the Medicaid QIO.

Note: The physician's procedure to insert the device is a covered service by Medicaid and requires no prior authorization. Only the device requires prior authorization and must be requested by the physician, not the hospital.

If the QIO approves the ITB device, The QIO will issue a prior authorization (PA) number to the physician. The physician must supply the PA number to the hospital so the hospital can bill for reimbursement of the device. The physician billing for the insertion of the ITB pump needs no PA number on his CMS-1500 claim to Medicaid. Payment will be made to the physician for the insertion of the device and not for the device itself.

Laboratory Services

Description

Laboratory services are services that apply laboratory procedures and techniques to investigate the nature and cause of disease.

Clinical Laboratory Improvement Amendments of 1988 (CLIA) Certification and Licensure

Practitioners who perform laboratory tests in their offices must be certified under the CLIA and have a current state of Florida clinical laboratory license.

Separate laboratory facilities require separate CLIA certifications and state licenses even if they are operated under the same management.

Laboratory Services, continued

Covered Services

All of the following laboratory services are covered by Medicaid:

- Histocompatibility
- Microbiology
- Diagnostic immunology
- Chemistry
- Hematology
- Immunohematology
- Clinical cytogenetics
- Genetic carrier screening

Specimen Collection

Medicaid does not reimburse providers for venipuncture, collection, handling or transportation of specimens. These tasks are part of the global fee for the laboratory service.

Organ or Disease Panels

There are test combinations for specific organ or disease oriented panels. When all or the majority of the individual component tests that make up a particular panel are performed, the provider must bill for the panel, if the reimbursement for the panel is less than the reimbursement for the tests billed individually.

Providers may order or bill for only those panels listed in the CPT codebook. If a provider orders a panel that is not recognized as a panel in the CPT codebook, the provider may be held liable for any costs incurred to Medicaid.

When the components of one panel are duplicated in another panel, only one panel code may be billed. Individual tests not included in the panel may be billed separately.

Fetal Fibronectin

Medicaid reimburses for fetal fibronectin, procedure code 82731, for diagnoses related to pregnancy risk factors. Medicaid reimburses a maximum of four tests per pregnancy.

Infectious Agent Antigen Detection by Nucleic Acid

The codes for infectious agent antigen detection by nucleic acid allow for coding of detection by direct probe technique, amplified probe technique, or quantification technique. Coding and reimbursement is limited to the technique that is performed. Additional molecular diagnostic codes 83890-83912 may not be billed in conjunction with the direct, amplified, or quantification procedure codes, unless it is for a separate and distinct test for the same recipient on the same day of service.

Laboratory Services, continued

Qualitative Antibody or Antigen	Performing qualitative antibody or antigen with a single strip assay measuring multiple analytes is reimbursable for one analyte.
Purpose of Preconception and Prenatal Genetic Carrier Screening Laboratory Testing	Asymptomatic recipients may receive genetic carrier screening laboratory testing. These are testing services to determine a recipient's risk of passing on a particular genetic mutation in X-linked and autosomal-recessive conditions. Genetic carrier screening laboratory testing services are performed to identify recipients who are themselves unaffected but are at risk for passing the condition to their off-spring.
Genetic Screening Services Coverage	Medicaid reimburses for preconception and prenatal genetic carrier screening laboratory tests that are accepted by the American College of Medical Genetics and that can be billed using HCPCS procedure codes. The laboratory testing method must be considered to be a proven method for the identification of a genetically linked inheritable disease (i.e., the genotypes to be detected by a genetic test must be shown by scientifically valid methods to be associated with the occurrence of a disease, and the observations must be independently replicated and subject to peer review).
Recipient Eligibility for Preconception and Prenatal Genetic Carrier Screening Laboratory Testing	Medicaid reimburses for preconception and prenatal genetic carrier screening laboratory testing services for the prospective or expecting mother and father when the following criteria are met: • Person being tested has a direct risk factor, based on family history or ethnicity analysis, for the development of a genetically linked inheritable disease. • Person being tested is at risk of passing on a particular genetic mutation in X-linked and autosomal-recessive conditions to their off-spring. • Person being tested is eligible for Medicaid on the date of service.
DNA-based Preconception and Prenatal Genetic Laboratory Services Limitations	The molecular diagnostics codes are reimbursed for preconception and prenatal DNA-based genetic testing when performed as a study to determine the genetic carrier status.

Laboratory Services, continued

Documentation Required for Preconception or Prenatal Genetic Carrier Screening Laboratory Testing	The recipient's medical record must clearly document the medical necessity for preconception or prenatal genetic carrier screening laboratory testing, which would include the direct risk factor (based on family history or ethnicity analysis) for the development of the genetically linked inheritable disease that prompted the testing.
Non-Covered Services	Providers must order only those tests that meet the Medicaid definition of medical necessity. Tests must reflect the least costly service available to meet the needs of the recipient. Services for specimens sent to an independent laboratory are only reimbursed directly to the independent laboratory.
Technical Component	The technical component (TC) is intended to reimburse the practitioner for the equipment, supplies, and technician services utilized during a procedure or diagnostic test. The modifier TC is appended to the procedure code to indicate the technical component.
Professional Component	The professional component (PC) is intended to reimburse the physician for the interpretation and report of certain procedures. A modifier 26 is appended to the procedure code to indicate the PC. For professional services rendered to a recipient in the inpatient or outpatient hospital or other facility, the provider may bill only a PC fee. Professional services rendered in the office may be billed with the PC only when the provider does not provide the TC. The PC and TC may not be billed separately if the same provider performed both the technical and professional components. Enrolled Medicaid physicians, licensed in Florida, will be reimbursed for the interpretation of diagnostic testing results from a distance through the use of HIPAA compliant technology. The technology used to transmit images and information for the diagnostic interpretation must meet nationally accepted medical standards of care. The physician billing the PC must use the PC modifier, the identical procedure code, place, and date of service as the technical component claim.

Neonatal Critical Care Services

Description

Inpatient neonatal critical care services are provided to critically ill neonates 28 days of age or younger.

Neonatal critical care is the care and monitoring of an unstable, critically ill, or injured neonate in a variety of medical emergencies that requires constant attention. The care of such infants involves decision-making of high complexity to assess, manipulate, and support central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, unpredictable post-operative complications, overwhelming infection, or other vital system functions to treat single or multiple vital system organ system failure or to prevent further deterioration. It may require extensive interpretation of multiple databases and the application of advanced technology to manage the patient. Critical care may be provided on multiple days when the condition requires the attention as described above.

Neonatal critical care services are not based on time, the type of unit (pediatric or neonatal) in which the neonate receives care or the type of provider delivering the care.

Service Components

Reimbursement includes the following services:

- Management of care
- Monitoring and treatment of the patient including respiratory, nutritional, metabolic and hematologic maintenance
- Parent counseling
- Direct supervision of the health care team in the performance of cognitive and procedural activities
- Pharmacological control of circulatory system
- Case management services

Neonatal Critical Care Services, continued

Included Procedures

In addition to those procedures listed for the critical care codes, the following procedures are also included in the reimbursement for the neonatal critical care services and cannot be reported separately by the professional.

- Invasive or non-invasive electronic monitoring of vital signs
- Vascular access procedures
  - Peripheral vessel catheterization
  - Other arterial catheters
  - Umbilical venous catheters
  - Central vessel catheterization
  - Vascular punctures
  - Umbilical arterial catheters
- Airway and ventilation management
  - Endotracheal intubation
  - Ventilatory management
  - Bedside pulmonary function testing
  - Surfactant administration
  - Continuous positive airway pressure (CPAP)
- Monitoring or interpretation of blood gases or oxygen saturation
- Transfusion of blood components
- Oral or nasogastric tube placement
- Suprapubic bladder aspiration
- Bladder catheterization
- Lumbar puncture

Any services performed which are not listed above may be reported separately by professionals.

Service Limitations

CPT code 99468 is billed to report the initial inpatient admission care by the attending practitioner when the neonate, 28 days of age or younger, qualifies for critical care services.

When due to a transfer situation, critical care services are provided to a neonate patient at two separate institutions by practitioner from different groups on the same date of service, the practitioner from the referring institution should report their critical care services with the critical care codes 99291 and 99292. The receiving institution should report the appropriate global admission code 99468 for the same date of service.

Critical care services provided to children, of any age, in an outpatient environment (emergency room or office) are reported with CPT codes 99291 and 99292.

Neonatal Critical Care Services, continued

Service Frequency	Services may be reimbursed only once per day, per recipient.
Additional Consultation for Separately Identifiable Medical Conditions	An additional initial consultation may be reimbursed to the same provider or provider group during the same hospitalization if, after 30 consecutive days, a separately identifiable medical condition warrants a new consultation from the specialist. Medical documentation of the consultation must be maintained in the medical record.
Intensive Observation	CPT code 99477 is billed to report the care by the attending practitioner of a neonate 28 days of age or younger who requires intensive observation, frequent interventions, and other intensive care services. This code cannot be billed in conjunction with other neonatal intensive care service codes.
Excluded Services	Services for a recipient who is no longer considered critical or low birth weight, but continues to receive care in a neonatal intensive care unit, must be billed using subsequent hospital care codes.

Neurology Services

Description	Neurology services provide for diagnosis and treatment of diseases of the nervous system.
Electrodiagnostic Studies	Florida Medicaid reimburses electromyography (EMG) and nerve conduction studies (NCS) under all of the following conditions: • Recipient's medical record clearly documents the medical necessity for the test. Diagnostic data gathered during NCS should reflect the actual numbers (latency, amplitude, etc.), preferably in a tabular (not narrative) format. • Reason for testing and a clear diagnostic impression by report are attached for each study. • If a treating practitioner refers a recipient to another physician for electrodiagnostic testing, both the ordering and testing physician maintain documentation justifying the need for testing.

Neurology Services, continued

Electrodiagnostic Studies, continued

The following table indicates the American Association of Electrodiagnostic Medicine's recommendations concerning a reasonable maximum number of NCV (nerve conduction velocity) studies per diagnostic category needed for a physician to render a diagnosis for the majority of cases:

Indications	NCV Studies CPT Codes 95900, 95903, 95904	
	Motor NCV Studies with and/or without F-wave	Sensory NCV Studies
Carpal Tunnel (unilateral)	3	4
Carpal Tunnel (bilateral)	4	6
Radiculopathy	3	2
Mononeuropathy	3	3
Polyneuropathy/Mononeuropathy Multiplex	4	4
Myopathy	2	2
Motor Neuropathy	4	2
Plexopathy	4	6
Neuromuscular Junction Disorder	2	2
Tarsal tunnel syndrome (unilateral)	4	4
Tarsal tunnel syndrome (bilateral)	5	6
Weakness, fatigue, cramps or twitching (focal)	3	4
Weakness, fatigue, cramps or twitching (general)	4	4
Pain, numbness, or tingling (unilateral)	3	4
Pain, numbness, or tingling (bilateral)	4	6

If the frequency or quantity of tests falls outside of the recommended guidelines some or all of the tests will be denied.

Neurology Services, continued

Non-Covered Services

Medicaid does not reimburse electrodiagnostic testing under any of the following circumstances:

- Examination and NCV studies done using portable hand-held devices, since these devices are incapable of waveform analysis.
- NCV studies for diagnosis of polyneuropathy of diabetes done more than twice a year, unless the medical record documentation justifies additional testing.
- NCV screening tests done for recipients with end-stage renal disease (ESRD), unless there is evidence of new onset of peripheral nerve disease.

Medicaid does not reimburse evaluation and management services on the same day that EMG or NCS studies are performed, unless the visit is a separate service and is not an interpretative part of the study. If the evaluation and management service is a separate service, the visit code must be billed with a modifier 25.

Polysomnography and Sleep Studies

Polysomnography must include documentation of sleep recording and staging with inclusion of a 1-4 lead electroencephalogram (EEG), an electro-oculogram (EOG), and a submental electromyogram (EMG).

Sleep studies must include recording, interpretation, and report.

The following criteria and documentation for medical necessity applies to all practitioners, regardless of their accreditation or certification level.

Polysomnography is indicated for the following:

- Diagnosis of sleep related breathing disorders.
- Continuous positive airway pressure (CPAP) titration in patient's sleep related breathing disorders.
- Documenting the presence of obstructive sleep apnea for patients 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.

Neurology Services, continued

Polysomnography and Sleep Studies, continued

Indications for polysomnography for adults include one or more of the following:

- Witnessed apnea during sleep.
- Any combination of two or more of the following:
  - Excessive daytime sleepiness as evidenced by one or more of the following
  - Inappropriate daytime napping (e.g., during driving, conversation, or eating)
  - Sleepiness that interferes with daily activities (the following should be ruled out as a cause for these symptoms: poor sleep hygiene, medication, drugs, alcohol, hypothyroidism, other medical diagnoses, psychiatric, or psychological disorders, social or work schedule changes)
  - An Epworth Sleepiness Scale score greater than 10
  - Persistent or frequent socially disruptive snoring
  - Obesity (BMI greater than 30 kg/m^2) or hypertension
  - Choking or gasping episodes associated with awakening
  - Symptoms suggesting narcolepsy, e.g., sleep paralysis, hypnagogic hallucinations, cataplexy
  - Violent or injurious behavior during sleep.

Other situations (if nocturnal pulse oximetry suggests nocturnal oxygen desaturation), such as:

- Unexplained right heart failure
- Unexplained polycythemia
- Presence of or increase in cardiac arrhythmias during sleep
- Unexplained pulmonary hypertension
- Excessive daytime sleepiness together with witnessed periodic lumb movements of sleep
- Unusual or atypical parasomnias based on patient's age, frequency, or duration of behavior
- Patients with moderate or severe congestive heart failure, stroke, transient escemic attacks (TIA), coronary artery disease, or significant tachycardic or bradycardic arrhythmias who have nocturnal symptoms suggestive of a sleep related breathing disorder or otherwise suspected of having sleep apnea

Neurology Services, continued

Non-Covered Services

The codes listed below are not covered by Florida Medicaid:

- 95806—Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow and respiratory effort; and
- 95807—Sleep study, simultaneous recording of ventilation, respiratory effort, ECG, or heart rate and oxygen saturation attended by a technologist.

Vagus Nerve Stimulator

Procedure codes for placement, removal, or revision of vagus nerve stimulators are covered for intractable epilepsy diagnoses for ages 12 and older.

Coverage for other medically necessary indications or ages will be considered on a case-by-case basis.

Newborn Hearing Screenings

Description

The newborn hearing screening is for the purpose of testing all Medicaid-eligible newborns for hearing impairment to alleviate the adverse effects of hearing loss on speech and language development, academic performance, and cognitive development. The screening is a test or battery of limited tests administered to determine the need for an in-depth hearing diagnostic evaluation by a hearing services specialist.

Newborns are required by state law to have either:

- Hearing screening prior to initial discharge from the hospital or birthing center.
- Hearing referral for the hearing screening to be performed after initial discharge from the hospital or birthing center.

Note: For additional information regarding newborn hearing services and appropriate procedure codes, please see the Florida Medicaid Hearing Services Coverage and Limitations Handbook.

Newborn Hearing Screenings, continued

Requirements for Newborn Hearing Screening Providers	All newborn and infant hearing screenings must be conducted by an audiologist licensed under Chapter 468, F.S., who meets the requirements of section 1861 [42 U.S.C.1395x(ll)(4)(B)] of the Social Security Act; a physician licensed under Chapter 458 or 459, F.S.; or an individual who has completed documented training specifically for newborn hearing screenings and who is under the supervision of a licensed physician or licensed audiologist. Supervision means the licensed physician or licensed audiologist directs and is fully legally responsible for the actions of the provider who renders the service.
Eligible Recipients	Medicaid reimburses newborn hearing screenings for all eligible recipients from birth through 12 months of age. Any testing services performed on recipients who are over 12 months of age must be performed based on medical necessity and prescribed by and documented by the physician.
Required Service Components	The required service components for infant hearing screening include at a minimum: • Recipient's name • Screening method (i.e., OAE or ABR) • Screening outcome for each ear • Any risk factors related to hearing loss
Required Diagnosis Code	All newborn hearing screening claims must include a diagnosis of V72.19 on the claim for appropriate reimbursement.

Newborn Hearing Screenings, continued

Allowable Reimbursements	Non-hospital based hearing services providers who perform screenings in a facility using their own equipment or equipment they lease may bill for a complete procedure, which includes both the technical and the professional components, and receive the maximum fee. Non-hospital based hearing services providers who perform screenings in a facility using facility-owned equipment may bill only the professional component, using a modifier on the CMS-1500 claim form. Medicaid reimburses for newborn hearing screenings when performed in conjunction with or on the same day of service as any of the following Child Health Check-Up (CHCUP) procedure codes: 99381, 99382, 99383, 99384, 99385 EP, 99391, 99392, 99393, 99394, or 99395 EP. This applies to newborn hearing screenings done on recipients who are from birth through 12 months of age when the screening was not done prior to discharge from the hospital or birthing center.
Required Referrals	Any child who is diagnosed as having a permanent hearing impairment must be referred to the primary care physician for medical management, treatment and follow-up services. In addition, in accordance with the Infants and Toddlers Program and the Individuals with Disabilities Education Act (Public Law 105-17), any child from birth to 36 months of age who is diagnosed as having a hearing impairment that requires special hearing services must be referred within two calendar days of identification to the Children's Medical Services, Early Steps Program serving the geographical area in which the child resides.
Refusal of Service	If the newborn's parent or legal guardian objects to a screening, the screening must not be completed. The provider must maintain a record that the hearing screening was not performed and attach a written objection that is signed by the parent or guardian.
Prior Authorization Requirements	There are no prior authorization requirements for newborn hearing screenings. Medicaid-eligible children who are enrolled in MediPass, ASN, MediPass pilot projects, HMOs, or Provider Service Networks (PSN) do not require prior authorization. Providers may bill Medicaid for screening services and receive the Medicaid rate of reimbursement.

Newborn Hearing Screenings, continued

Requirements for Medical Records

Appropriate written documentation of the service must be placed in the recipient's medical record within 24 hours after the provider completes the screening procedure or within 24 hours of the parent or guardian's signed refusal of screening. The documentation must include:

- Referrals or reason for the screening (i.e., universal or hearing loss risk factors)
- Screening completion including type of screen test administered, date of test and tester name
- Results
- Interpretation
- Recommendations
- Follow-up referrals for treatment, if applicable
- Parent or guardian's refusal of screening, if applicable

Service Limitations

Medicaid reimburses a maximum of two newborn hearing screenings per eligible newborn using auditory brainstem response, evoked otoacoustic emissions, or appropriate technology as approved by the United States Food and Drug Administration.

If the screening procedure is interrupted because of recipient status or excessive noise, the screening must be performed until a pass or fail outcome is received. The process to obtain a pass or fail outcome will result in only one screening reimbursement regardless of the number of screenings performed to obtain the pass or fail outcome.

Medicaid reimburses the second screening only if the child does not pass the initial hearing-screening test in each ear.

Any additional testing required must be based solely on medical necessity. Additional testing requires a signed statement from the physician. The statement must be filed in the recipient's medical record.

Nursing Facility Services

Description

Nursing facility evaluation and management services are reimbursable when provided to recipients in skilled nursing facilities.

Service Requirements

For service requirements specific to the nursing facility, refer to the Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook.

The provider must bill the nursing facility evaluation and management procedure codes when providing services to a recipient at a nursing facility.

Nursing Facility Services, continued

Service Requirements, continued	A physician may delegate the visits to a physician assistant (PA), advanced registered nurse practitioner (ARNP), or clinical nurse specialist (CNP). The non-physician practitioners (PA, ARNP, CNP) who perform the visits must have a direct relationship with the physician and not be employed by the facility.
Service Limitations	Evaluation and management services for chronic care management are limited to one medically necessary visit per month, per practitioner or provider group, per recipient. Subsequent ventilator management visits can be reimbursed up to four times per month.
Exception to Service Limitation	A second visit is allowed if the service or treatment is necessary to protect and enhance the health status of the recipient and could adversely affect the recipient's condition if omitted, in accordance with accepted standards of medical practice. The service must be: • Appropriate for the diagnosis or treatment of a condition, illness or injury. • Provided for the diagnosis or the direct care and treatment of the condition, illness or injury. • In accordance with the standards of good medical practice. • Not primarily for the convenience of the recipient or practitioner. • The most appropriate level or type of service for the condition, illness or injury. The procedure code for the visit must be billed with a 22 modifier. A report documenting the care provided must be submitted with the claim for review.
Facility Visit	A nursing facility evaluation and management visit cannot be reimbursed in addition to any other evaluation and management visit on the same date, for the same provider or provider group, for the same recipient.
Excluded Services	Medicaid does not reimburse consultation and psychiatric services, including pharmacologic management rendered in a nursing facility or skilled nursing facility. Medicaid reimbursement for evaluation and management services in a skilled nursing facility or nursing facility are limited to nursing facility evaluation and management CPT codes. Medicaid does not reimburse "office and other outpatient" codes provided in the skilled nursing and nursing facility places of service.

Obstetrical Care Services

Description	Obstetrical care services include prenatal, delivery, and postpartum care for the pregnant Medicaid recipient.
Reimbursement for Delivery Services	Obstetrical delivery services must be billed by the rendering practitioner. A supervising physician may not bill as the treating provider.
Delivery by an On-Call Physician	When a delivery is performed by a practitioner rendering on-call services for another practitioner, the delivery will be reimbursed to the on-call practitioner.
Required Prenatal Services at Each Visit	All of the following components must be provided at each prenatal visit and documented in the recipient's medical record: • Physical examination • Recording of weight and blood pressure • Recording of fetal heart tones when clinically appropriate • Urinalysis and collection of specimens for the laboratory once per pregnancy and at subsequent visits if appropriate • Hemoglobin or hematocrit once per pregnancy and at subsequent visits if appropriate • Recipient education, if appropriate • Plan of treatment Procedure code H1000 is used for prenatal visits. Refer to the section below for Healthy Start screening.
Florida's Healthy Start Prenatal Risk Screening	The Healthy Start Prenatal Risk Screening should be offered at the first prenatal visit. The prenatal visit that includes completion of the Healthy Start Prenatal Risk Screening is reimbursed once per pregnancy by billing procedure code H1001. If the Healthy Start Prenatal Risk Screening is completed during the first trimester, procedure code H1001 with modifier TG should be billed. H1001 is included in the total number of prenatal visits. Do not bill H1001 with a modifier 22. This is not a valid modifier for this code.

Obstetrical Care Services, continued

Florida's Healthy Start Prenatal Risk Screening Form

The provider must retain a copy of the Healthy Start Prenatal Risk Screening form in the recipient's medical record to indicate that the screening was completed.

Do not submit the Healthy Start Prenatal Risk Screening form with the CMS-1500 claim form. (Follow the instructions on the form for the distribution of copies.)

If the recipient declines the Healthy Start Prenatal Risk Screening, the provider must document the refusal in the recipient's medical record, and bill for a prenatal visit (procedure code H1000) instead of a prenatal visit plus Healthy Start Prenatal Risk Screening.

Note: Healthy Start Prenatal Risk Screening forms may be obtained from the local county health department. Information on the Healthy Start Program is available at www.doh.state.fl.us.

Laboratory Specimens

The following are included in the reimbursement for any type of prenatal visit:

- Venipuncture, collection, handling, and transportation of specimens sent to an outside laboratory
- Urinalysis
- Hemoglobin and hematocrit

Other Required Prenatal Services During Pregnancy

All of the following components must be provided at some point during the pregnancy and documented in the recipient's medical record:

- Initial and subsequent history.
- Florida's Healthy Start Prenatal Risk Screening or documentation of refusal.
- Offer of testing for sexually transmitted diseases (STD), at a minimum to include, chlamydia, gonorrhea, hepatitis B, HIV, and syphilis. In accordance with section 384.31, F.S. and Rule 64D-3.042, F.A.C., testing must occur at the new visit and again at 28 to 32 weeks gestation. If refused by the pregnant women, a statement of objection must be signed by the woman and placed in her medical record for each time and each test refused. Results of testing must be submitted to a licensed laboratory and the specimen must contain documentation that the recipient is a pregnant or a postpartum woman. In addition, birth certificates and stillbirth certificates must document if any of the above STDs were present or treated during the pregnancy.
- Screening of all pregnant women for tobacco use with provision of smoking cessation counseling and appropriate treatment as needed.

Obstetrical Care Services, continued

Prenatal Hospital Visits	Prenatal hospital visits in the obstetrical unit for a length of stay less than 24 hours are billed with the appropriate evaluation and management observation codes.
Prenatal Visit Frequency	The procedure code for follow-up prenatal visits is H1000. Prenatal visits are limited to a maximum of 10 per recipient. Additional visits, up to a total of 14, may be reimbursed if the diagnosis is listed in Appendix A, Diagnosis Code List for Additional Prenatal Services for Pregnant Women. Reimbursement for the 10 or 14 visits is the maximum reimbursement for the full course of prenatal care, and is payment in full. Additional visits are not reimbursed by Medicaid. The provider cannot bill Medicaid or the recipient for the additional visits. To prevent inappropriate claim denials, the provider should bill prenatal visits as they occur. Conditions related to the prenatal period must be billed as prenatal visits. Services provided during the pregnancy that are not related to the pregnancy may be billed as evaluation and management visits, with the appropriate non-pregnancy diagnosis code.
Prenatal Visit Limitations	An office visit cannot be reimbursed in addition to a prenatal visit on the same day, same recipient, same provider or provider group. A prenatal visit and a delivery service cannot be reimbursed on the same day, same recipient, same provider or provider group. An office visit cannot be billed for routine prenatal care. Prenatal visits are reserved strictly for the primary OB provider. In the event the recipient is referred to a Maternal Fetal specialist for consultation, the Maternal Fetal specialist must bill a consultation, and any additional visits, as evaluation and management visits. Maternal Fetal specialist providing consultative services, instead of primary OB services, must not bill the H1000 code for those visits.
Presumptively Eligible Pregnant Women	During the period of presumptive eligibility, prenatal services provided prior to the delivery in the office or outpatient hospital are reimbursable. No inpatient hospital services can be reimbursed. Note: See Florida Medicaid Provider General Handbook for additional information on presumptively eligible pregnant women.

Obstetrical Care Services, continued

Undocumented Non-Citizens (Aliens)	Medicaid reimburses providers for the treatment of undocumented non-citizens (aliens) for the treatment of emergency medical conditions as defined in section 409.901(10), F.S. Labor and delivery are considered emergencies and are payable without a report, when the emergency indicator is marked “Y” on the claim form. Routine prenatal and postpartum services, ultrasound services, and bilateral tubal ligations are not emergencies and cannot be reimbursed for aliens. As noted above, for inpatient, outpatient and emergency, alien CMS 1500 claims require no medical record or documentation and can be billed electronically. Note: See the Florida Medicaid Provider General Handbook for additional information on emergency Medicaid for aliens. Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on completing the emergency field on the claim form. Note: See Title 42, Code of Federal Regulations (CFR), Part 440.255, Limited Services Available to Certain Aliens, for an explanation of services to aliens. The CFR is available on the Internet at www.fdsys.gov.
Ultrasounds	One ultrasound (procedure code 76801 or 76805) is reimbursed per pregnancy regardless of pregnancy risk factors. Modifier 22 cannot be used with procedure code 76801 or 76805.
Detailed Ultrasound	Complex pregnancy conditions may require a detailed fetal anatomic examination. Florida Medicaid will reimburse one ultrasound (procedure code 76811) to provider specialties 47 (radiology) and 65 (maternal/fetal). This procedure is limited to one procedure per pregnancy and must include a detailed anatomic evaluation of fetal brain and ventricles, face, heart with outflow tracts, chest anatomy, abdominal organ specific anatomy, and limbs. As clinically indicated, a detailed evaluation of the umbilical cord, placenta and other fetal anatomy must be documented and maintained in the medical record. For multiple gestations, an additional procedure code, 76812, must be included to identify the additional gestation with a detailed fetal anatomic examination. Documentation must include the same components as procedure code 76811, and maintained in the medical records.

Obstetrical Care Services, continued

Follow-up Ultrasounds

Follow-up ultrasounds (procedure code 76815 or 76816) are reimbursed for recipients who have a diagnosis listed on the Diagnosis Code List for Additional Ultrasounds for Pregnant Women (Appendix C). A maximum of three follow-up ultrasounds may be reimbursed with a diagnosis code on Appendix C with no documentation of medical necessity.

If more than three follow-up ultrasounds are required, the additional ultrasound(s) must be billed with a modifier 22. A report must be submitted with the claim that documents the medical necessity, its findings, and a plan of care. Only the diagnosis or diagnoses justifying the reason or reasons for the follow-up ultrasound should be included on the claim. Supporting documentation must be included for each diagnosis listed on the claim. Without all components of this documentation, claims will be denied.

Plan of care or Plan of treatment means an individualized written program for a recipient that is developed by health care professionals based on the need for medical care established by the attending physician and designed to meet the health or rehabilitation needs of a patient per Rule 59G-1.010(214), F.A.C.

If the diagnosis code is not listed in Appendix C, the provider may submit documentation and bill with a modifier 22.

For professional services rendered to a recipient in the inpatient or outpatient hospital or other facility, the provider may bill only a professional component fee. The maximum fee is intended to pay the provider for performing the complete procedure including both the technical and professional components and can be billed only when all parts of the procedure are provided in the provider's office or birthing center.

Note: See Appendix C for the Diagnosis Code List for Additional Ultrasounds for Pregnant Women. For the diagnosis of diabetes mellitus, including gestational diabetes (648.03 or 648.83), documentation showing the dosage and frequency, as well as the current blood sugar level must be submitted with each claim. Diet-controlled diabetes mellitus is not considered a valid reason for follow-up ultrasounds.

Abbreviated ultrasounds (procedure code 76815) are reimbursed for fetal position, fetal heart beat, placenta location or qualitative amniotic fluid volume when clinically indicated.

Follow-up ultrasounds (procedure code 76816) are reimbursed when findings including fetal measurements for assessment of fetal size, and interval growth or re-evaluation of one or more anatomic abnormalities are documented in the report.

Obstetrical Care Services, continued

Ultrasound Service Limitations	CPT code 76811 includes a detailed fetal anatomic examination. This code is limited to physician provider specialties 47 (radiology) and 65 (maternal/fetal). CPT code 76811 is limited to one procedure per pregnancy. Only one of the following ultrasound procedure codes is reimbursed on the same date of service for the same recipient: 76801, 76805, 76811, 76815, 76816, 76818, or 76819. Obstetrical ultrasounds require direct supervision by the treating provider. ARNPs and PAs may order ultrasounds for pregnant recipients. Medicaid will reimburse the practitioner or hospital that provides the service.
Ultrasounds for Multiple Gestations	CPT codes 76802, 76810, and 76812 may be reimbursed without medical documentation when using diagnosis codes 651.03, 651.13, 651.23, 651.83, or 651.93 for multiple gestations up to four fetuses. These codes must be billed with their primary CPT codes 76801, 76805, or 76811, respectively. For multiple gestations up to four fetuses, CPT codes 76816, 76818, and 76819 require the addition of modifier TH and diagnosis codes are limited to 651.03, 651.13, 651.23, 651.83, or 651.93. Medical documentation is not required with these diagnosis codes. One claim line utilizing these procedure codes and modifier with the appropriate diagnosis code and the units of service based on the number of gestation is reimbursed when billed on the claim form or electronically. Multiple claim lines are not acceptable and will be denied. If more than four fetuses, CPT codes 76816, 76818, and 76819 require the addition of modifiers TH and 22. Supporting medical documentation must be attached to the claim documenting the number of fetuses. Ultrasounds for multiple gestations are ordered by and reimbursed to the physician only.
Transvaginal Ultrasounds	Ultrasound screening of the cervix should not begin before 16 to 20 weeks of gestation because the upper portion of the cervix is not easily distinguished from the lower uterine segment in early pregnancy. Florida Medicaid will reimburse for a transvaginal ultrasound when a cerclage or FDA-approved tocolytic agents are documented in the report.

Obstetrical Care Services, continued

Transvaginal Ultrasounds, continued

A transvaginal ultrasound is reimbursed in addition to other obstetrical ultrasounds if medical necessity, and should be documented on the report as a separate identifiable procedure. The report must include evidence of medical necessity, a plan of care and the results of the ultrasound study. This report must be submitted with the claim.

Transvaginal ultrasounds are limited to three per pregnancy, with the following diagnosis codes:

- 632
- 634.91
- 640.03
- 641.03
- 641.13
- 654.53
- 654.63

If more than three transvaginal ultrasounds are required, the additional ultrasounds must be billed with a modifier 22. A report must be submitted with the claim that includes documentation of medical necessity, a plan of care and the results of the ultrasound study.

If the diagnosis code is not included in the above list, the ultrasound must be billed with a modifier 22. A report submitted with the claim must include documentation of medical necessity, a plan of care, and the results of the ultrasound study. Transvaginal ultrasounds are not reimbursable as a predictor of preterm labor.

Non-Stress Test for Multiple Gestations

For multiple gestations up to four fetuses, CPT code 59025 requires the addition of modifier TH with diagnosis codes 651.03, 651.13, 651.23, 651.83, or 651.93. Medical documentation is not required with these diagnosis codes. One claim line utilizing this procedure code and modifier with the appropriate diagnosis code and the units of service based on the number of fetuses is reimbursed when billed on the CMS-1500 claim form or electronically. Multiple claims lines are not acceptable and will be denied.

If there are more than four fetuses, CPT code 59025 requires the addition of modifiers TH and 22. Supporting medical documentation must be attached to the claim documenting the number of fetuses.

Obstetrical Care Services, continued

Fetal Velocimetry

Reimbursement to the physician is limited for procedure code 76820 (doppler velocimetry, umbilical artery) to two per pregnancy for the growth-restricted fetus or diabetic pregnant woman.

Reimbursement to the physician is limited for procedure code 76821 (doppler velocimetry, middle cerebral artery) to two per pregnancy to evaluate fetal anemia.

For multiple gestations up to four fetuses, CPT codes 76826 and 76828 require the addition of modifier TH with diagnosis codes 651.03, 651.13, 651.23, 651.83, or 651.93. Medical documentation is not required with these diagnosis codes. One claim line utilizing these procedure codes and modifier with the appropriate diagnosis code and the units of service based on the number of fetuses is reimbursed when billed on the CMS-1500 claim form or electronically. Multiple claims lines are not acceptable and will be denied.

If there are more than four fetuses, CPT codes 76826 and 76828 require the addition of modifiers TH and 22. Supporting medical documentation must be attached to the claim documenting the number of fetuses.

Fetal velocimetries are not limited to multiple gestations.

Nuchal Translucency Measurement

The recording of nuchal translucency measurement is reimbursed (CPT code 76813) when performed for the detection of Down Syndrome once per pregnancy. Risk of Down Syndrome must be documented in the report. This code will be reimbursed using diagnosis codes 758.0-758.9 or V28.3.

For multiple gestations, an additional code (CPT code 76814) must be included to identify the additional gestation with a nuchal translucency measurement and the risk for Down Syndrome documented.

Fetal Echocardiography

CPT codes 76825 and 76827 are reimbursed to physicians once per pregnancy for a fetus with an abnormality of the heart structure or rhythm, or the fetus is in a high-risk group for fetal heart disease.

Follow-up or repeat fetal echocardiograms are reimbursed to physicians using CPT code 76826 or 76828 with a confirmed high-risk diagnosis code. These procedure codes are limited to two per pregnancy.

CPT codes 76826 and 76828 require the addition of modifier TH and diagnosis codes are limited to 651.03, 651.13, 651.23, 651.83, or 651.93 for multiple gestations up to four fetuses. Medical documentation is not required with these diagnosis codes. One claim line utilizing these procedure codes and modifier with the appropriate diagnosis code and the units of service based on the number of gestation is reimbursed when billed on the CMS-1500 claim form or electronically. Multiple claims lines are not acceptable and will be denied.

Obstetrical Care Services, continued

Fetal Echocardiography, continued

If more than four fetuses, 76826 and 76828 require the addition of modifiers TH and 22. Supporting medical documentation must be attached to the claim documenting the number of fetuses.

Color flow mapping must be documented in the report for reimbursement of the separate procedure code 93325.

All essential components of the fetal echocardiogram listed below must be documented:

- Anatomic overview
- Biometric examination
- Cardiac imaging views
- Doppler examination
- Measure data
- Examination of rhythm and rate

Fetal Biophysical Profile

A fetal biophysical profile (CPT code 76818 or 76819) and a non-stress test (CPT code 59025) are not reimbursable for the same recipient, same provider, on the same date of service.

Biophysical profiles are limited to two per pregnancy when medically necessary. If more than two biophysical profiles are required, the additional biophysical profiles must be billed with a modifier 22 and a report must be submitted with the claim that documents the medical necessity for the biophysical profile and the result of each component. Without all of these components and proper documentation, including a plan of care, the claim will be denied.

CPT code 76819 requires a maximum score of 8 with 4 listed components. These components include fetal breathing, fetal movements, fetal muscle tone, fetal heart rate, and amniotic fluid volume. CPT code 76818 requires a maximum score of 10 with 5 listed components. These components include fetal breathing, fetal movements, fetal muscle tone, fetal heart rate, amniotic fluid volume, and a non-stress test.

Biophysical testing should not be performed earlier than the gestational age at which extra-uterine survival or active intervention for fetal compromise is possible.

Obstetrical Care Services, continued

Intrauterine Fetal Surgery	Medicaid does not reimburse for intrauterine fetal surgery when it is considered experimental or under research protocol.
Neonatology Consult	Medicaid will reimburse a neonatologist for a hospital inpatient consultation under the pregnant woman's Medicaid number when an obstetrician or maternal-fetal specialist consults with the neonatologist for discussion of fetal outcome. The consult is limited to one per pregnancy, per specialty referral. A modifier TH is required with documentation of the referral.
Twin-to-Twin Transfusion Syndrome	Medicaid will reimburse CPT code S2411, fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome to physician providers who are enrolled in Medicaid with a maternal-fetal medicine subspecialty (specialty type 65). The procedure requires prior authorization through the QIO. Coverage will be considered for inpatient hospital settings only.
Birth Center Services	Medicaid reimburses licensed birth centers and licensed midwifes for providing antepartum, delivery, postpartum and related services to low medical risk pregnant Medicaid recipients. Note: See the Florida Medicaid Birth Center and Licensed Midwife Handbook for more information.
Delivery Services	Delivery care services include one or more of the following: • Routine hospital admission • Labor management • Fetal monitoring • Intravenous infusion • Caudal or pudendal block • Delivery of neonate, vaginal or cesarean section • Delivery of placenta • Episiotomy or vaginal repair • Hospital visits subsequent to delivery • Family planning counseling
Delivery Services Include Postpartum Services	Delivery procedure codes 59410, 59515, 59614, and 59622 include immediate postpartum services within the delivery hospitalization.

Obstetrical Care Services, continued

CPT Codes 59400 and 59510	CPT codes 59400 and 59510 are only active when Medicaid is the payer of last resort. These codes are for third party claims purposes only.
High-Risk Deliveries	For the physician to receive enhanced reimbursement for a high-risk delivery, the recipient must have a diagnosis listed on the Diagnosis Code List for Delivery of High-Risk Pregnant Women. Note: See Appendix B for the Diagnosis Code List for Delivery of High-Risk Pregnant Women.
Elective Cesarean Sections	All elective cesarean sections require prior authorization through the contracted Medicaid Quality Improvement Organization (QIO).
Inpatient Deliveries	All inpatient labor and delivery services require an authorization number for reimbursement purposes.
Deliveries of Less Than 20 Weeks Gestation	Deliveries of less than 20 full weeks of gestation are reimbursed using procedure codes 59820 or 59821, not a delivery procedure code.
Non-Practitioner Delivery	If a recipient does not deliver with the assistance of a practitioner, the delivery is not reimbursable. However, appropriate postpartum evaluation and management codes are reimbursable.
Delivery of More Than One Infant	Delivery of two or more infants from one pregnancy, by the same delivery method, can be reimbursed as only one delivery. When there is a vaginal delivery followed by a cesarean section, the provider must bill both the procedure code for the vaginal delivery and the procedure code for the cesarean section with a modifier 22 on the same claim form. If the deliveries occur on multiple dates of service, reimbursement is available for both deliveries. Medical documentation must be provided with the claim.
Emergency Room Delivery	Only the emergency department physician can be reimbursed for a precipitous delivery in the emergency room by billing procedure code 59409. Reimbursement of this service is not available to an ARNP.

Obstetrical Care Services, continued

Postpartum Services

All of the following components of a postpartum office visit must be provided and documented in the recipient's medical record:

- Subsequent history and physical exam
- Urinalysis, hemoglobin or hematocrit, and collection of specimens for the laboratory as indicated
- Counseling regarding family relationships
- Education regarding breast self-exam
- Referrals and counseling as indicated
- Provision of family planning method chosen by the recipient

Postpartum Visit Frequency

Two postpartum visits within 90 days following delivery may be reimbursed per pregnancy when medically necessary.

Abortions

Federal regulations allow payment for abortions only for specific reasons and require the physician to certify the reason for the abortion.

Medicaid reimburses for therapeutic abortions when:

- The woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.
- The pregnancy is the result of rape as defined in section 794.011, F.S.
- The pregnancy is the result of incest as defined in section 826.04, F.S.

Abortion procedures are reimbursed only for diagnoses 635.00 through 635.92. These diagnosis codes require a fifth digit for reimbursement.

An Abortion Certification Form must be completed and signed by the physician who performed the abortion. The form must be submitted with the claim.

The physician must record the reason for the abortion in the medical records for the recipient.

Note: The Abortion Certification Form is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support and then Forms. See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for the instructions for completing the form.

Ophthalmological Services

Description

Ophthalmological services are performed by an ophthalmologist in the diagnosis and medical or surgical treatment of a reported vision problem, illness, disease, or injury of the eye and related structures.

Note: See the Florida Medicaid Optometric Services and the Visual Services Coverage and Limitations Handbooks for additional information.

Visual Services Enrollment

A physician with an ophthalmology specialty may also enroll as a Visual Services provider. Enrollment in this program will enable the ophthalmologist to bill for services related to the provision, fitting, dispensing and adjusting of corrective lenses.

If a provider does not offer optical services, he must have ongoing arrangements for referrals to optical services providers.

Note: Contact the Medicaid fiscal agent for information on adding a specific provider contract (category of service) by calling Provider Enrollment at 1-800-289-7799 or by visiting their Web site at www.mymedicaid-florida.com.

Service Reimbursement

Ophthalmological services are reimbursed using one or more of the following:

- An evaluation and management code meeting the key components of the service provided as appropriate for the patient.
- An appropriate surgery procedure code (65091–68899).
- An appropriate ophthalmological service procedure code (92002–92499).

Service Limitation

Medicaid does not reimburse for both an evaluation and management visit and a general ophthalmological visit on the same day for the same recipient.

Only evaluation and management procedure codes are reimbursable in a nursing facility, an intermediate care facility for the developmentally disabled (ICF/DD), a recipient's home, or a custodial care facility. See the criteria on the next page for visual exams using evaluation and management procedure codes in these places of service.

Ophthalmological Services, continued

General and Special Services

Medicaid covers general and special ophthalmological services as described in the current CPT codebook. Please refer to the CPT codebook for complete descriptions of the services included in intermediate and comprehensive general ophthalmological visits.

Medicaid may reimburse special ophthalmological services, in addition to a general ophthalmological visit or an evaluation and management visit, if a special evaluation of part of the visual system is made or if special treatment is given.

General and special ophthalmological services are not reimbursed when they are performed as part of a routine screening for eyeglasses for adults. General and special ophthalmological services for all conditions are not reimbursed when they are performed in a nursing facility, an ICF/DD, a recipient's home, or a custodial care facility.

Note: See the Florida Medicaid Optometric Services and the Visual Services Coverage and Limitations Handbooks for additional information.

Surgical Care Only

If performing surgical care only, the provider must bill using modifier 54 appended to the appropriate surgery procedure code.

Blepharoplasty

Blepharoplasty is surgical repair of drooping eyelids by removing excess skin, muscle and fat. This surgical procedure is considered cosmetic, unless the drooping or sagging of the eyelid(s) interferes with the recipient's vision.

Blepharoplasty procedures require prior authorization from Medicaid. Requests for prior authorization of blepharoplasty procedures must be submitted with all of the following documents and information:

- History and physical.
- Automated perimeter test results.
- Frontal photographs (including the chin) with:
  - Head perpendicular to the camera (not tilted)
  - Showing the light reflex on the cornea.

Ophthalmological Services, continued

Blepharoplasty, continued	Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information regarding prior authorizations.
Re-Examinations	Medicaid does not reimburse for vision re-examinations that include CPT evaluation and management codes and general ophthalmological visits, performed exclusively for checking an eyeglasses prescription dispensed by the same provider within the previous 30 days.
Intravitreal Implant	An intravitreal implant is reimbursed using HCPCS procedure code J7310. A copy of the invoice must be maintained in the recipient's medical record. Reimbursement is limited to four implants per year, per recipient.
Computerized Corneal Topography	Medicaid reimburses computerized corneal topography up to a maximum of four times per year, per recipient.
Refractions	Refractions are reimbursable to physicians with an ophthalmology specialty. Medicaid will reimburse two medically necessary refractions in 365 days, per recipient. The date of the first refraction begins the 365 day period. For dually eligible Medicare and Medicaid recipients, providers must enter keyed claim type 63 in item 19 on a paper CMS-1500 claim form when submitting claims for refractions and visual examinations using a refractive error diagnosis (367.0-367.9). Providers with ophthalmology specialty should also enroll in the Medicaid Optometric and Visual Services Programs to bill for services related to the provision, fitting, dispensing and adjusting of corrective lenses. See Visual Services Enrollment in this section for more information. Medicaid does not reimburse refractions performed in a nursing facility, an ICF/DD, a recipient's home, or a custodial care facility.

Ophthalmological Services, continued

Refractions, continued

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for information.

Note: See the Florida Medicaid Optometric Services Coverage and Limitations Handbook for additional information.

Lacrimal Punctum Plugs

Medicaid reimburses for medically necessary lacrimal punctum plugs.

Service Requirements

Medicaid reimburses for lacrimal punctum plugs for recipients who meet the following criteria:

- Are diagnosed with either:
  - 375.15—Tear film insufficiency, unspecified; dry eye syndrome
  - 370.33—Keratoconjunctivitis sicca, not specified as Sjögren's.
- Have complaints that are normally associated with dry eye syndrome.
- Have a positive Schirmer's test or some other measurement of lacrimal gland deficiency or evidence of corneal decomposition by slit lamp exam.
- Have undergone two to four weeks of conventional treatment using eye drops, gels, or ointments.
- Show no evidence of any improvements after conventional treatments.

Required Documentation

The provider must maintain all of the following documentation for each claim in the recipient's medical record:

- Recipient's diagnosis code supporting the medical necessity for the procedure.
- Results of Schirmer test or equivalent tear break-up time, tear assay, zone-quick and slit lamp exam.
- Operative report that contains:
  - Patient's signature consenting to the procedure
  - Which puncta were involved
  - What plugs were used, described by type (collagen, silicone acrylic), brand and size
  - Whether the patient received topical anesthesia
  - What were pre-operative and post-operative diagnoses
  - Discharge instructions.

If the above-listed above listed documentation is not in the recipient's medical record, the claim is subject to recoupment.

Ophthalmological Services, continued

Contraindications

Use of lacrimal punctum plugs is contraindicated in recipients with any of the following:

- Signs and symptoms of an infection
- Inflammation of eyelids
- Dacryocystitis
- Allergies to bovine collagen or silicone

Reimbursement Limitations

Temporary lacrimal punctum plugs are limited to 12 per year (maximum of four plugs every four months), for procedure code 68761, for treatment of dry eye syndrome when a more permanent conservative treatment will cause discomfort to the recipient. Documentation must be maintained in the recipient's medical record.

Procedure code 68761, (closure of lacrimal punctum by plug, each), includes reimbursement for plugs; therefore, the plug may not be billed separately.

Service Exclusions

A routine eye exam in the absence of a reported vision problem, an illness, disease, or injury is not reimbursable.

MediPass Authorization Exemption

Ophthalmologists are not required to obtain MediPass authorization, except for prosthetic eye services.

Oral And Maxillofacial Services

Description

Oral and maxillofacial services are medically necessary services provided by a physician or oral surgeon for the treatment of disease or injury to the jaw or any structure contiguous to the jaw and the reduction of any fracture of the jaw or facial bone.

Covered Procedures

Medicaid-enrolled dentists who are also enrolled with a specialty in oral surgery may be reimbursed for specific radiology and evaluation and management procedure codes. In addition, dentists who are enrolled with a specialty in oral surgery may be reimbursed for the surgical procedures codes listed on the Oral and Maxillofacial Surgery Fee Schedule.

Note: See the Florida Medicaid Dental Services Coverage and Limitations Handbook for additional information.

Organ and Bone Marrow Transplant Services

Description	Organ and bone marrow transplant services are performed by specialized transplant physicians or teams of physicians at Agency for Health Care Administration (AHCA) Medicaid-designated transplant hospitals for the purpose of replacing bone marrow or a vital solid organ that is no longer functional with an organ or bone marrow from a human donor.
Guidelines for Transplantation	Organ transplantation guidelines are based on Medicare and the Organ Procurement and Transplantation Network (OPTN) criteria as outlined in section 765.53, F.S. Bone marrow transplant reimbursement guidelines are based on Rule 59B-12.001, F.A.C, as adopted by the AHCA Bone Marrow Advisory Panel.
Medically Accepted Determination	Determinations for medically accepted transplants are established within the guidelines of the AHCA Organ Transplant Advisory Council, the AHCA Bone Marrow Advisory Panel, and Medicaid medical consultants. Acceptance for transplant candidacy is determined by the designated transplant hospital performing the comprehensive evaluation. Reimbursement of Medicaid-covered organ or tissue transplants is limited to those services that are determined to be reasonable, medically necessary, and be standard medical procedures.
Bone Marrow, Cord Blood, and Stem Cell Transplants	Medicaid considers cord blood and stem cell transplants as synonymous with bone marrow transplants. For the purposes of reimbursement under Medicaid, these transplants utilize the same illnesses, diagnoses, conditions, and disease states for which bone marrow transplant procedures are acceptable. Medicaid does review individual cases within the guidelines of the Organ Transplant Advisory Council and the Bone Marrow Advisory Panel when medically indicated.
Age 20 Years and Under	For recipients age 20 years and younger, Medicaid covers transplants that are medically necessary and appropriate as determined by the Medicaid medical consultant; and the Bone Marrow Advisory Panel or the Organ Transplant Advisory Council. Recipients age 20 years and younger should be enrolled in Children's Medical Services (CMS) for case management and assistance.

Organ and Bone Marrow Transplant Services, continued

Age 21 Years and Over	For recipients age 21 years and older, Medicaid covers cornea, heart, intestine, liver, lung, multivisceral, pancreas, and bone marrow transplants that are medically necessary and determined appropriate by the Medicaid medical consultant; and the Bone Marrow Advisory Panel or the Organ Transplant Advisory Council.
AHCA-Designated Transplant Centers	Transplants are restricted to organ transplant programs approved by the Secretary for AHCA, based on the recommendations of the Organ Transplant Advisory Council and the Florida Medicaid Program. All transplant hospitals must request the AHCA transplant center designation application from the AHCA transplant coordinator. The application will be reviewed by AHCA and the Organ Transplant Advisory Council. A recommendation will be presented to the AHCA Secretary for designation. A site review may be performed by a representative from AHCA and the Organ Transplant Advisory Council if the facility is not presently designated as a Medicaid transplant center for other solid organ transplants. The address for the AHCA transplant coordinator is: Agency for Health Care Administration Attn: Transplant Coordinator 2727 Mahan Drive, MS 20 Tallahassee, FL 32308 Note: Contact the area Medicaid office for a list of AHCA-designated transplant centers. See the Florida Medicaid Provider General Handbook for a list of area Medicaid office telephone numbers. Area office telephone numbers are also available on the AHCA Web site at www.ahca.myflorida.com.
In-State Transplants and Evaluations	In-state transplants and evaluations must be performed at an AHCA-designated transplant center.
Organ Transplants Reimbursed by Global Payment Methodology	Global payment methodology is utilized for all of the following: • Adult heart, liver, lung, and intestine/multivisceral transplants. • Pediatric lung and intestine/multivisceral transplants.
Transplant Evaluation	A comprehensive evaluation must be performed at an AHCA-designated transplant facility. The comprehensive evaluation is completed by the AHCA-designated facility's transplant team for determination of candidacy for a transplant surgical procedure.

Organ and Bone Marrow Transplant Services, continued

Transplant Evaluation, continued	The comprehensive transplant evaluation may be performed in either the inpatient hospital setting, if the recipient requires hospitalization, or outpatient hospital setting. Inpatient evaluations are not permitted solely for the convenience of the physician or the recipient.
Children Enrolled in Children's Medical Services (CMS)	If the recipient is enrolled in CMS, a Division of the Florida Department of Health, the CMS nurse must be contacted for coordination and processing of all medical records and compiling of all necessary documents to forward to the Medicaid contracted QIO. The CMS nurse will also provide pre-transplant and post-transplant case management.
Adult Heart, Liver, Lung, and Intestine/ Multivisceral and Pediatric Lung and Intestine/ Multivisceral Transplant Global Reimbursement	Adult heart, liver, lung, and intestine/multivisceral, as well as pediatric lung and intestine/multivisceral transplant services are reimbursed with an all-inclusive global payment to include the facility and physician fees for the transplant surgery, complications, and related follow-up care for 365 days post-discharge. Pre-transplant medical care coverage ends the day before the transplant surgery. Re-transplantation of the same organ occurring within the initial transplant hospitalization is reimbursed at 25 percent of the global transplant fee for the facility and physician costs. Re-transplantation of the same organ that occurs after discharge from the initial transplant episode through the first 365 days will be reimbursed 75 percent of the global transplant fee for the facility and physician costs. The transplant facility must notify the Medicaid transplant coordinator within three days of the organ transplantation surgery. Failure to notify Medicaid per policy may result in the forfeiture of global payment. Recipients must be eligible for Medicaid at the time transplantation services are rendered for providers to receive global reimbursement. Global reimbursement for lung transplant is the same for single or bilateral lung transplantation. Global reimbursement for multivisceral transplants must include the intestine as one of the organs that was transplanted. All other unrelated care is reimbursed to physicians on a fee-for-service basis according to the Medicaid Provider Fee Schedule.

Organ and Bone Marrow Transplant Services, continued

Submitting the Global Reimbursement Package

The global reimbursement package must contain all of the following:

- Global Reimbursement Form
- Dates of transplant and date of discharge
- Totaled amounts of transplant charges and expected reimbursement
- UB-04 and/or CMS-1500 original claim forms
- Transplant operative reports and discharge summary

Mail the completed global reimbursement package to:

Agency for Health Care Administration
Attn: Transplant Coordinator
2727 Mahan Drive, MS 20
Tallahassee, Florida 32308

Requirements for Out-of-State Transplants

A written statement from each AHCA designated center must be submitted with an explanation of why the services cannot be rendered.

MediPass authorization by the primary care provider (PCP) or any other form of authorization by a PCP is not considered prior authorization for out-of-state organ and bone marrow transplant services.

Note: See in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for general information on prior authorization and a copy of the Florida Medicaid Authorization Request Form.

Prior Authorization Process and Documentation for Out-of-State Transplants

Requests for prior authorization must include the following documentation:

- Florida Medicaid Authorization Request Form, completed and signed by a Florida transplant physician for the organ transplant specialty team indicating the type of transplant requested.
- Description of the medical condition necessitating transplant.
- Statement regarding the recipient's prognosis and life expectancy with and without the transplant.
- Identification of treatment alternatives considered, used, and discarded, and why.
- Documentation of a comprehensive examination, evaluation, and recommendation for transplant by a board-certified or board-eligible specialist in the field directly related to the condition necessitating the transplant.
- The name, address and contact person of the requested out-of-state facility and physician.

Organ and Bone Marrow Transplant Services, continued

Out-of-State Facility Requirements

The Florida Medicaid program requires that all transplant facilities requesting approval to perform transplants for Florida Medicaid recipients must be approved by the Centers for Medicare and Medicaid Services (CMS) for solid organ transplants or the Foundation of the Accreditation of Cellular Therapy (FACT) for bone marrow transplants.

For reimbursement from the Florida Medicaid program for an out-of-state transplant, the facility and professional providers must be enrolled as Florida Medicaid providers. Prior authorizations for out-of-state transplants must be initiated by the transplant physician at the AHCA-designated transplant center in Florida.

Prior authorizations for organ transplants are valid for 365 days.

Where To Submit Out-of-State Prior Authorization Requests

Submit all prior authorization requests for organ and bone marrow transplants to:

eQHealth Solutions - Florida Division
5802 Benjamin Center Drive, Suite 105
Tampa, FL 33634

Pre-transplant Care

A recipient who receives a transplant that is not covered by Medicaid may still be eligible for pre-transplant and post-transplant care. Pre-transplant and post-transplant medical care is reimbursable, if medically necessary and appropriate as determined by the Medicaid medical consultant.

Medicaid can reimburse for those services considered as “wrap around charges” for the pre-transplant and post-transplant episode of any non-reimbursable transplant service, provided the clinical protocol is reviewed by Medicaid and the transplant service is approved through the prior authorization process by the AHCA Organ Transplant Advisory Council.

Pre-transplant medical care coverage ends the day before the transplant surgery.

Post-transplant Care

Post-transplant medical care coverage begins when the recipient is discharged from the inpatient hospital following the transplant procedure.

All Medicaid program limitations apply to the services received.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for instructions regarding the prior authorization process.

Organ and Bone Marrow Transplant Services, continued

Anti-Rejection Medications	Anti-rejection medications and other reimbursable medications prescribed specifically for use in preventing organ rejection are reimbursable under the Medicaid Pharmacy Services program, even if the transplant was not reimbursed by Medicaid. Medications must be FDA approved for use as a primary or adjunct therapy for the prevention of organ rejection. All Medicaid Pharmacy Services program limitations and restrictions apply.
Non-FDA Approved Medications	Medicaid reimbursement is not available for non-FDA approved medications. Reimbursement is not available for transplant surgery if experimental (except as outlined in Rule 59B-12.001, F.A.C.), or non-FDA approved medications that are included in the transplant protocol.
Procurement	Organ procurement costs, and tissue typing, searches and matches are included in the reimbursement for the transplant procedure. These costs are not separately reimbursed.
Donor Expenses	Medicaid does not reimburse for cadaveric or living donor expenses, even if the donor is a Medicaid-eligible recipient. Medicaid does reimburse for certain reimbursable procedure codes related to autologous bone marrow transplantation. Medicaid does not reimburse for organ transplant procedures involving living donor organs except for kidney and pediatric liver transplants. Medicaid does not reimburse separately for the living donor expenses related to kidney or pediatric liver transplants.
Hospice Services	Medicaid does not reimburse transplant services for adult recipients while enrolled in hospice care.

Organ and Bone Marrow Transplant Services, continued

Artificial Hearts and Ventricular Assist Devices	Medicaid does not reimburse for procedures involving artificial hearts. Medicaid does not reimburse for the cost of the ventricular assist device separately. These costs are included in the procedure. All inpatient and outpatient limitations apply. Only FDA approved ventricular assist devices may be utilized. The Florida Medicaid program requires that all ventricular assist device procedures be performed in facilities that are approved by the Centers for Medicare and Medicaid Services (CMS) for ventricular assist device destination therapy.

Orthopedic Services

Description	Orthopedic services provide for prevention or correction of deformities or disorders of the musculoskeletal system.
Closed Fracture Treatment	Initial treatment of a closed fracture requiring no manipulation or anesthesia is reimbursed by billing only the appropriate closed fracture treatment code.
Initial Casting and Strapping	The supplies, application and removal of the first cast or strapping are included in the reimbursement for the initial service.
Subsequent Casting and Strapping	Subsequent strapping or replacement of a cast during or after the period of follow-up care for management of a fracture may be reimbursed separately using the allowed casting and strapping codes. These codes include casting or strapping supplies, application and removal. Medicaid does not reimburse for waterproof cast lining material.
Surface Neurostimulator	Application of a transcutaneous neurostimulator (TENS) is reimbursable for the purpose of recipient instruction three times per year, per recipient.
Service Limitations	In order to reimburse a procedure code in the surgical code range during the follow-up days for a fracture, a modifier 78 must be added to the procedure code on the claim.

Otolaryngology Services

Description	These services provide for diagnosis and treatment of diseases related to otology, otorhinolaryngology, and laryngology.
Service Reimbursement	These services are reimbursed using any of the following: • An evaluation and management procedure code • An appropriate surgery procedure code • An evaluation and management procedure code and a procedure code from the special otorhinolaryngologic services (92500 series)
Included Tests	Otoscopy, rhinoscopy, and tuning fork tests are not reimbursed separately from an evaluation and management visit.

Pain Management Services

Facet Joint Injections Definition	A paravertebral facet joint or facet joint nerve block (also known as medial branch nerve block) is a local anesthetic procedure that is performed under fluoroscopic guidance to temporarily denervate (block) the facet joint. This procedure is used to differentiate between facet joint syndrome and other causes of neck or back pain. During this procedure a needle is placed in the paravertebral facet joint or facet joint nerve, generally under fluoroscopic guidance, and a long acting local anesthetic agent (with or without a steroid) is injected in the joint to temporarily denervate the facet joint. After a satisfactory blockade of the pain has been obtained, the patient is asked to perform activities that usually aggravate the pain and to record the effect of the procedure 4-8 hours after the injection. Temporary or prolonged relief of the pain suggests that facet joints were the source of the symptoms and appropriate therapeutic treatment may then be prescribed (e.g., percutaneous radiofrequency facet nerve denervation) for long-term pain relief. These techniques are to be performed using fluoroscopy visualization for needle placement. The procedure may generally be safely performed in the outpatient setting.
Medical Necessity	Facet joint steroid injections performed under fluoroscopic guidance meet the definition of medical necessity for the treatment of acute and chronic neck and low back pain only when used as a: • Diagnostic trial to determine the origin of the pain. • Therapeutic injection for low back pain when conservative treatment has failed (e.g., oral medications, rest and limited activity, or physical therapy).

Pain Management Services, continued

Limitations	Facet joint injections, in any combination, are limited to 12 injections in a six-month period.
Percutaneous Radiofrequency Neurolysis Definition	Percutaneous radiofrequency neurolysis is a technique where painful nerve fibers are selectively destroyed by heat delivered through needle electrodes. A critical part of the procedure is the use of fluoroscopic guidance to confirm the proper positioning of the needle electrode. Percutaneous radiofrequency neurolysis is performed to provide long-term pain relief for facet joint pain, which is determined by performing a diagnostic facet joint injection. If the diagnostic facet joint injection provides temporary or prolonged pain relief, this would indicate the facet joint was the source of pain.
Medical Necessity	Percutaneous radiofrequency neurolysis performed under fluoroscopic guidance meets the definition of medical necessity when all of the following criteria are met: • Low back (lumbar/sacral) or neck (cervical/thoracic) pain is suggestive of facet joint origin as documented in the medical record on history, physical and radiographic evaluations. • Pain has failed to respond to conservative management (e.g., oral non-steroidal anti-inflammatory medications, rest and limited activity, or physical therapy) as documented medical record. • A diagnostic temporary block and injections with local anesthetic of the facet nerve (medial branch block) under fluoroscopic guidance into the facet joint has resulted in at least 50 percent reduction in pain. • A minimum time of six months has elapsed since prior percutaneous radiofrequency neurolysis treatment.
Limitations	Percutaneous radiofrequency neurolysis, in any combination, is limited to four in a six-month period. See appropriate practitioner's fee schedule for the procedure codes and fees. Fee schedules are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support and then Fee Schedules.

Pathology Services

Description	Pathology services are services that apply pathological procedures and techniques to investigate the nature and cause of disease.
CLIA Certification and Licensure	Practitioners who perform laboratory tests in their offices must be certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and have a current state of Florida clinical laboratory license. Separate laboratory facilities require separate CLIA certifications and state licenses even if they are operated under the same management.
Maximum Fee	Pathology services in a practitioner's office must include both the technical and professional components if the physician is to receive maximum reimbursement.
Professional Component	A professional service component is physician interpretation of the results of a pathology service. A professional service component is identified by modifier 26 and is reimbursed for services provided in the inpatient or outpatient hospital setting only. If a professional service component is provided for a recipient in an emergency room, use the place of service "outpatient hospital" code on the claim. Enrolled Medicaid physicians, licensed in Florida, will be reimbursed for the interpretation of diagnostic testing results from a distance through the use of HIPAA compliant technology. The technology used to transmit images and information for the diagnostic interpretation must meet nationally accepted medical standards of care. The physician billing the PC must use the PC modifier (26), the identical procedure code, place, and date of service as the technical component claim.
Technical Component	The technical component is not reimbursed separately to providers for procedure codes related to laboratory or pathology services.
Specimen Collection	Medicaid does not reimburse providers for venipuncture, collection, handling or transportation of specimens. This is considered part of the global fee for the service.

Pathology Services, continued

Pap Test	Reimbursement for interpretation of the pap test is made to the pathologist. Medicaid does not reimburse for collection and handling of the specimen. Normal pap tests are limited to one per 200 days, per recipient. Exceptions to the limitation may be made for recipients with abnormal cytology reports. Medically indicated repeat services must be billed with modifier 22. The previous pap test report and the current pap test report for medical documentation must be submitted with the claim.
Independent Lab	Pathology services for specimens sent to an independent laboratory are reimbursed directly to the independent laboratory.

Pediatric Critical Care Services

Description	Inpatient pediatric critical care services are provided to children, 29 days through 71 months of age admitted to an intensive care unit, and reported using CPT codes 99471-99476. Children who are older than 6 years of age who are admitted to an intensive care unit are billed with hourly critical care codes 99291 and 99292 if they qualify for critical care services.
Service Requirements	Pediatric critical care codes are not applied based upon the type of unit (pediatric or neonatal) in which the child receives care or the type of provider delivering the care.
Service Components	Reimbursement includes one or more of the following services: • Management of care • Monitoring and treatment of the patient including respiratory; nutritional, metabolic and hematologic maintenance • Parent counseling • Direct supervision of the health care team in the performance of cognitive and procedural activities • Pharmacological control of circulatory system • Case management services

Pediatric Critical Care Services, continued

Included Procedures

In addition to those procedures listed for the critical care codes, the following procedures are included in the reimbursement for pediatric critical care services and cannot be reported separately by the professional:

- Invasive or non-invasive electronic monitoring of vital signs
- Vascular access procedures
  - Peripheral vessel catheterization
  - Other arterial catheters
  - Umbilical venous catheterization
  - Central vessel catheterization
  - Vascular punctures
  - Umbilical arterial catheterization
- Airway and ventilation management
  - Endotracheal intubation
  - Ventilatory management
  - Bedside pulmonary function testing
  - Surfactant administration
  - Continuous positive airway pressure (CPAP)
- Monitoring or interpretation of blood gases or oxygen saturation
- Transfusion of blood components
- Oral or nasogastric tube placement
- Suprapubic bladder aspiration
- Bladder catheterization
- Lumbar puncture

Service Frequency

Services may be reimbursed once per day, per recipient.

Additional Consultation for Separately Identifiable Medical Conditions

An additional initial consultation may be reimbursed to the same provider or provider group during the same hospitalization if after 30 consecutive days a separately identifiable medical condition warrants a new consultation from the specialist.

Medical documentation of the consultation must be maintained in the recipient's medical record.

Pediatric Critical Care Services, continued

Service Limitations	The provider should use CPT code 99471 or 99475 (depending on the age of the child) to report the initial inpatient admission on the date that the child qualifies for critical care. When critical care services are provided to a pediatric patient, less than five years of age at two separate institutions (transferred) by a physician from a different group on the same date of service, the physician from the referring institution should report their critical care services with the critical care codes 99291 and 99292. The receiving institution should report the appropriate global admission code of 99471 or 99475, for the same date of service. Inpatient critical care services to a child six years of age or older are reported with CPT codes 99291 and 99292. Critical care services provided to children, of any age, in an outpatient environment (emergency room or office) are reported with CPT codes 99291, 99292.
Excluded Services	Services for a recipient who no longer requires the level of care for critical care services, but continues to receive care in the intensive care unit, must be billed using subsequent hospital care codes.

Psychiatric Services

Description	Psychiatric services are evaluation, diagnosis, and therapy services for Medicaid recipients experiencing mental disorders.
Who Can Provide Psychiatric Services	Psychiatric services must be directly rendered by the practitioner who is being reimbursed for the services. The only exception is that Medicaid will reimburse for psychiatric services rendered by a psychiatric resident under the direct supervision of a psychiatrist who is a member of the medical faculty at an accredited medical school or a teaching hospital as defined in Section 408.07(44), F.S. To be reimbursed by Medicaid, a psychiatric service must be rendered face-to-face by a practitioner who has a psychiatric specialty on file with the fiscal agent, or by a resident under the direct supervision of a psychiatrist.

Psychiatric Services, continued

Place of Service Requirement	To be reimbursed by Medicaid, the psychiatric service must be provided in an inpatient hospital, outpatient hospital or practitioner's office only. Medicaid does not reimburse psychiatric services rendered at any other place of service including nursing facilities or custodial care facilities.
Consultations	To be reimbursed by Medicaid, a consultation for psychiatric evaluation must include an examination of the recipient, exchange of information with attending physician and family member, and a written report.
Hospital Visits	A hospital visit to a recipient in an acute care hospital psychiatric unit for a medical illness diagnosis must be reported using the appropriate level evaluation and management procedure code and the specific medical illness diagnosis code. All components of the code must be documented in the medical record. A hospital visit to a recipient in an acute care hospital psychiatric unit for a psychiatric diagnosis must be reported using a psychiatric procedure code and psychiatric diagnosis code.
Timed Visits	All procedures codes in the CPT book that indicate an approximate time frame are considered, for purposes of Medicaid reimbursement, to be the minimum time requirements. Specific time spent with the recipient must be documented in the medical record.
Community Behavioral Health Services	Services rendered by practitioners in Medicaid-enrolled community behavioral health centers must be billed by the community behavioral health center with the practitioner listed as the treating provider. All services must be provided in accordance with the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook.

Psychiatric Services, continued

Exclusions of Institutions for Mental Diseases	Medicaid does not reimburse for practitioner services provided in freestanding psychiatric hospitals. These are known as Institutions for Mental Diseases (IMDs) and are defined in 42 CFR 435.1010.
Psychiatric Service and a Physician Visit	An office or hospital visit and a psychiatric service for the same recipient cannot be reimbursed for the same date of service, by the same physician or physician provider group. An office visit and group therapy cannot be reimbursed for the same date of service, by the same practitioner or practitioner provider group.
Service Exclusions	Medicaid does not reimburse for any psychiatric services, including pharmacologic management of medications, provided in nursing facilities, skilled nursing facilities, domiciliary homes, or assisted living facilities.
Procedure Codes	See appropriate Florida Medicaid Coverage and Limitations Handbooks for specific facilities and programs also at the Medicaid fiscal agent's Web site. Select Public Information for Providers, then Provider Support and then Provider Handbooks.

Pulmonary Services

Description	Pulmonary services are evaluation, diagnosis, and therapy services for Medicaid recipients experiencing respiratory disorders.
Apnea Monitoring	Home apnea monitoring is reimbursable for recipients age 1 year and younger who are diagnosed by a physician as having one or more of the following: • Clinically significant apnea. Clinically significant apnea is defined as breathing cessation for 20 seconds or longer, or an absence of breathing of any length of time accompanied by a decrease in heart rate (bradycardia). Apnea can be associated with bluish discoloration of the skin or mucous membrane caused by a decrease in oxygenated hemoglobin in the bloodstream with or without a marked reduction in muscle tone. • An infant who is a biological sibling of a Sudden Infant Death (SIDS) victim. Monitoring of siblings of SIDS victims will require a prior authorization after a period of three months of normal results. • An infant whose birth weight was 1,500 grams (3.3 pounds) or less.

Pulmonary Services, continued

Apnea Monitoring, continued	Physician review, interpretation, and preparation of a report of the home monitoring event recording will be reimbursed using the appropriate CPT procedure code. Medicaid will reimburse for only one apnea monitor for a 30-day period of patient use time. 94799 is not a valid CPT code for reimbursement of home apnea monitoring. The provider must maintain documentation indicating the period of time the recipient actually used the apnea monitor including the number of hours of use per day. The number of days actually interpreted must also be clearly documented.
Apnea Monitoring Limitations and Exclusions	Medicaid will not reimburse apnea monitoring after a period of three continuous months when the interpretation of the results indicates the apnea monitoring is normal. Medicaid will not reimburse for any day of apnea monitoring when the recipient usage falls below 20 hours in a 24-hour period.
Apnea Monitoring and Reporting	The interpretation and report by the physician of any apnea monitor must be conclusive based on the findings within the reviewed analysis of the data retrieved from the recording device. Without a complete report of results obtained, the billed service for the entire month of monitoring will be denied. Inconclusive data, illegible data, or data that cannot be interpreted by the physician will be denied by Medicaid.
Ventilatory Support	Medicaid reimburses only one provider for initiation of ventilation assistance and management; first day. This procedure code is only reimbursed in the inpatient hospital and emergency room. Ventilation assistance and management on subsequent days is reimbursed to only one provider, per day, for inpatient hospital stays. Ventilator assistance and management; subsequent days may be billed daily for those recipients residing in a nursing home and require frequent maintenance of the ventilator settings for pulmonary support. These codes cannot be billed in addition to an evaluation and management code.

Pulmonary Services, continued

Limitations and Exclusion	Medicaid does not reimburse for the interpretation of arterial blood gases.

Radiology and Nuclear Medicine Services

Description	Radiology and nuclear medicine services include diagnostic radiology, diagnostic ultrasound, radiation therapy, oncology, and nuclear medicine services.
Supervision Requirements	Non-invasive radiological studies do not require direct physician supervision to be reimbursed by Medicaid, but do require indirect supervision. Indirect supervision means that the supervising physician is not required to be physically present when the procedure is performed, but must be reasonably available, so as to be physically present to provide consultation or direction in a timely fashion as required for appropriate care of the recipient. Invasive radiological studies require personal physician supervision to be reimbursed by Medicaid. Personal supervision pursuant to Rule 59G-1.010(276), F.A.C., means that the services are furnished while the supervising physician is in the building, and that the supervising physician signs and dates the medical records (chart) within 24 hours of the provision of the service.
Maximum Fee	When a non-invasive radiological study is performed in an office setting, the physician billing the maximum fee must either directly or indirectly supervise the technical component of the study. The provider must directly perform the interpretation and results of the study. To be reimbursed the maximum fee for a radiology service, the physician must provide both the technical and professional components. The maximum fee includes the professional component and the technical component of the radiological service.

Radiology and Nuclear Medicine Services, continued

Technical Component (TC)

A TC service includes the use of equipment, personnel, and supplies in the performance of a radiological exam and is identified by adding a TC modifier to the procedure code.

Medicaid reimburses the radiological technical component for physicians in the office setting only.

For non-invasive radiology studies, the physician billing the technical component must either perform or indirectly supervise the performance of the radiological study; or if a group practice, a member of the group must perform or indirectly supervise the radiological study.

In order to bill for the technical component, the physician must personally supervise and be responsible for the operation of the practice on a daily basis.

For invasive radiology studies, the physician billing the technical component must perform or directly supervise the performance of the radiological study; or if a group practice, a member of the group must perform or directly supervise the radiological study.

Professional Component (PC)

A PC service is the physician's interpretation and reporting of the radiological exam and is identified by adding a modifier 26 to the procedure code on the claim form.

For professional services rendered to a recipient in the inpatient or outpatient hospital or other facility that receives a facility fee, the provider may bill only a PC fee.

When an X-ray is performed for a recipient in the emergency room, either the emergency room physician or a radiologist is reimbursed for the PC, but not both.

A separate charge for an X-ray interpretation billed by an attending, consulting, or emergency room physician is not allowed concurrently with that of the radiologist. Interpretations are usually considered part of the treating physician's evaluation and management of the patient. If a physician other than a radiologist provides the sole interpretation of the radiology exam, and that report is complete and separate from the evaluation and management procedure, the physician may bill for the exam, using the place of service where the recipient is being treated. If duplicate billings are found between radiologists and other physicians for the same exam, the radiologist will be paid, and the other provider will be denied.

Radiology and Nuclear Medicine Services, continued

Professional Component (PC), continued	Enrolled Medicaid physicians, licensed in Florida, will be reimbursed for the interpretation of diagnostic testing results from a distance through the use of HIPAA compliant technology. The technology used to transmit images and information for the diagnostic interpretation must meet nationally accepted medical standards of care. The physician billing the PC must use the PC modifier (26), the identical procedure code, place, and date of service as the technical component claim.
Radionuclide(s)	Contrast material is included in the reimbursement for the procedure. Administration of therapeutic radionuclides is billed using the appropriate HCPCS level I code. These should be billed on the same claim with the procedure. See the current Radiology fee schedule to assure procedures are covered by Florida Medicaid. Radiopharmaceuticals for nuclear medicine procedures supplied by the physician in the office setting must be billed using HCPCS codes on the current fee schedule A4641 (diagnostic imaging agent), or A9699 (therapeutic imaging agent). A report with the procedure, contrast material cost, the dose, and medical necessity must be submitted with the claim that utilizes A4641 or A9699, or when the fee schedule indicates “R” for review and pricing.
Diagnostic Radiology	Diagnostic radiology includes one the following: • Limited exam that includes anterior, posterior and lateral views and is only part of a complete exam, use modifier 52 to indicate limited • Complete exam that includes all necessary views for optimal examination All procedures are considered complete unless otherwise indicated. The procedure is done by a single physician and includes injection of contrast media.
Radiation Therapy	Radiation therapy includes teletherapy, radium, cobalt, brachytherapy, and other high-energy modalities. These include surface, intracavitary, or interstitial applications. Medicaid does not reimburse radiation therapy services that are considered investigational or experimental.

Radiology and Nuclear Medicine Services, continued

Components of Radiation Therapy

Radiation services include the following:

- Initial treatment planning
- Initial and serial beam verification
- Central axis-based calculations
- Normal follow-up care during radiation therapy and for 3 months after completion

Radiotherapy Physics

Radiotherapy physics service, when necessary to calculate dosimetry, design, and construction of beam shaping devices are reimbursed if performed by a physician or a qualified radiological physicist when under the direct supervision of a physician.

Initial evaluation or consultation prior to radiation therapy is billed separately.

Multiple treatment devices can be reimbursed during a course of therapy if documentation submitted, with modifier 22, substantiates multiple volumes of interest or ports, the use of custom-made devices, or the necessity of replacement devices.

Prior Authorization of Outpatient Non-emergent Diagnostic Imaging

Prior authorization (PA) is the approval process required prior to providing certain Medicaid services to recipients. Medicaid will not reimburse for the designated outpatient, non-emergent diagnostic imaging services without prior authorization. Florida Medicaid contracts with QIO entities to safeguard against unnecessary utilization and to assure the quality of care provided to Medicaid recipients. All diagnostic imaging providers are required to adhere to the established requirements and submit the necessary information to Florida Medicaid or the Medicaid QIO currently in place for this process.

Note: The current QIO PA process is available on the Web at www.medsolutions.com/implementation/AHCA.

Computerized Tomography (CT)

To receive Medicaid reimbursement for CT, the primary diagnosis code must be listed in Appendix D, Diagnosis Code List for MRI and CT Scans. Use the most appropriate diagnosis code from that appendix. Modifier 22 cannot be utilized to override this requirement.

The maximum fee is the maximum allowable for a scan with or without contrast media. Contrast material is included in the reimbursement for the procedure.

Reimbursement for a follow-up visit on the same day is included in the fee for the scan.

Note: See Appendix D for the Diagnosis Code List for MRI and CT Scans.

Radiology and Nuclear Medicine Services, continued

Magnetic Resonance Imaging (MRI)

To receive Medicaid reimbursement for an MRI, the primary diagnosis code must be listed in Appendix D, Diagnosis Code List for MRI and CT Scans. Modifier 22 cannot be used to override this requirement.

Reimbursement for a follow-up visit on the same day is included in the fee for the scan.

Note: See Appendix D for the Diagnosis Code List for MRI and CT Scans.

Invasive Vascular Studies

Invasive vascular studies are divided into two types:

- Serialographic procedures are described by the code for the initial projection and each serialograph procedure, and include personnel, room setup, contrast material, transportation, and trays.
- Cineradiographic procedures include all projections.

The catheterization and the injection procedure by the physician are not separately reimbursable.

Tumor Imaging by Positron Emission Tomography (PET)

Tumor imaging by PET should be reported with CPT codes 78811-78816. If a concurrent CT scan is performed for attenuation correction and anatomical localization, CPT codes 78814-78816 should be reported rather than CPT codes 78811–78813. A CT scan should not be reported separately with codes 78811–78816. These claim documents should indicate such terms for malignancy or neoplasm as: diagnosis, staging, restaging, and monitoring the response of treatment protocols.

Neurology indications for PET CPT code 78608 are covered for pre-surgical evaluation for the purpose of localization of a focus of refractory seizure activity, and differential diagnosis of fronto-temporal dementia and Alzheimer's disease which should be included in the claim documents provided.

Cardiology indications for PET CPT code 78459 are covered for evaluation of myocardial viability as primary or initial diagnostic study prior to revascularization. CPT 78491-78492 would only be in place of, but not in addition to, a single-photon emission computed tomography (SPECT), or following an inconclusive SPECT.

Note: Radiopharmaceuticals are billed separately with the correct code and should be on the same claim as the PET scan.

Radiology and Nuclear Medicine Services, continued

Non-Obstetrical Pelvic Ultrasounds	These procedures are limited to one every 365 days. For any additional ultrasound claims, a report of the procedure with details explaining the medical necessity must be submitted with modifier 22 attached to the claim.
Nuclear Medicine	Nuclear medicine services include the evaluation. The physician provision of diagnostic radionuclides in the office setting is billed using HCPCS level II code, A4641. When the fee schedule indicates “R”, the report or invoice of the actual material cost, the dose, the procedure that required the material, and the medical necessity of the service must be submitted with the claim. The physician provision of therapeutic radionuclides in the office setting is billed using HCPCS level II code A9699. When the fee schedule indicates “R”, the report or invoice of the actual material cost, the dose, the procedure that required the material, and the medical necessity of the service must be submitted with the claim.
Mammography	To receive Medicaid reimbursement for mammography, the primary diagnosis code must be listed in Appendix E, Mammography Diagnosis Codes. Modifier 22 cannot be used to override this requirement. Note: See Appendix E for the mammography diagnosis codes.
Radiology Frequency	Only one interpretation per radiology procedure is reimbursable.
Non-Covered Services	Medicaid does not reimburse radiology and ultrasound services to mobile providers, unless the mobile unit is an FDA-approved mammography provider affiliated with a hospital or a physician. When billing for mobile mammography, use the place of service code for hospital on the claim. The recipient must have a mammography referral from a physician. Medicaid does not reimburse radiology and ultrasound services that are considered investigational or experimental.

Regional Perinatal Intensive Care Center Services

Description

The Regional Perinatal Intensive Care Center (RPICC) services provides inpatient hospital obstetrical and neonatal care for high-risk pregnant women and newborns enrolled in Children's Medical Services (CMS), RPICC programs located in designated hospitals.

Note: The RPICC fee schedule is diagnosis driven.

Provider Requirements

The RPICC neonatal provider group must provide services in accordance with the hospital or physician RPICC contract and have a signed contract with Children's Medical Services to provide the neonatology services.

The RPICC obstetrical provider group must provide services in accordance with the hospital or physician RPICC contract and have a signed contract with Children's Medical Services to provide the obstetrical services.

RPICC provider groups and RPICC-approved physicians must have a provider contract code of 82 listed on their provider files for RPICC reimbursement eligibility.

The RPICC provider group must include only RPICC-approved physicians who provide services in accordance with the CMS RPICC administrative rule and as monitored annually by CMS and the Agency for Health Care Administration.

RPICC Reimbursement

Payment for inpatient professional services is based on CPT codes for obstetrics and neonates as listed on the RPICC Fee Schedule.

To receive the RPICC reimbursement, all physician care must be directly rendered or directly supervised by the RPICC provider submitting the claim.

The RPICC payment is a global fee that covers all services or procedures performed by the RPICC provider group.

RPICC care cannot be billed with pediatric critical care, critical care or neonatal critical care codes.

Only inpatient professional services may be billed through the RPICC provider group number. All other Medicaid fee-for-service reimbursement must be billed through the non-RPICC provider group number.

When the recipient is an inpatient, all testing is included in the hospital payment. No testing that is performed outside the facility is reimbursed separately during the recipient's inpatient stay.

Regional Perinatal Intensive Care Center Services, continued

Physician Supervision

All delivery services must be done by or under the direct supervision of the physician.

Direct supervision means the supervising physician must:

- Be on the premises when the services are rendered.
- Review, sign, and date the medical record.

Neonatal Billing Limitations

RPICC neonatal billing can only be utilized in any of the following situations:

- RPICC neonates who are discharged home or expire in the RPICC NICU
- RPICC neonates who are transferred to another RPICC facility
- RPICC neonates transferred to another unit in the RPICC center with the neonatologist's continuing daily participation in the neonate's care with medical record documentation

The provider must bill using Medicaid fee-for-service methodology if the RPICC patient is transferred to a non-RPICC Level III or Level II facility or to another unit in the RPICC when a neonatologist transfers care to another physician.

Recipients with Third Party Liability

RPICC services cannot be reimbursed by Medicaid for recipients who have other health insurance.

Reimbursement for RPICC services to a Medicaid HMO recipient must be negotiated between the RPICC provider group and the respective HMO.

Undocumented Non-citizens (Aliens)

Providers can be reimbursed only for emergency services provided to undocumented non-citizens (aliens) who are not eligible for full Medicaid benefits due to their alien status. The global fee for RPICC services does not apply in the case of undocumented non-citizens (alien) deliveries.

Routine prenatal and postpartum services, ultrasound, and sterilization procedures are not emergency services. Medicaid cannot reimburse non-emergency services for undocumented non-citizen recipients.

Note: See the Florida Medicaid Provider General Handbook for additional information on undocumented non-citizens who are eligible for emergency services only.

Regional Perinatal Intensive Care Center Services, continued

Medically Needy

Providers cannot receive reimbursement through the RPICC program for medically needy recipients. Services for medically needy recipients must be billed through the Medicaid fee-for-service methodology.

Note: See the Florida Medicaid Provider General Handbook for information regarding medically needy eligibility.

Fee-for-Service

Any of the following services provided to a RPICC recipient are reimbursed on a fee-for-service basis using CPT procedure code billing:

- Outpatient services
- Medically necessary consultations provided by physicians who are not part of the RPICC group
- Radiology and pathology services provided by physicians who are not part of the RPICC group
- Nurse midwife services including those provided under the direct supervision of the RPICC medical consultant

These services should be billed using the non-RPICC Medicaid group number.

Antepartum and Postpartum Inpatient Professional Reimbursement

One all-inclusive fee is paid for a total number of antepartum or postpartum hospital days accumulated during one or more hospitalizations.

When billing multiple antepartum or postpartum hospitalizations for the same recipient, enter the appropriate CPT code with the TG modifier along with a modifier 22 on each claim line for each hospitalization. Include from-through days, length of stay (LOS), usual and customary fee, and submit the RPICC Entitlement Report. The usual and customary charges must be at least equal to the entitlement.

Deliveries of less than 20 full weeks gestation are reimbursed as an antepartum hospitalization and not a delivery.

An antepartum hospitalization that progresses to a delivery is reimbursed only as a delivery.

All claims for antepartum services must have an “F” in the family planning indicator in order to exempt the claim from the recipient copayment.

Antepartum hospitalization of less than one day is considered an outpatient service and cannot be billed as an Obstetrical Care Group (OBCG).

Regional Perinatal Intensive Care Center Services, continued

Non-hospital Delivery

If the recipient does not deliver in the hospital, the delivery is not reimbursable. However, Medicaid will reimburse for the postpartum hospitalization.

Paper Claims

All paper claims must include the RPICC Entitlement Report obtained from the RPICC Data System.

The following situations must be submitted on paper claims and sent to the Medicaid fiscal agent:

- Antepartum or postpartum hospitalizations that are inclusive of two or more hospitalizations
- Hospitalizations that include a hysterectomy
- Hospitalizations that include a sterilization
- Transfers of a neonate from one RPICC facility to another RPICC facility, if that neonate has been in the facility at least two days

The following situations must be submitted on paper claims and sent to the RPICC Coordinator:

- A neonate expires and has a length of stay that equals 1 day
- A neonate transfers from one RPICC facility to another RPICC facility, and the length of stay for the facility equals 1 day

RPICC claims may be mailed to:

Agency for Health Care Administration
Bureau of Medicaid Services
RPICC Coordinator
2727 Mahan Drive, MS #20
Tallahassee, FL 32308

Assistant at Delivery

An assistant surgeon cannot be reimbursed in addition to the RPICC reimbursement.

Sterilization and Hysterectomy

Sterilizations and hysterectomies are reimbursable using the appropriate CPT code, TG modifier, and diagnosis code.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for instructions on completing the Sterilization Consent Form, Hysterectomy Acknowledgment Form, and the Exception to Hysterectomy Acknowledgment Requirement Form. Copies of these forms are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support and then Forms.

Abbreviations and signature stamps are not acceptable on these forms.

Regional Perinatal Intensive Care Center Services, continued

Excluded Services	A prenatal visit and a delivery service cannot be reimbursed on the same day, same recipient, same provider or provider group.
Neonatal Eligibility Criteria	Only neonates of more than 20 weeks gestation who are admitted to Level III nurseries and are considered viable are eligible for RPICC reimbursement. Hospice type care is not eligible for RPICC reimbursement. Neonates must be in the RPICC Level III nursery a minimum of 48 hours to be eligible for RPICC reimbursement.
Exception to Required 48 Hour Nursery Stay	RPICC reimbursement can be billed for a neonate who is in a RPICC Level III nursery less than 48 hours, only if the neonate: • Expires prior to 48 hours • Is transferred to another RPICC facility with ongoing RPICC services
RPICC Transfer	When a neonate is transferred from one RPICC to another RPICC, both neonatal physician provider groups share the one RPICC fee. RPICC claims should not be submitted until the infant is discharged from the last RPICC center and the RPICC program. If an infant is transferred from a RPICC to a non-RPICC hospital, the RPICC payment stops and all future billing must be fee-for-service using CPT procedure codes. If the treating provider at the non-RPICC hospital is enrolled as a RPICC provider, all professional services at both hospitals must be billed fee-for-service by the individual treating provider. If an infant is transferred from one RPICC to another RPICC, a modifier 22 must be used with the appropriate CPT code and TG modifier for RPICC reimbursement. The RPICC Exception Report must be submitted with the claim. The dates of service for the multiple RPICC facilities cannot overlap, as this will cause the subsequent claims to deny. All RPICC transfers must have a RPICC Exception Report generated by the RPICC Data System staff at the University of Florida.
Child Health Check-Up	Child Health Check-Up screenings are considered part of the RPICC care and cannot be reimbursed separately.

Regional Perinatal Intensive Care Center Services, continued

Neonatal Reimbursement

Neonates are eligible for RPICC payment up to 365 days if they remain hospitalized continuously in RPICC hospitals, and the RPICC physician group continues to provide the care.

On day 365 of continuous hospitalization, RPICC payment ends and subsequent days are reimbursed under Medicaid fee-for-service using CPT codes.

The 12-month claim submission deadline begins with the date of discharge from the RPICC program.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for information on the claim submission deadline.

Procedure Codes and Fees

RPICC services have specific procedure codes, modifiers and diagnosis code requirements for the neonatal and obstetrical care groups.

Retail Clinic Services

Description

Retail clinics are located in a retail setting and function similarly to a practitioner's office. These clinics are utilized for care that is minor in nature and act as a diversion from emergency room services. With claim submissions, the place of service code is 17, Walk-in Retail Health Clinic. There is a limited list of procedures that are approved for this setting.

Advanced registered nurse practitioners are the primary rendering providers.

Covered Procedures

The following services are covered in the retail clinic setting.

CPT	Description
81002	Urine Dip Stick—nonautomated without microscopy
82947	Blood Sugar (glucose)—quantitative
87040	Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates
87650	Streptococcus—group A, direct prove technique
87880	Streptococcus—Quick Strep Test
99201	New Patient Problem Focused Visit
99202	New Patient Expanded Visit
99203	New Patient Detailed Visit
99212	Established Patient Problem Focused Visit
99213	Established Patient Expanded Visit
99214	Established Patient Detailed Visit

Retail Clinic Services, continued

Excluded Services

Only minor care is provided in the retail clinic setting.

Excluded retail clinic services are:

- Care that requires immediate attention and is serious in severity.
- Routine care that would be directed to the recipient's medical home practitioner.

Surgery Services

Description

Surgical services are manual and operative procedures for correction of deformities and defects, repair of injuries, and diagnosis and cure of certain diseases.

Global Surgical Package

The payment for a surgical procedure includes a standard package of pre-, intra-, and post-operative services. The pre-operative period that is included in the global fee for surgery is the day of surgery—day one.

Global Surgical Package Components

All of the following services are included in the payment for a global surgery and are not reimbursable in addition to the surgical procedure codes 10000-69999:

- Evaluation and management services on the day of surgery, unless the visit includes the initial decision for surgery and is billed with a modifier 25. A new patient visit may also be reimbursed on the day of surgery if the visit meets CPT requirements.
- Evaluation and management services, subsequent to a decision for surgery, that are limited in focus to determine the health of the individual prior to surgery, are included in the global surgical package and may not be billed separately.
- Intra-operative services are a usual and necessary part of a surgical procedure. Examples are local anesthetic, digital block, or topical anesthesia.
- All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications that do not require additional trips to the operating room.
- Postoperative pain management by the surgeon.
- All miscellaneous services and supplies such as dressing changes, local incisional care, removal of operative pack, removal of sutures, staples, lines, wires, tubes, drains, insertion, irrigation or removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes.
- Follow-up visits within the postoperative period of the surgery related to recovery from the surgery.

Surgery Services, continued

Global Surgical Package Exclusions	None of the following services are included in the payment amount for a global surgery: • Diagnostic tests and procedures, including diagnostic radiological procedures; • Treatment for postoperative complications that require a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing surgical procedures. It does not include a patient's room, a minor treatment room, a post-anesthesia care unit, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR); or • Critical care services unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.
Postoperative Period Follow Up Days	The post-operative postoperative follow-up period for minor surgery is 0–10 days and for major surgery is 90 days depending on the procedure.
Surgical Care Only	If performing surgical care only, the provider must bill using modifier 54 with the appropriate surgery code.
Surgery Authorization	Surgery that requires prior authorization when performed in a setting outside the inpatient hospital is identified on the Physician Fee Schedule by "PA" in the "Spec" column. If a surgical procedure requiring prior authorization is performed as an emergency service, authorization is required after the service is rendered through the retrospective authorization process by the Medicaid QIO (Quality Improvement Organization). If the service does not require authorization by the Medicaid QIO, but is identified as "PA" in the "Spec" column, a prior authorization is still required by Medicaid for the physician claim to be reimbursed. Note: Refer to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for prior authorization procedures.

Surgery Services, continued

Surgical Trays	Surgical trays used for office surgery are not reimbursed separately from the surgical procedure.
Incidental Procedures	Procedures performed as part of a surgical procedure that are secondary, minor, non-essential, or incidental surgical procedures are not separately reimbursable services. Example: Lysis of adhesions is not a reimbursable service when performed incidental to an abdominal surgical procedure.
Assistant at Surgery	Only one assistant surgeon (physician, physician assistant, registered nurse first assistant, or advanced registered nurse practitioner) may be reimbursed per operative session for limited surgical procedures. Assistant surgeons are not reimbursed for minor procedures.
Registered Nurse First Assistant (RNFA)	The RNFA may only be reimbursed by Medicaid for those fees listed on the RNFA fee schedule. RNFAs must adhere to the guidelines established in this section for surgical services. Delivery of all RNFA services must be under the direct supervision of a physician. Direct supervision means the physician: • Is in the building when the services are rendered. • Reviews, signs, and dates the medical record. Services provided by an RNFA must be within the specialty of the supervising physician.
Unlisted Procedures	Unlisted (non-priced) procedure codes may be billed only when there is no available procedure code. If the provider bills an unlisted procedure code when there is an appropriate procedure code, the claim will be denied. An unlisted procedure code requires an operative report, documenting the service provided, to be submitted with the claim. Documentation must clearly indicate which procedure the unlisted code represents and must also include the CPT codes of similar procedure codes to aid the reviewer in pricing the non-priced code.

Surgery Services, continued

Gastric Bypass or Bariatric Surgery	All bariatric surgical procedures require prior authorization by the inpatient hospital Medicaid QIO. All bariatric surgical procedures requested for overweight and obesity must use the additional diagnosis code to identify body mass index (V85.1-V85.45). Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for the inpatient hospitalization authorization procedures.
Reconstructive Surgery Following Gastric Bypass or Bariatric Surgery	Medicaid does not reimburse for reconstructive procedures that are the result of significant weight loss following gastric bypass or bariatric surgery. If there is a medically necessary reason for these procedures to be performed, they require prior approval from Medicaid with clearly supportive medical documentation of the medical necessity other than excessive skin. The Medicaid medical consultant will review all prior authorization requests.
Cosmetic Surgery	Cosmetic surgery is not reimbursable. Removal of common warts, skin tags, seborrheic keratoses, and sebaceous cysts are considered medically necessary only if one of the following criteria is met: • Skin lesions are causing symptoms such as burning, itching, irritation, pain, or bleeding • Lesion has evidence of inflammation • Due to its anatomic location, the lesion has been subject to recurrent trauma • Lesion restricts vision or movement • Lesion appears to be dysplastic or malignant Medical necessity must be clearly documented in the medical record.
Abortions	See Obstetrical Care Services in this chapter for information on abortions.

Surgery Services, continued

Hysterectomy

Hysterectomy means a medical procedure or operation for the purpose of removing the uterus. Medicaid will reimburse for a hysterectomy only if one of the following applicable documents is included with the claim:

- Hysterectomy Acknowledgment Form
- Exception to Hysterectomy Acknowledgment Requirement Form

For services performed in an outpatient hospital setting, the Outpatient Hysterectomy Diagnosis Codes list, Appendix F, in this handbook lists diagnosis codes that are approved for Medicaid reimbursement. The physician does not need prior authorization if the primary diagnosis code is listed in Appendix F. If the primary diagnosis code is not listed on Appendix F, the physician must request prior authorization from Medicaid.

For services performed in an inpatient hospital setting, prior authorization from the Medicaid QIO is required, even if the diagnosis for the hysterectomy is on Appendix F.

Sterilization by Hysterectomy

Medicaid does not reimburse for a hysterectomy if:

- Performed solely for the purpose of rendering an individual permanently incapable of reproducing.
- There was more than one purpose to the procedure, (it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing). That is, the medical condition by itself would not have warranted a hysterectomy.

Hysterectomy Acknowledgment Form

A Hysterectomy Acknowledgment form indicates that the recipient, or her representative, was informed orally and in writing that the procedure would make her permanently incapable of reproducing. In acknowledgment, the recipient, or her representative, signs the form.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for a copy of the Hysterectomy Acknowledgment form. The form is also available on the Medicaid fiscal agent's Web site at www.mymedicaid-fl.com. Select Public Information for Providers, then Provider Support, and then Forms.

Surgery Services, continued

Exception to Hysterectomy Acknowledgment Requirement Form

An Exception to Hysterectomy Acknowledgment Requirement form may be submitted with the claim in lieu of the Hysterectomy Acknowledgment form, if any of the conditions listed below were present:

- Recipient was sterile. The cause of the sterility must be identified.
- Procedure was performed under a life-threatening situation. The physician must submit documentation with a description of the emergency.
- Recipient is postmenopausal.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for a copy of the Exception to Hysterectomy Acknowledgment Requirement form. The form is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms.

Retroactive Eligibility for Hysterectomy

The physician who performs a hysterectomy during a period of an individual's retroactive Medicaid eligibility must certify in writing that the individual was informed before the operation that the hysterectomy would make her permanently incapable of reproducing or that one of the conditions listed above was met. The appropriate hysterectomy form must be submitted with the claim for payment.

Recipient Requirements for Non-Hysterectomy Sterilization

Voluntary sterilization procedures performed for the primary purpose of rendering a recipient (male or female) incapable of reproducing are reimbursable by Medicaid.

All of the following criteria per 42 CFR 441.253, Subpart F must be met for Medicaid reimbursement:

- Recipient must be at least 21 years old at the time of signing the State of Florida Sterilization Consent Form.
- Recipient must voluntarily give informed consent.
- Recipient must be mentally competent and not institutionalized in a correctional, penal, or rehabilitation facility or a facility for mental diseases.
- A State of Florida Sterilization Consent Form must be correctly completed and signed at least 30 days, but not more than 180 days, prior to sterilization.
- Provider must submit the State of Florida Sterilization Consent Form with the claim. Medicaid will not reimburse the provider without the required form.

Surgery Services, continued

Recipient Requirements for Non-Hysterectomy Sterilization, continued	Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for a copy of the Florida Sterilization Consent form. The form is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms.
Coverage for Essure®	Florida Medicaid reimburses CPT code 58565, the non-incisional surgical procedure for the placement of Essure®, to permanently prevent pregnancy for Medicaid recipients age 21 years and older. When inserted in a physician's office, the Essure® device is billed with HCPCS code A4264. Claims billed for the reimbursement of 58565 and A4264 (Essure®) must include a sterilization consent form. In order to distinguish the Essure® procedure from other methods of sterilization, please be sure that the consent form clearly indicates that the Essure® procedure is the method of sterilization. Claims without the Essure® procedure indicated on the consent form will be denied. Note: Refer to the Medicaid Provider Reimbursement Handbook, CMS-1500, for instructions on how to complete the sterilization consent form. Note: The Physician Surgical Fee Schedule is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules.
Reduction Mammoplasty Services	Breast reduction surgery is considered cosmetic unless prior authorized as part of post-mastectomy reconstruction for breast cancer, or determined as medically necessary. Documentation required to support medical necessity is described in the sections below. If a bilateral procedure is requested, the appropriate code modifier and quantity must be entered on the completed Medicaid Authorization Request form (PA 01). Note: Medicaid Forms are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms.

Surgery Services, continued

Prior Authorization Requirements for Reduction Mammoplasty Services

Reduction mammoplasty must be prior authorized by Medicaid, regardless of the place of service. The rendering surgeon must obtain prior authorization for the procedure. Requests for outpatient surgical procedures must be submitted through the fiscal agent and requests for in-patient procedures must be submitted through the Medicaid QIO. Medical necessity for reduction mammoplasty may be determined through the prior authorization process for women aged 18 or older, or for females under age 18 years for whom growth is complete.

Along with the prior authorization request, the surgeon must submit original color photographs that clearly present the recipient's body area from mid-chin to waistline. Hair must be secured up and off of the shoulders. Photographs must include a:

- Frontal view
- Right lateral view
- Left lateral view
- Closer view of the inframammary folds, if clinical documentation includes chronic skin conditions

The surgeon must document and submit with the authorization request the amount of breast tissue, not fatty tissue, (in grams) that will be removed from each breast.

All of the following criteria must be met for reduction mammoplasty:

- Recipient has moderate to severe persistent symptoms in two or more of the anatomical areas listed below, affecting specified daily activities for at least 12 continuous months:
  - Pain in upper back
  - Pain in neck
  - Pain in shoulders
  - Chronic headaches
  - Painful kyphosis, documented by x-rays
  - Pain with ulceration from bra straps cutting into shoulders.
- Photographic documentation confirms severe breast hypertrophy.
- Recipient has undergone an evaluation by her primary care physician who determined that all of the following criteria are met, and the requesting surgeon concurs:
  - A signed and dated statement letter from the primary care physician and the surgeon stating that there is a reasonable likelihood that the symptoms are primarily due to macromastia, the recipient has been compliant with all alternative therapeutic measures prescribed, breast reduction is the recipient's last resort, and reduction mammoplasty is likely to result in an improvement of the recipient's chronic and specifically described pain that affects specified daily activities.

Surgery Services, continued

Prior Authorization Requirements for Reduction Mammoplasty Services, continued

- Pain symptoms have persisted, as documented in the physician's clinical notes, despite at least a six-month trial of well-documented therapeutic measures, such as:
- Supportive devices (describe device and continuous length of time used);
- Analgesic or non-steroidal anti-inflammatory drugs interventions (list drug, dosage and length of continuous treatment);
- Physical therapy, exercises, and posturing maneuvers (describe type and length of treatment).

- Women who are 40 years of age or older are required to have a mammogram that is negative for cancer, performed within 6 months prior to the date the surgeon signed the authorization request for reduction mammoplasty. A copy of the mammogram report must accompany the authorization request.

It must be noted that chronic intertrigo, eczema, dermatitis, and or ulceration in the inframammary fold in and of themselves are not considered medically necessary indications for reduction mammoplasty. The condition not only must be unresponsive to dermatological treatments (e.g., antibiotics or antifungal therapy) and conservative measures (e.g., good skin hygiene, adequate nutrition) for a period of six months or longer, but must also satisfy criteria stated above.

Documentation of medical necessity must also include:

- Detailed statement of recipient's complaints and symptoms
- Current height
- Current weight
- Documentation of weight loss or gain during past 12 months
- Current bra size (including cup)
- A list of prescribed, over-the-counter medications and supplements used by the recipient during the past 12 months (including dosage, frequency, purpose, and duration of treatment)
- A list of current medications used to address breast-related skin conditions, infections, or pain
- Procedure to be used for removing breast tissue
- Description of the surgical procedure to be used for removal of excess breast tissue

Surgery Services, continued

Prior Authorization for Gigantomastia of Pregnancy Surgery

Prior authorization is required for reduction mammoplasty for a recipient who has a diagnosis of Gigantomastia of Pregnancy. The diagnosis must be accompanied by any of the following complications, and delivery is not imminent:

- Ulceration of breast tissue
- Massive infection
- Tissue necrosis with slough
- Significant hemorrhage

Post-authorization may only be requested for reduction mammoplasty performed as an emergency surgical intervention, for complications of Gigantomastia of Pregnancy stated above.

Note: Refer to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for prior authorization procedures. The Florida Medicaid Authorization Request Form is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms.

Prior Authorization for Gynecomastia Surgery

Gynecomastia surgery may be determined medically necessary by Medicaid for post-pubescent males, age 20 years and younger. Conservative management of symptoms must first be aimed at identifying and correcting any reversible causes of gynecomastia, with complaints of moderate to severe pain.

Documentation of diagnostic tests and any therapeutic trials used for at least three months, and no more than six months prior to the date of the request for surgery, must be submitted, with original color photographs.

Along with the prior authorization request, the surgeon must submit original color photographs that clearly present the recipient's body area from mid-chin to waistline. Photographs must include a:

- Frontal view
- Right lateral view
- Left lateral view
- View of the inframammary fold(s) is required if clinical documentation includes chronic skin conditions

Note: Refer to the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for prior authorization procedures. The Florida Medicaid Authorization Request Form is available on the Medicaid Web site at www.mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and then select Forms.

Surgery Services, continued

Breast Reconstructive Surgery

Breast reconstructive surgery is performed following a mastectomy for treatment of breast cancer or medically necessary breast surgery, to establish symmetry with the contralateral breast or following bilateral mastectomy. It includes the surgical creation of a new breast mound and the nipple and areolar reconstruction, which is accomplished with small local flaps for the nipple and either tattooing or a skin graft for the areola. Reconstructive breast surgery may also include reduction mammoplasty, mastopexy, or augmentation on the contralateral breast to establish symmetry. Breast implants, tissue flaps, or both are surgically placed in the area where natural breast tissue has been removed.

Prior Authorization Requirements for Breast Reconstructive Surgery

Breast reconstruction surgery must be prior authorized by Medicaid, regardless of the place of service. The surgeon must obtain prior authorization for the procedure. Requests for outpatient surgical procedures must be submitted through the fiscal agent and requests for inpatient procedures must be submitted through the Medicaid QIO.

The best candidates for breast reconstructive surgery are women whose cancer, as far as can be determined, seems to have been eliminated by mastectomy. It is understood that patients with known metastasis would not be candidates for reconstruction.

Breast reconstructive surgery of the affected breast and reduction, mastopexy, with or without augmentation of the contralateral breast are covered in association with the primary mastectomy procedure for one or more of the following conditions:

- Malignant neoplasm of the breast.
- Secondary malignant neoplasm of the breast.
- Carcinoma in situ of the breast, either lobular or ductal.
- Congenital absence of the breast (Poland's syndrome).
- Prophylactic mastectomy when one of the following criteria are met:
  - Breast biopsy indicates the recipient is at high risk for breast cancer, that is has atypical hyperplasia or lobular carcinoma-in-situ (LCIS), which may be an indication for bilateral mastectomy
  - Personal history of breast cancer (invasive ductal, invasive lobular, or ductal carcinoma in-situ) in the contralateral breast with or without positive BRCA1 or BRCA2 genetic testing
  - Personal history of contralateral breast cancer in the pre-menopausal woman

Surgery Services, continued

Prior Authorization Requirements for Breast Reconstructive Surgery, continued	• Breast implants are covered when surgically placed in the area where the natural breast tissue has been removed for a medically necessary mastectomy or to achieve symmetry after medically necessary breast surgery. • Periprosthetic capsulotomy or capsulotomy procedures are covered for contractions or adhesions following reconstruction surgery when the contractions or adhesions are caused by medically necessary chemotherapy or radiation treatments for breast cancer.
Limitations for Breast Reconstruction Surgery	Limitations for breast reconstructive surgery are: • Breast reconstruction, including implant material, only once per occurrence of breast cancer. • Implant replacement for cosmetic intention is not covered. • Prior authorization is required for breast reconstruction as a result of pain, visible distortion or malposition of an implant and reconstruction following a prophylactic mastectomy. The prior authorization request and supporting documents must indicate medical necessity.
FDA Approval	FDA-approved prosthetic implants must be utilized for post-mastectomy breast reconstructive surgery. Breast implants must be used in accordance with all FDA requirements current at the time of the surgery. A statement signed by the surgeon, certifying that all FDA requirements for the implant have been met, must be retained in the recipient's medical record and must be available for review upon request.
Pediatric and Urological Surgery	To receive increased reimbursement for certain surgery procedures rendered to recipients under the age of 21 years, the physician must be board-certified in pediatric surgery or urology. The provider's physician specialty code as a pediatric surgeon or urology (specialty codes 59 or 63) must be on their Medicaid provider file. Documentation of board certification must be provided to Medicaid in order to add these specialty codes to the provider file.

Surgery Services, continued

Circumcision	Elective circumcision is not reimbursed by Medicaid. Medicaid does reimburse medically necessary circumcisions. Medicaid coverage is limited to the following diagnosis codes: 605, 607.1, and 607.81. If a circumcision is performed for medical necessity with another diagnosis code, the provider may bill with a modifier 22 and submit medical necessity documentation with the claim for review.

Telemedicine Services

Definition	For purposes of Medicaid reimbursement, telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient, and the physician at the distant site.
Who Can Provide Services	Only physicians can provide and receive reimbursement for telemedicine services.
Definition of Distant or Hub Site	The distant or hub is the site where the consulting physician delivering the service is located at the time the telecommunications service is provided.
Originating or Spoke Site	The spoke is the location of the Medicaid recipient at the time the service occurs via a telecommunications system. This site does not receive reimbursement unless the provider at the spoke site performs a separately identifiable service for the recipient on the same day as the telemedicine service.
Telemedicine Communication Requirements	The telecommunication equipment must meet the technical safeguards required by 45 CFR 164.312, where applicable. Telemedicine services must comply with HIPAA and other state and federal laws pertaining to patient privacy.
Telemedicine Referral	A physician, ARNP or PA may initiate a consultation from the spoke site. The referring practitioner must be present during the consultation as well as the recipient.

Telemedicine Services, continued

Telemedicine Limitations

None of the following interactions are Medicaid reimbursable telemedicine services:

- Telephone conversations
- Video cell phone conversations
- E-mail messages
- Facsimile transmission
- Telecommunication with recipient at a location other than the spoke
- "Store and forward" consultations which are transmitted after the recipient or physician is no longer available

Medicaid does not reimburse for the costs or fees of any of the equipment necessary to provide this service.

Document Requirement

When telemedicine services are provided, the clinical record must include the following:

- A brief explanation of why the services were not provided face-to-face;
- Documentation of telemedicine service provided including the results of the assessment; and
- A signed statement from the recipient (parent or guardian if a child), indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or a one-time visit, as applicable to the services provided.

Limitations

The only codes reimbursed for telemedicine purposes are the consultation codes 99241 through 99255 with the addition of the modifier GT. The policy in this section that applied to the consultation codes is applicable to these codes when used for telemedicine services. Telemedicine services are limited to the hospital outpatient setting, inpatient setting, and physician office.

Undocumented Non-Citizens (Aliens)

Emergencies: Medicaid for Undocumented Non-Citizens (Aliens)

Medicaid reimburses providers for the treatment of undocumented non-citizens (aliens) for the treatment of medical conditions as defined in section 409.901(10), F.S.

CHAPTER 3
PRACTITIONER SERVICES
MODIFIERS AND REIMBURSEMENT GUIDELINES

Overview

Introduction

This chapter describes the modifiers that are approved for use by Medicaid and is a guide for this handbook.

In This Chapter

This chapter contains:

Reimbursement Information

Procedure Codes

The procedure codes listed in this handbook or any of the appropriate Fee Schedules are Healthcare Common Procedure Coding System (HCPCS) Levels I and II. Both levels are part of the nationally standardized code sets.

Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association. All rights reserved. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. CPT codes are identified using five numeric digits.

Level II of the HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes. HCPCS Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter (A – V) followed by four numeric digits.

Reimbursement Information, continued

Claims Editing	Florida Medicaid uses a claims editing system that is consistent with national coding standards. This includes editing for services that are incidental or mutually exclusive. Practitioners should report procedures with the most current complete and comprehensive procedure code that describes the service performed.
Claim Questions	Claim questions may be directed to the practitioner's Medicaid area office. The phone numbers of the area offices are available on the fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers and then select Area Offices.
Diagnosis Code	A diagnosis code is required on the CMS-1500 claim form for all medical procedures. Use the most specific and appropriate diagnosis code. Fourth and fifth digits are required when available.
Copayment	Medicaid recipients, unless they are exempt, are responsible for a copayment, for practitioner services. Note: See the Florida Medicaid Provider General Handbook for information on recipient copayments including categories of recipients and services that are exempt from the copayment.

How to Read Fee Schedules

Introduction	Specific CPT codes are reimbursed by Medicaid to physicians. These CPT codes are listed on the various fee schedules. The fee schedules are described below. Note: All fee schedules are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules.
Description	The fee schedules are tables of columns listing CPT procedure codes, and payment information pertinent to each code.
Code (Procedure Code)	The number in this column identifies the procedure code being billed.

How to Read Fee Schedules, continued

Modifier	Modifiers for a particular procedure code are listed in this column. This column may have a label of Modifier, Mod., or Mod.1, 2, etc.
21+ Max Fee	The dollar amount in this column is the allowable reimbursement Medicaid will pay for the procedure for Medicaid recipients that are age 21 years and older.
00-20 Max Fee	The dollar amount in this column is the allowable reimbursement Medicaid will pay for the procedure for Medicaid recipients that are age 20 years and younger. For services provided to children age 20 years and younger, there is a 4 percent increase over the adult fee. To calculate reimbursement for children's services, multiply the base fee by 1.04.
Base Fee	The dollar amount in this column is the allowable reimbursement Medicaid will pay for the procedure code for Medicaid recipients.
Professional Component (PC) Fee, Base PC Fee	The dollar amount in this column is the allowable reimbursement Medicaid will pay for the PC for this procedure code. The rate noted for certain procedures in this column are reimbursement for a procedure performed in an inpatient hospital, outpatient hospital, emergency department and an ambulatory surgical setting.
Technical Component (TC) Fee, Base TC Fee, TC Max Fee	The dollar amount in this column is the allowable reimbursement Medicaid will pay for the TC for this procedure code.
PC Age 00-20 (Professional Component)	The dollar amount in this column designates the allowable reimbursement for the PC of the procedure code for Medicaid recipients that are age 20 years and younger. For services provided to children that are age 20 years and younger, there is a 4 percent increase over the base fee. To calculate reimbursement for children's services, multiply the base fee by 1.04.
PC Age 21+ (Professional Component)	The dollar amount in this column designates the allowable reimbursement for the PC of the procedure code for Medicaid recipients that are age 21 years and older.

How to Read Fee Schedules, continued

FUD (Followup Days)	The number in this column designates the number of days following the date of surgery during which practitioner visits are included in the surgical fee. Evaluation and management and routine follow-up procedures related to the surgery are not separately reimbursable services during this time period.
UOS, UNOS (Units of Service)	The number in this column indicates the number of units of service that may be billed on one claim line.
Spec (Special)	An “R” in this column Identifies a “by-report” procedure code for which either documentation of medical necessity for the procedure performed is required or information is needed in order to review and price the procedure correctly. This requires a written report to be submitted with the claim.
PA (Prior Authorization)	A “Y” in this column identifies a procedure code that requires written prior authorization from the Medicaid contract QIO when the procedure is performed in the outpatient setting. Procedures performed without prior authorization as indicated in this column will not be reimbursed. Note: See the QIO Web site for information on obtaining prior authorizations at www.eqhs.org for additional information on the prior authorization process.
AS (Assistant Surgeon)	A “Y” in this column identifies a procedure that allows reimbursement for an assistant surgeon.
Abortion	A “Y” in this column identifies an abortion or abortion-related code. An Abortion Certification Form must be submitted with the claim. The Abortion Certification Form is available on the Medicaid fiscal agent’s Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms. Note: See Abortion Certification Form in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information.

How to Read Fee Schedules, continued

Sterilization	A "Y" in this column identifies a sterilization or sterilization-related procedure code. A Sterilization Consent Form must be submitted with the claim. The Sterilization Consent Form is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms. Note: See Sterilization Consent Form in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information.
Hysterectomy	A "Y" in this column identifies a hysterectomy or hysterectomy-related procedure code. The appropriate hysterectomy form must be submitted with the claim. The Hysterectomy forms are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms. Note: See Hysterectomy Acknowledgement Form or Exception to Hysterectomy Acknowledgement Form in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information.
Physician Pediatric Fee Schedule	The physician pediatric fee schedule contains legislative set rates that apply only to Pediatric Surgery (059) and Urology (063) Physician Specialists. Procedures on this fee schedule are subject to the same requirements as the same codes on the Physician Surgical Fee Schedule. For example, if a prior authorization is required for the same code on one fee schedule, it will require a prior authorization on the other one also.

Practitioner Fees

Physician	For services provided to children age 20 years and younger, the reimbursement is increased by 4 percent. The exceptions are: Regional Perinatal Intensive Care Centers (RPICC), injectable medications, supplies, devices, laboratory and pathology services. When performing as an assistant to a surgeon, the assisting physician is reimbursed at 16 percent of the physician rate. The following specialty types receive a 24 percent fee increase in addition to the above mentioned 4 percent fee increase for services provided to children age 20 years and younger: 002, 003, 004, 005, 008, 010, 014, 015, 017, 021, 022, 023, 029, 030, 031, 036, 037, 038, 039, 043, 046, 051, 053, 055, 057, 058, 060, 062. Florida Medicaid reimburses an enhanced fee to board-certified pediatric surgeons and urologists for certain procedures provided to Medicaid recipients that are under the age of 21 years. Providers requesting the enhanced fees for pediatric surgery or urology must be certified by the American Board of Pediatrics or American Board of Urology and must submit copies of their board certification to the Medicaid fiscal agent.
ARNP	ARNPs are reimbursed at 80 percent of the physician rate. When performing as an assistant to the surgeon, the ARNP is reimbursed at 12.8 percent of the physician rate. For services provided to children age 20 years and younger, reimbursement is increased by 4 percent.
PA	PAs are reimbursed at 80 percent of the physician rate. When performing as an assistant to the surgeon, the PA is reimbursed at 12.8 percent of the physician rate. For services provided to children age 20 years and younger reimbursement is increased by 4 percent.
RNFA	RNFAs are reimbursed at 12.8 percent of the physician rate. For services provided to children that are age 20 years and younger, reimbursement is increased by 4 percent.
AA	AAs are reimbursed at 80 percent of anesthesiology physician rate and the increase reimbursement for children that are age 20 years and younger does not apply.

Modifiers and Descriptions

Definition of Modifier	A modifier is a two-digit code that is used with a procedure code to more fully describe the procedure performed so that accurate reimbursement may be determined. There are three different types of modifiers that practitioners use: pricing modifiers, informational modifiers, and local-code modifiers. The three types of modifiers are described on subsequent pages.
Entering Modifiers on the Claim Form	The modifier is entered in the field next to the procedure code field in item 24D, Modifier, on the CMS-1500 claim form.

Pricing Modifiers

Introduction	The modifiers listed in this section are the valid pricing modifiers, which are used with the procedure codes listed in the fee schedule to affect the procedure code's reimbursement.
26 (Professional Component)	Certain procedures are a combination of a PC and a TC. For professional services rendered in the hospital, outpatient hospital, emergency room, or ambulatory surgery center, the practitioner may bill only the PC. Use modifier 26 to separately report the professional component. If the same provider renders both the PC and the TC service, do not bill the professional and technical components separately. Enrolled Medicaid physicians, licensed in Florida, will be reimbursed for the interpretation of diagnostic testing results from a distance through the use of Health Insurance Portability and Accountability Act (HIPAA) compliant technology. The technology used to transmit images and information for the diagnostic interpretation must meet nationally accepted medical standards of care. The physician billing the PC must use this modifier, the identical procedure code, place, and date of service as the technical component claim.

Pricing Modifiers, continued

50 (Bilateral Procedure)	Use modifier 50 to identify bilateral procedures that are performed during the same operative session. The procedure code along with modifier 50 should be identified on one claim line. If bilateral pricing rules apply to a procedure, bill the procedure code on one claim line with modifier 50, do not bill on separate lines with LT (left) and RT (right). Modifier 50 reimburses 150 percent of the allowable reimbursement for a procedure code or suspends for multiple surgery pricing, if applicable. Do not use modifier 50 if the CPT definition identifies the service solely as a bilateral procedure or as a “unilateral or bilateral” procedure in the descriptor. The quantity, or number of units, to be entered on the same claim line as a bilateral procedure is 1 (one).
51 (Multiple Procedures)	Use modifier 51 when multiple surgeries are performed on the same recipient, same date of service. Payment for these procedures is as follows: • 100 percent of highest reimbursed CPT code • 50 percent of second highest reimbursed CPT code • 25 percent of all others Do not append modifier 51 to add-on codes.
52 (Reduced Services)	Use modifier 52 when under certain circumstances, a service or procedure is partially reduced at the practitioner’s discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. Reimbursement rate is 50 percent of the allowable fee for the procedure code.

Pricing Modifiers, continued

53 (Discontinued Services)	Use modifier 53 under circumstances when the practitioner elects to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier 53 to the code reported by the physician for the discontinued procedure. Reimbursement rate is 25 percent of the allowable fee for the procedure code.
54 (Surgical Care Only)	Use Modifier 54 to indicate that the practitioner performed surgical care only, and another practitioner managed the pre- and post-operative care. Reimbursement rate is 50 percent of the maximum allowable fee for the procedure code.
55 (Post-Operative Management Only)	Use modifier 55 to identify post-operative care only. When one practitioner performs the postoperative management and another practitioner has performed the surgical procedure, the postoperative component may be identified by adding the modifier 55. Reimbursement rate is 30 percent of the maximum allowable fee for the procedure code.
56 (Pre-Operative Management Only)	Use modifier 56 to indicate pre-operative care only. When one practitioner performs the pre-operative care and evaluation and another practitioner performs the surgical procedure, the pre-operative component may be identified by adding the modifier 56. Reimbursement rate is 20 percent of the maximum allowable fee for the procedure code.
62 (Two Surgeons)	Use modifier 62 to indicate that two practitioners worked together as primary surgeons performing distinct parts of a single reportable procedure. When the same procedure code is used, both practitioners must use modifier 62.

Pricing Modifiers, continued

62 (Two Surgeons), continued	If both practitioners do not report the modifier 62, this can result in one practitioner being reimbursed at 100 percent and the other physician's claim being denied as a duplicate claim. Medicaid reimburses each practitioner 60 percent of the allowable fee for the procedure code. If the practitioner performs additional procedures during the same operative session without a co-surgeon, report those procedures without the modifier. If one of the co-practitioners acts as an assistant in the performance of any additional procedures during the same operative session, report the procedure separately with modifier 80.
66 (Surgical Team)	Use modifier 66 to indicate a complex procedure requiring the skill of several practitioners of the same or different specialties. Medicaid reimburses a maximum of three practitioners at 100 percent of the maximum allowable fee for procedures requiring a surgical team. The practitioner must submit documentation with the claim to receive surgical team reimbursement. Currently, this modifier is limited to practitioners performing organ transplants.
80 (Assistant Surgeon)	Use modifier 80 to identify procedures that require medically necessary surgical assistant services. Only one assistant surgeon may be reimbursed for each operative session. For physician providers, modifier 80 reimburses 16 percent of the maximum fee for the procedure code. Multiple surgical procedures are reimbursed as follows: • 16 percent of 100 percent of the maximum allowable fee for primary surgical procedure (first claim line) • 16 percent of 50 percent of the maximum allowable fee for the second surgical procedure • 16 percent of 25 percent of the maximum allowable fee for all other surgical procedures ARNPs, PAs, and RNFAs are reimbursed at 80 percent of the physician's assistant surgeon rate, which is 16 percent of the maximum fee. So that the rate for ARNPs, PAs, and RNFAs is 12.8 percent of the maximum fee.

Pricing Modifiers, continued

QK (Physician Supervision of Anesthesia Performed by a CRNA)	Use modifier QK when an anesthesiologist supervises the concurrent anesthesia services performed by two, three, or four certified registered nurse anesthetists (CRNA. These services reimburse 20 percent of the anesthesia fee allowed for that procedure.
TC (Technical Component)	Certain procedures are a combination of a PC and a TC. Procedure codes reimbursable with a TC are radiology procedure codes (70000-79999) in the practitioner office setting only. A separate TC modifier for other procedure codes is only reimbursable for Medicare cross-over claims. Use modifier TC when the radiological technical component is reported separately. Acceptable procedure codes billable for TC are identified in the "TC" column in the radiology fee schedule. Do not bill the TC separately, if the same provider performs both the technical and professional components.

Informational Modifiers

Introduction	The modifiers listed in this section are informational modifiers, which are used with the procedures listed in the fee schedule to indicate additional information and either allow the procedure code to bypass system edits or cause the claim to suspend for medical review.
Q6 (Locum Tenens)	Use modifier Q6 to identify the services furnished by a locum tenens practitioner.
22 (Unusual Procedural Services)	Use modifier 22 only according to policy outlined in this handbook. The use of modifier 22 does not result in an increase in reimbursement. The use of modifier 22 will suspend the claim for review of attached documentation. Failure to include required supporting documentation will result in denial of the claim.
24 (Unrelated Evaluation and Management Services)	Use modifier 24 to indicate that the practitioner performed an evaluation and management (E&M) service during the postoperative period for reasons unrelated to the original procedure.

Informational Modifiers, continued

25 (Separate Evaluation and Management Services)	Use modifier 25 to indicate a separately identifiable evaluation and management (E&M) service on the same day of a procedure or other service, by the same practitioner or group. Practitioners may also use modifier 25 to bill for an E&M service that results in the decision to perform a surgical procedure on the same day as the surgical procedure.
58 (Staged or Related Procedure or Service by the Same Practitioner during the Postoperative Period)	Use modifier 58 to indicate the practitioner performed a procedure or service during the postoperative period that was planned or anticipated (staged), or more extensive than the original procedure.
59 (Distinct Procedural Service)	Use modifier 59 to indicate that a procedure or service is distinct or independent from other services performed on the same day. Use modifier 59 for procedures that normally would be considered an integral component of another procedure performed, or ordinarily not performed during the same operative session. Modifier 59 is not to be used with evaluation and management services.
76 (Repeat Procedure by Same Practitioner)	Use modifier 76 to indicate a procedure was repeated by the same practitioner who performed the original procedure.
77 (Repeat Procedure by Another Practitioner)	Use modifier 77 to indicate a repeat procedure was performed by another practitioner on the same date of service.
78 (Unplanned Return to the Operating Room, Related Procedure)	Use modifier 78 to identify a return to the operating room for a related additional unplanned procedure during the post-operative period. The initial surgery must have been performed by the same physician or physician's group.

Informational Modifiers, continued

79 (Unrelated Procedure or Service by the Same Practitioner during the Postoperative Period)	Use modifier 79 to identify an unrelated additional procedure or service performed by the same physician during a previous post-operative period. The return trip to the operating room is during the postoperative period when the service is provided by the same physician or physician group that performed the surgical procedure relating to the postoperative period.
GT (Telemedicine)	Use modifier GT to indicate that telemedicine services were provided.
QS (Monitored Anesthesia Care)	Use modifier QS when billing for monitored anesthesia care.
LT and RT (Left and Right Modifier)	Use modifiers LT and RT to indicate left (LT) or right (RT) side of body for radiological, surgical, or diagnostic procedures.

Local Code Modifiers

Local Code Modifiers	The Health Insurance Portability and Accountability Act (HIPAA) required Florida Medicaid to convert its locally assigned procedure codes to national HCPCS codes effective October 16, 2003. Some of the procedures that Florida Medicaid covers are not adequately defined by HCPCS procedure codes, so Florida Medicaid added modifiers to the HCPCS procedure code to better define the procedure. Practitioners use local code modifiers with procedure codes for Child Health Check-Up screenings, RPICC, immunization, certain prenatal services, family planning, and certain vision and hearing services. The procedure codes with local code modifiers are listed on the fee schedules. Local code modifiers can only be used with the procedure codes listed. Use of local code modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.
EP (Child Health Check-Up)	The EP modifier is used to identify a Child Health Check-Up with procedure code 99385 (new patient visit) and 99395 (established patient visit) to identify service provided to recipients 18 through 20 years of age.

Local Code Modifiers, continued

FP (Family Planning Services)	The FP modifier is used to identify services specific to family planning, with CPT procedure codes for preventive medicine.
TG (Regional Perinatal Intensive Care Center Services) (RPICC)	The TG modifier is used to indicate RPICC claims according to RPICC policy and fee schedule
TG (With code H1001)	The modifier TG is used with procedure code H1001 to indicate that a Healthy Start Prenatal Risk Screening was completed during the first trimester by the practitioner.
TH (Obstetrical Modifier)	The TH modifier is used with obstetrical CPT codes as indicated by policy and the fee schedule.

Review Claim Inquiries and Special Claim Requirements

Definition of a Reviewed Claim	The Medicaid review team reviews certain claims for: • Accuracy. • Utilization control measures. • Pricing of unlisted procedure codes. These codes require documentation to be submitted with the claim.
Claim Questions	Claim questions may be directed to the practitioner's local Medicaid area office or the Medicaid fiscal agent. Contact information for the area offices is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers and then select Area Offices.
Suspended Claim Status	Claims that require Medicaid review are adjudicated with a status of "suspended" in the Florida Medicaid Management Information System (FMMIS). If a claim is suspended and the provider does not know why, the provider may call the local Medicaid area office or the Medicaid fiscal agent's provider inquiry line to determine the status of the claim. Note: The fiscal agent's provider inquiry phone number is 1-800-289-7799.

Review Claim Inquiries and Special Claims Requirements, continued

Denied Claim Status

If the Medicaid review results in a denial, and the provider does not understand the reason for the denial, the provider may contact the Medicaid area office for assistance. The Medicaid area office will review the claim denial and explain to the provider why the claim was denied. If the claim was denied because the provider did not submit adequate documentation, the provider may resubmit the claim with appropriate documentation.

Contact information for the area offices is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers and then select Area Offices.

Request to Reconsider a Denied Claim

To request reconsideration of a medically reviewed denied claim, the provider must send all of the following information to the area Medicaid office:

- Cover letter requesting reconsideration of the denied claim
- Explanation of the medical reasons why the provider disagrees with the original denial
- Any supporting, peer-reviewed literature to support the provider's opinion of medical necessity

The Medicaid area office will forward the request to the medical review team. The medical review team will notify the Medicaid area office of the determination, and the Medicaid area office will notify the provider.

All correspondence and communication regarding the status of the reconsideration must be made directly to the Medicaid area office for proper coordination.

Note: The Medicaid area office phone numbers and addresses are on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers and then select Area Offices.

CHAPTER 4
RECIPIENT ASSIGNMENT PROGRAM

Overview

Introduction

This chapter describes the Recipient Assignment Program (RAP), the criteria for recipient enrollment in the program, how primary care physicians are assigned, physician responsibilities, and the excluded services.

Legal Authority for RAP

The legal authority governing RAP is section 1915 (a) of the Social Security Act; Title 42 of the Code of Federal Regulations, Part 431.54(e); section 409.912(43), Florida Statutes; and Rule Division 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

Description and Purpose

Description

The Recipient Assignment Program (RAP) was established to monitor Medicaid recipients who over utilize or inappropriately access Medicaid goods and services. The program is similar to managed care in regard to the assignment of the recipient's health care services to a primary care physician (PCP). The physician acts as a case manager or "gatekeeper" for individual management of illnesses, disease processes, and non-emergency medical services that are provided by a physician. The PCP must authorize all referrals to specialists when required by medical necessity. Certain services listed in this chapter under Services Excluded from RAP are exempt from management by the PCP.

Description and Purpose, continued

Purpose

RAP is designed to promote cost efficient management of health care services and provide continuity of care for Medicaid recipients. The program prevents duplication of services and reduces frequency of medically unnecessary health care services. Cost savings can be realized by a reduction in unnecessary office visits and non-emergency visits to hospital emergency rooms.

Recipient Enrollment in RAP

Initial RAP Enrollment

Medicaid recipients who meet all of the following criteria are enrolled in RAP:

- Recipients who are 21 years old and older
- Not enrolled in a managed care program
- Enrolled in the MediPass program
- Are enrolled in the Pharmacy Lock-In Program

Recipients are initially enrolled in RAP for 12 months.

Note: See the Florida Medicaid Provider General Handbook for a description of Medicaid Managed Care Programs and MediPass.

Note: See the Florida Medicaid Prescribed Drug Services Coverage, Limitations, and Reimbursement Handbook for information on the Pharmacy Lock-In Program.

The handbooks are available on the Medicaid fiscal agent's website at www.mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and then select Provider Handbooks.

Recipients Excluded from RAP Participation

Medicaid recipients who meet any of the following criteria are excluded from enrollment in RAP:

- Are age 20 years and younger
- Are enrolled in a Health Maintenance Organization (HMO)
- Are enrolled in a Provider Service Network (PSN)
- Have Medicare coverage (any type)
- Have third party liability (TPL) insurance
- Reside in nursing facilities or long-term care facilities
- Are hospitalized for any inpatient psychiatric treatment
- Are pregnant at the time of Pharmacy lock-in
- Do not meet criteria to be enrolled in MediPass at the time of lock in

Recipient Enrollment in RAP, continued

Duration of Assignment

Recipient enrollment in RAP and assignment to a PCP is required for a minimum of 12 months or the duration of Medicaid eligibility, whichever ends first.

If a recipient who is enrolled in RAP loses Medicaid eligibility and is subsequently reinstated in Medicaid, he will be re-enrolled in RAP for a new 12-month enrollment period.

A recipient who is disenrolled from an HMO or a PSN who meets the RAP criteria will be enrolled in RAP.

Recipient Notification

Before a Medicaid recipient is enrolled in RAP, a 21-day advance notice on an Enrollment Notification Letter must be issued. The letter contains the following information:

- RAP enrollment is for up to one year
- Name, address, and phone number of the PCP to which the recipient has been assigned
- Process for requesting a different PCP, if the recipient desires
- Notice that the recipient is responsible for reporting a change of address
- Notice that the recipient has a right to a fair hearing regarding his enrollment in RAP and PCP assignment

Note: A sample Enrollment Notification Letter is included in this chapter.

Ongoing Enrollment in RAP

After the recipient's initial 12-month enrollment period, recipients who meet any of the following criteria are considered for continued RAP enrollment:

- More than two visits to the hospital emergency room for non-emergency services within a three-month period
- More than two office visits to more than two primary care physicians within a three-month period
- Received duplicate services
- Multiple inpatient hospital admissions within one year

A recipient may be disenrolled, if determined to have developed a chronic medical condition that would contraindicate such assignment to the program.

Recipient Enrollment in RAP, continued

Assignment Extension

A recipient's extended assignment beyond the initial 12 months in RAP is determined by utilization trends as identified through utilization review reports. The Medicaid medical consultant reviews each case to determine the need for a recipient's extended enrollment in RAP.

Prior to the one-year anniversary date of the original RAP enrollment, Medicaid will notify the recipient in writing of its decision to continue the RAP enrollment.

Fair Hearing Notification

The right of notice and the opportunity for a fair hearing applies to both the initial assignment and any future assignments.

The recipient must request a fair hearing in writing within ninety (90) days of the date of the Enrollment Notification Letter. An optional hearing request form is available from the recipient's Medicaid area office. The recipient may use the area Medicaid office's hearing request form or make the request on a plain piece of paper.

The recipient may submit the request to his area Medicaid office or directly to:

Office of Appeal Hearings
Department of Children and Families
1317 Winewood Blvd., Bldg. 5
Tallahassee, FL 32399-0700

Note: The Medicaid area offices' addresses and telephone numbers are available on AHCA's Web site at www.ahca.myflorida.com. Select the Site Menu tab, then under the Division of Medicaid, select the Area Office bullet.

Primary Care Physician Assignment

Introduction

Enrollment in RAP requires the recipient to obtain Medicaid services from the assigned primary care physician (PCP). The recipient may only receive care from other practitioners as directed or referred by the assigned PCP, unless the services are otherwise excluded from RAP.

Primary Care Physician Assignment, continued

Designation of Primary Care Practitioners

Medicaid will initially assign the recipient's PCP. A pool of enrolled MediPass providers will be utilized as PCPs. The PCP assignment will be determined jointly by the Medicaid area office, Bureau of Medicaid Services, and the Bureau of Medicaid Program Integrity. Medicaid will notify the primary care physician of his RAP enrollees on an Enrollee Physician Notification form.

In designating the PCP, Medicaid will ensure that the recipient has reasonable access by taking into account geographic location and reasonable travel time.

Recipients may request to be assigned to a different MediPass PCP by the procedures described in this chapter.

Note: A copy of the Enrollee Physician Notification form is included in this chapter.

Recipient Option to Change PCP When Notified of Enrollment in RAP

When the recipient receives the Enrollment Notification Letter, the recipient may request a different PCP than the one assigned. The request to change the PCP must be received by Medicaid within 21 days from the date on the Enrollment Notification Letter. The request must be made by the recipient to the Medicaid area office

Medicaid will consider the request and have final authority for the selection of another PCP. The Medicaid area office will notify the recipient in writing whether the request was approved or denied. The assignment to the original PCP will continue until the recipient receives written notification from Medicaid that his PCP has been changed.

Note: The Medicaid area offices' addresses and telephone numbers are available on AHCA's Web site at http://ahca.myflorida.com. Select the Site Menu tab, then under Division of Medicaid, select the Area Office bullet.

Good Cause for an Enrolled RAP Recipient to be Reassigned to New PCP

A recipient who is enrolled in RAP may request a reassignment to another PCP once during a 12-month enrollment period for any of the following good cause reasons:

- Recipient or PCP relocates, causing a transportation hardship
- Assigned PCP sells or closes his practice
- Assigned PCP requests a reassignment
- Assigned PCP declines to manage a RAP participant
- Assigned PCP's Medicaid provider eligibility is terminated
- Recipient or the assigned PCP requests reassignment based on evidence of medical necessity

Primary Care Physician Assignment, continued

Recipient's Process for Requesting Reassignment

Enrolled RAP recipients must request reassignment in writing. The recipient must explain in detail the reason for the reassignment request. Medicaid will determine appropriate action and notify the recipient and involved PCPs in writing. The recipient mails the request to:

Agency for Health Care Administration
Recipient Assignment Program
Bureau of Medicaid Services
2727 Mahan Drive, M.S. #20
Tallahassee, FL 32308

Recipient Change of Address

Recipients who change their addresses must notify Medicaid in writing 30 days prior to the change. Recipients receive a Request for Change of Address for Recipient Assignment Program (RAP) with their Enrollment Notification Letter. The recipient must mail the change of address information to:

Agency for Health Care Administration
Recipient Assignment Program
Bureau of Medicaid Services
2727 Mahan Drive, M.S. #20
Tallahassee, FL 32308

Note: A copy of the Request for Change of Address for Recipient Assignment Program (RAP) form is included in this chapter.

Primary Care Termination

If a PCP terminates care of a recipient, the PCP must notify Medicaid in writing 30 days prior to the termination. The practitioner should also send the same notification to the recipient. This confirmation will allow Medicaid time to reassign the recipient to another PCP. The recipient remains assigned to the PCP until a new practitioner is assigned. The provider must send the termination notice to:

Agency for Health Care Administration
Recipient Assignment Program
Bureau of Medicaid Services
2727 Mahan Drive, M.S. #20
Tallahassee, FL 32308

Physician Responsibilities

Specialty Care Referral	The assigned PCP determines medical necessity for a RAP recipient when the services of a specialist are required and refers the recipient to the specialist.
Physician Verification of Recipient Eligibility	Practitioners are required to verify the recipient's eligibility prior to rendering health care services. Recipient enrollment in RAP will be identified on the Medicaid Eligibility Verification System (MEVS). Note: See the Florida Medicaid Provider General Handbook for information on verifying recipient eligibility.
Specialty Care Claim Submission	To be reimbursed by Medicaid, the specialist must enter the PCP's name in item 17 and the PCP's Medicaid provider identification number in item 17a on the CMS-1500 claim form. Note: See the Florida Medicaid Reimbursement Handbook, CMS-1500, for additional information on completing the claim form.
Billing the Recipient	A recipient who is enrolled in RAP is responsible for payment of services if the recipient chooses to receive services from practitioners other than those referred to by the PCP, except for the excluded services. Note: See the Florida Medicaid Provider General Handbook for additional information on billing the recipient.
Utilization Management	Medicaid conducts reviews of monthly, quarterly, and annual reports to determine utilization of health care services, to reassess RAP, and to identify trends and compliance. The following activities can be identified from the reports: • Utilization pattern in excess of the established criteria • Abuse, misuse of services, and fraudulent actions related to Medicaid services and benefits • Non-compliance resulting in services received from one or more non-assigned practitioners without a designated PCP referral or in the absence of a medical emergency

Services Excluded from RAP

Excluded Services

Medicaid recipients who are enrolled in RAP may access the following services without authorization or referral from their primary care physicians (PCPs):

- Behavioral health
- Chiropractic (first 10 visits)
- Dental
- Family planning
- Home and community-based waiver services
- Mental health targeted case management
- Optometric
- Podiatry (first 4 visits)
- Transportation
- Vision

Emergency Care

Emergency services and care provided to recipients who are enrolled in RAP by hospital emergency rooms do not require authorization or referral from the recipients' PCPs.

Illustration 4.1: Enrollment Notification Letter (Front)

ENROLLMENT NOTIFICATION LETTER

Date:

Recipient Name, Recipient Medicaid ID #
Recipient Address
Recipient City, State, Zip

Dear _____

This letter is to tell you that beginning 21 days from the date of this letter, you will be enrolled in the Recipient Assignment Program (RAP) for one year, unless you lose your Medicaid eligibility. The Recipient Assignment Program is authorized by section 409.912(45), Florida Statutes.

This program will benefit you by giving you a single physician called a primary care physician (PCP), who will help manage your health care. Other than the services listed on the back of this letter, you must get authorization from your primary care physician prior to receiving Medicaid-covered services. If you seek services that are not authorized by your primary care physician, you may have to pay for the services.

Medicaid has selected the following physician to be your primary care physician. This choice was based upon the location of your current address, the physician's address, and reasonable travel time to the physician's office.

Name: _____, M.D.
Address: _____
City, State, Zip: _____
Phone: _____

You may ask Medicaid to reassign you to another Medicaid primary care physician by calling your area Medicaid office and requesting the change. A list of area Medicaid offices' phone numbers and addresses is enclosed. You must make this request within 21 days of the date on this letter. Medicaid will notify you in writing if your request has been approved or denied.

If you wish to contest this agency action, you have the right to request a fair hearing. You may represent yourself or be represented by a lawyer, a relative, a friend, or other spokesperson.

You must request a hearing in writing within 90 days of the date on this letter. A hearing request form is available from your area Medicaid office. You may make the hearing request on area office's form or a plain piece of paper. Submit the hearing request to your area Medicaid office or directly to:

Office of Appeal Hearings
Department of Children and Families
1317 Winewood Blvd., Bldg. 5
Tallahassee, FL 32399-0700

If you move from your current address to another location, you must submit the enclosed Request for Change of Address for Recipient Assignment Program form 30 days prior to your move. Medicaid will determine if you will need to be reassigned to a new primary care physician who is nearer to your new address. You must also let the Department of Children and Families know about your new address. Medicaid will send you a letter at your new address to tell you if your primary care physician has changed.

If you have any questions, please contact your area Medicaid office.

AHCA-Med Serv Form 001, August 2011 (incorporated by reference in Rule 59G-4.230, F.A.C.)

Illustration 4.2: Enrollment Notification Letter (Back)

MEDICAID SERVICES THAT DO NOT REQUIRE AUTHORIZATION:

You do not need to have your primary care physician's authorization to receive the following Medicaid-covered services:

- Behavioral health
- Chiropractic (first 10 visits)
- Dental
- Family planning
- Home and community-based waiver services
- Mental health targeted case management
- Optometric
- Podiatry (first 4 visits)
- Transportation
- Vision

Also, you do not need authorization to receive emergency services from a hospital emergency room.

AHCA-Med Serv Form 001, August 2011 (incorporated by reference in Rule 59G-4.230, F.A.C.)

Illustration 4.3: Spanish Version of the Enrollment Notification Letter (Front)

NOTIFICACION DE ENROLAMIENTO

Fecha:

Nombre del beneficiario y su Medicaid ID #
Dirección
Ciudad, estado, código postal

Estimado _____

Esta carta es para informarle que efectivo 21 días después de la fecha de esta carta, usted será enrolado en el Programa de Asistencia al Recipiente (RAP) por un año, a no ser que usted pierda su elegibilidad de Medicaid. El Programa de Asistencia al Recipiente es autorizado por la sección 409.912(45), de los Estatutos de la Florida.

Este programa le beneficiará asignándole un solo doctor llamado médico de cuidado primario (PCP), quien le ayudará a administrar el cuidado de su salud. Para otros servicios que los enumerados detrás de esta carta, usted **deberá** obtener autorización de su médico de cuidados primarios antes de recibir servicios cubiertos por Medicaid. Si usted busca servicios que no son autorizados por su médico de cuidados primarios, usted deberá pagar por los servicios.

Medicaid ha seleccionado el siguiente médico para ser su médico de cuidados primarios. Esta selección fue basada en la localización de su dirección actual, la dirección del médico y el tiempo razonable de viaje a la oficina del médico.

Nombre: _____MD
Dirección: _____
Ciudad, Estado, Código: _____
Teléfono: _____

Usted puede pedirle a Medicaid que le reasigne a otro médico de cuidados primarios de Medicaid llamando a su área de Medicaid y pidiendo el cambio. Una lista de los teléfonos y direcciones de las oficinas de áreas de Medicaid está incluida. Usted debe hacer este pedido dentro de los 21 días de la fecha de esta carta. Medicaid le notificará por escrito si su petición fue aprobada o negada.

Si usted desea apelar la decisión de la agencia, usted tiene derecho a solicitar una apelación. Usted puede representarse a si mismo o ser representado por un abogado, un familiar, un amigo o una persona que hable por usted. Usted debe solicitar la apelación por escrito dentro de los 90 días de la fecha de esta carta. Las formas para solicitar una apelación están disponibles en la oficina de Medicaid de su área. Usted puede solicitar la apelación en las formas disponibles o en un simple pedazo de papel. Envíe su solicitud de apelación a la oficina de Medicaid de su área o directamente a:

Office of Appeal Hearings
Department of Children and Families
1317 Winewood Blvd., Bldg. 5
Tallahassee, FL 32399-0700

Si usted se muda de su dirección actual a otra localidad, usted debe enviar la forma incluida de Petición de Cambio de Dirección para el Programa de Asistencia al Recipiente 30 días antes de su mudada. Medicaid determinará si usted necesita ser reasignado a un nuevo médico que esté más cerca a su nueva dirección. Usted debe también dejarle saber al Departamento de Niños y Familias sobre su nueva dirección. Medicaid le enviará una carta a su nueva dirección para decirle si su médico de cuidados primarios ha sido cambiado.

Si usted tiene alguna pregunta, por favor contacte la oficina de Medicaid de su área.

AHCA-Med Serv Form 001-Spanish, August 2011 (incorporated by reference in Rule 59G-4.230, F.A.C.)

Illustration 4.4: Spanish Version of the Enrollment Notification Letter (Back)

Page 2

SERVICIOS DE MEDICIAD QUE NO REQUIEREN AUTORIZACION:

Usted no necesita tener autorización de su médico de cuidados primarios para recibir los siguientes servicios cubiertos por Medicaid:

- Salud de comportamiento
- Quiropráctico (primeros diez visitas)
- Dental
- Planificación familiar
- Servicios waiver en el hogar y la comunidad
- Administración de casos de salud mental
- Optometrista
- Podiatría (cuatro primeras visitas)
- Transportación
- Vision

También usted no necesita autorización para recibir servicios de emergencia en una sala de emergencia en un hospital.

AHCA-Med Serv Form 001-Spanish, August 2011 (incorporated by reference in Rule 59G-4.230, F.A.C.)

Illustration 4.5: Request for Change of Address

REQUEST FOR CHANGE OF ADDRESS FOR RECIPIENT ASSIGNMENT PROGRAM (RAP)

This request must be filed 30 days prior to your relocation to a new address. Mail the form to Recipient Assignment Program, Bureau of Medicaid Services, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop #20, Tallahassee, FL 32308.

Please **print** all information below.

YOU MUST ALSO NOTIFY THE DEPT. OF CHILDREN & FAMILIES OF YOUR ADDRESS CHANGE.

_____ _____

Recipient's Name **Medicaid ID Number**

_____

Old Street Address

_____

Old City, State, Zip

_____

Phone

_____

New Street Address

_____

New City, State, Zip

_____ _____

Recipient's Signature **Date**

AHCA-Med Serv Form 002, December 2009 (incorporated by reference in Rule 59G-4.230, F.A.C.)

Illustration 4.6: Spanish Version of the Request for Change of Address

PETICION DE CAMBIO DE DIRECCION PARA EL PROGRAMA DE ASISTENCIA AL RECIPIENTE (RAP)

Esta petición debe enviada 30 días antes de su relocalización a su nueva dirección. Envíe la forma a Recipient Assignment Program, Bureau of Medicaid Services, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop #20, Tallahassee, FL 32308.

Por favor, escriba con letra de imprenta toda la información siguiente.

USTED DEBE TAMBIEN NOTIFICAR AL DEPARTAMENTO DE NIÑOS Y FAMILIAS SU CAMBIO DE DIRECCION.

_____ _____

Nombre del recipiente **Número de Medicaid**

_____

Dirección anterior

_____

Ciudad, Estado y Código postal anteriores

_____

Teléfono

_____

Nueva dirección

_____

Nueva Ciudad, Estado, Código postal

_____ _____

Firma del recipiente **Fecha**

AHCA-Med Serv Form 002-Spanish, August 2011 (incorporated by reference in Rule 59G-4.230, F.A.C.)

Illustration 4.7: Enrollee Physician Notification (Front)

RECIPIENT ASSIGNMENT PROGRAM (RAP)
ENROLLEE PHYSICIAN NOTIFICATION

Physician Name:_____

Physician Address:_____

Physician City, FL Zip:_____

If you have any questions regarding the Recipient Assignment Program (RAP), please call the RAP RN Consultant in the Bureau of Medicaid Services at (850) 412-4230 or your local Medicaid area office.

Recipient Name:_____

Recipient Medicaid Number:_____

RAP Start Date:_____ **RAP End Date**:_____

Recipient Name:_____

Recipient Medicaid Number:_____

RAP Start Date:_____ **RAP End Date:**_____

Recipient Name:_____

Recipient Medicaid Number:_____

RAP Start Date:_____ **RAP End Date:**_____

AHCA-Med Serv Form 003, December 2009 (incorporated by reference in Rule 59G-4.230, F.A.C.)

Illustration 4.8: Enrollee Physician Notification (Back)

Enrollee Physician Notification, Page Two

Recipient Name:_____

Recipient Medicaid Number:_____

RAP Start Date:_____ **RAP End Date:**_____

Recipient Name:_____

Recipient Medicaid Number:_____

RAP Start Date:_____ **RAP End Date:**_____

Recipient Name:_____

Recipient Medicaid Number:_____

RAP Start Date:_____ **RAP End Date:**_____

Recipient Name:_____

Recipient Medicaid Number:_____

RAP Start Date:_____ **RAP End Date:**_____

Recipient Name:_____

Recipient Medicaid Number:_____

RAP Start Date:_____ **RAP End Date:**_____

AHCA-Med Serv Form 003, August 2011 (incorporated by reference in Rule 59G-4.230, F.A.C.)

CHAPTER 5
Family Planning Waiver Services

Overview

Introduction

This chapter defines Florida Medicaid family planning waiver services, and identifies covered services under the waiver.

Background

Waiver services are authorized through section 409.904(5), F.S. and Rule Division 59G, F.A.C.

Legal Authority

The federal authority governing the provisions, requirements, benefits, and service payment of the Family Planning Waiver Services Program is section 1115(a) of the Social Security Act and 42 U.S.C. §1315(a).

In This Chapter

This chapter contains:

Family Planning Waiver Services

Description

The family planning waiver (FPW) covers family planning services up to 24 months to eligible women, ages 14 through 55. Eligibility for the FPW is limited to family incomes at or below 185 percent of the Federal Poverty Level who are not otherwise eligible for Medicaid, Children's Health Insurance Program (CHIP), or health insurance coverage that provides family planning services; and who have lost Medicaid eligibility within the last two years. This includes women losing Medicaid managed care coverage.

Recipients losing SOBRA (pregnancy Medicaid) eligibility will have passive enrollment during the first 12 months of losing Medicaid. Non-SOBRA women will have to actively apply for the first year of benefits at their local county health department. All women enrolled in the family planning waiver will have active re-determination of eligibility through their local county health department after 12 months of family planning waiver eligibility. In order to receive the second year of FPW benefits, recipients must reapply at their local health department.

Family Planning Waiver Services, continued

Description, continued

Recipients are no longer eligible if they leave Florida, became Medicaid eligible in another category, request that their Medicaid be terminated, or become pregnant. Recipients may request to be disenrolled from the program at any time.

Recipients who become pregnant or think they may be eligible for Medicaid coverage under a different category must reapply for Medicaid through the Department of Children and Families.

Note: A list of county health departments' addresses and phone numbers is available on the Department of Health's Web site at www.doh.state.fl.us.

Note: The Department of Children and Families (DCF) service centers' addresses and phone numbers are available on the DCF Web site at www.dcf.state.fl.us/. In the "About us" selection box choose Regions & Circuits, on the Florida map that appears, select the region that contains the county in which you live. Recipients may also call the DCF Access FLORIDA toll free number at 1-866-762-2237.

Note: See the Florida Medicaid Provider General Handbook for additional information on Family Planning Waiver Services.

Covered Services

Eligible recipients may receive Medicaid covered family planning services. The following services are benefits under the family planning waiver:

- New and established patient family planning visits, family planning counseling visits, family planning supply visits, and HIV pre- and post-screening counseling visits.
- Family planning related pharmacy services, including oral contraceptives. Services that are provided in a practitioner's office such as IUDs, Depo-Provera, and Norplant can be reimbursed to the practitioner; they are not covered as a pharmacy service if the practitioner purchases the product and receives reimbursement from Medicaid.
- Approved sterilization procedures performed in the practitioner's office or performed in an outpatient setting.
- Colposcopies and treatment for sexually transmitted infections (STI) are limited to a six-week period after a family planning examination, a family planning counseling visit, or a family planning supply visit. Approved antibiotics and vaginal antifungal and anti-infectives are available to treat limited STIs. Prescriptions to treat STIs must have the "FP" designation written on them.

Family Planning Waiver Services, continued

Covered Services, continued

Note: See the Florida Medicaid Prescribed Drug Services Coverage and Limitations Handbook for additional information.

No other Medicaid services are covered, including emergency room visits and inpatient services.

Service Exclusions

All other Medicaid services are excluded, including emergency room visits and inpatient services, from coverage and reimbursement.

Primary Care Referrals

The federal Centers for Medicare and Medicaid Services requires Medicaid practitioners of family planning waiver services to make appropriate referrals to primary care practitioners as medically indicated, although the costs of those primary care services are not reimbursable by Medicaid.

Referrals for primary care services must be documented in the recipient's medical record with the following required information:

- Practitioner name and telephone number to whom the recipient was referred.
- Reason for referral.
- Follow-up from recipient at next family planning visit of whether recipient followed referral recommendations.

Note: Some county health departments may provide primary care services on a sliding scale fee. A list of county health departments' addresses and phone numbers is available on the Department of Health's website at www.doh.state.fl.us.

Federally Qualified Health Care Centers (FQHCs) and Rural Health Clinics (RHCs) also provide primary care services on a sliding scale fee. A list of FQHCs addresses and phone numbers can be found on the Florida Association of Community Health Centers website www.fachc.org. Click on "Find a Health Center". A list of Rural Health Networks can be found on the following Department of Health website www.doh.state.fl.us/workforce/ruralhealth/ruralhlthnetworks.htm. Click on "Rural Health Network Directory".

Family Planning Waiver Services, continued

Reimbursable Services

Claims for extended family planning services must be submitted with the following specific procedure codes and diagnosis codes. All claims submitted for any other codes will be denied.

CPT Codes	
CPT Code	**Description of Covered Codes**
99384FP	Family Planning New/Established Visit
99385FP	
99386FP	
99394FP	
99395FP	
99396FP	
99403FP	Family Planning Counseling Visit
99211FP	Family Planning Supply Visit
99070	Physician office supplies for reimbursement of permanent implants (see 58565)
99201	Extended family planning services-new patient (treatment of STI)
99211	Extended family planning services-established patient (Treatment of STI)
J1055	Injection Medroxyprogesterone Acetate (Depo-Provera)
J7300	Intrauterine Copper Device (Paraguard)
J7302	Levonorgestrel-Releasing Intrauterine Device (Mirena)
J7307	Etonogestrel implant system, including implant and supplies (Implanon)
00840	Anesthesia For Intraperitoneal Procedures In Lower Abdomen Including Laparoscopy
00851	Anesthesia for tubal ligation/transection
11976	Removal of Implantable Contraceptive Capsules
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
11981	Insertion, non-biodegradable drug delivery implant
11982	Removal, non-biodegradable drug delivery implant
11983	Removal with reinsertion, non-biodegradable drug delivery implant
57170	Diaphragm or Cervical Cap fitting with instructions
57452	Colposcopy of the cervix
57454	Colposcopy with biopsy(s) of the cervix and endocervical curettage
57460	Colposcopy with loop electrode biopsy(s)
58300	Insertion of Intrauterine Device
58301	Removal of Intrauterine Device
58340	Catheterization and introduction of saline or contrast material for saline infusion for hysterosalpingography
58565	Bilateral fallopian tube occlusion by permanent implants
58600	Ligation or transection of fallopian tube(s)

Family Planning Waiver Services, continued

Reimbursable Services, continued

CPT Codes	
CPT Code	**Description of Covered Codes**
58615	Occlusion of fallopian tube(s) by device (e.g. band, clip, Falope ring)
58670	Surgical laparoscopy, with fulguration of oviducts (with or without transection)
58671	Surgical laparoscopy, with occlusion of oviducts by device (e.g. band, clip, or Falope ring)
76856	Ultrasound of pelvis, nonobstetric (to check placement of intrauterine devices)
76882	Ultrasound of extremity, limited, anatomic specific (to check for implantable contraceptive device)
Laboratory Procedures	
81001	Automated, with microscopy
81002	Non-automated, without microscopy
81003	Automated, without microscopy
81005	Urinalysis; Qualitative or semiqualitative
81007	Urinalysis; bacteriuria screen, by kit
81015	Urinalysis; bacteriuria screen, microscopic only
81025	Urine pregnancy test, by visual color comparison
82947	Glucose; quantitative, blood
84702	Gonadotropin, chorionic (hCG); quantitative
84703	Gonadotropin, chorionic (hCG); qualitative
85007	Blood count; manual differential WBC count
85014	Hematocrit
85018	Hemoglobin
86255	Fluorescent antibody; screen, each antibody (HIV & Herpes)
86382	Neutralization test, viral
86403	Rubella screen (IgG)
86580	Tuberculosis, intradermal
86592	Syphilis test; qualitative (e.g., VDRL, RPR,ART)
86593	Syphilis test; quantitative
86689	HTLV or HIV antibody, confirmatory test (western blot)
86694	Herpes simplex, non-specific type test
86695	Herpes simplex, type I
86701	HIV-1
86703	HIV-1 and HIV-2, single assay
86706	Hepatitis B surface antibody (HBsAb)
86707	Hepatitis Be antibody (HBeAb)
86762	Rubella titer
86780	Antibody; Treponema Pallidum (Syphilis Confirmatory)
86803	Hepatitis C antibody
87060	Throat culture

Family Planning Waiver Services, continued

Reimbursable Services, continued

CPT Codes	
CPT Code	**Description of Covered Codes**
Laboratory Procedures, continued	
87070	Culture, bacterial, definitive; any other source (GC)
87075	Culture, bacterial, any source; anaerobic (isolation)
87081	Culture, bacterial, screening only (GC)
87086	Culture, bacterial, urine; quantitative, colony count
87088	Culture, bacterial, urine; quantitative colony count, with isolation and presumptive identification of each isolate
87110	Culture, chlamydia
87164	Dark field examination, any source, includes specimen collection
87205	Neisseria gonorrhoeae smear
87206	Smear, primary source, with interpretation; (chlamydia)
87210	Smear, primary source, wet mount isolation, with stain
87252	Virus identification; tissue culture inoculation & observation
87340	Hepatitis B surface antigen (HBsAg)
87350	Hepatitis Be antigen (HBeAg)
87480	Candida species, direct probe technique
87481	Candida species, amplified probe technique
87490	Chlamydia trachomatis, direct probe technique
87491	Chlamydia trachomatis, amplified probe technique
87510	Gardnerella vaginalis, direct probe technique
87515	Hepatitis B virus, direct probe technique
87516	Hepatitis B virus, amplified probe technique
87520	Hepatitis C virus, direct probe technique
87521	Hepatitis C virus, amplified probe technique
87522	Hepatitis C virus, quantification
87528	Herpes simplex virus, direct probe technique
87529	Herpes simplex virus, amplified probe technique
87590	Neisseria gonorrhoeae, direct probe technique
87591	Neisseria gonorrhoeae, amplified probe technique
87620	Papillomavirus, human, direct probe technique
87621	Papillomavirus, human, amplified probe technique
88141	Cytopathology, cervical or vaginal (any system) requiring physician interpretation
88142	Cytopathology, cervical or vaginal (preservative fluid) under physician supervision
88143	Cytopathology, cervical or vaginal with manual screen & re-screen under physician supervision
88150	Cytopathology, slides, cervical or vaginal, manual screen under physician supervision

Family Planning Waiver Services, continued

Reimbursable Services, continued

CPT Codes	
CPT Code	**Description of Covered Codes**
Laboratory Procedures, continued	
88152	Cytopathology, slides, cervical or vaginal with manual screening and computer-assisted rescreen under physician supervision
88153	Cytopathology, slides, with manual screen & re-screen under physician supervision
88154	Cytopathology, slides with manual screen & computer-assisted re-screening using cell selection and review under physician supervision
88155	Cytopathology, slides, cervical or vaginal, with definitive hormonal evaluation
88164	Cytopathology, slides, cervical or vaginal, (Bethesda System); with manual screening under physician supervision
88165	Cytopathology. slides, cervical or vaginal (Bethesda System);with manual screen & re-screen under physician supervision
88166	Cytopathology, slides, cervical or vaginal (Bethesda System), manual screen & computer-assisted re-screen under physician supervision
88167	Cytopathology, slides, cervical or vaginal, (Bethesda System), using cell selection and review under physician supervision
88174	Cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, screen by automated system, under physician supervision
88175	With screen by automated system and manual rescreening or review, under physician supervision
88302	Level II surgical pathology, gross and microscopic (sterilization)
88305	Level IV surgical pathology, gross and microscopic (colposcopy)
HIV Counseling Codes	
99401	HIV counseling (pre-test)
99402	HIV counseling (post-test)
Diagnosis Codes to be used with Family Planning Waiver Services	
V25.01	Prescription of oral contraceptives
V25.02	Initiation of other contraceptive measures
V25.03	Encounter for emergency contraceptive counseling and prescription

Family Planning Waiver Services, continued

Reimbursable Services, continued

CPT Codes	
CPT Code	**Description of Covered Codes**
Diagnosis Codes to be used with Family Planning Waiver Services, continued	
V25.04	Counseling and instruction in natural family planning to avoid pregnancy
V25.11	Encounter for insertion of IUD
V25.12	Encounter for removal of IUD
V25.13	Encounter for removal and replacement of IUD
V25.2	Sterilization
V25.41	Surveillance of previously prescribed contraceptive method- contraceptive pill
V25.42	Surveillance of previously prescribed contraceptive method-IUD
V25.43	Implantable subdermal contraceptive
V25.5	Insertion of implantable subdermal contraceptive
V72.31	Routine gynecological examination
V72.32	Encounter for Pap cervical smear to confirm findings of recent normal smear following initial abnormal smear
V76.2	Routine cervical Papanicolaou (Pap) smear
Diagnosis Codes to be used with Sterilization Procedures	
V25.2	Sterilization
Diagnosis Codes to be used with Colposcopies	
622.0	Erosion and ectropion of cervix
622.10	Dysplasia of cervix, unspecified
622.11	Mild dysplasia of cervix
622.12	Moderate dysplasia of cervix
622.2	Leukoplakia of cervix (uteri)
795.00	Abnormal glandular Papanicolou (Pap) smear of cervix
795.01	Pap smear of cervix with atypical squamous cells of undetermined significance (ASC-US)
795.02	Pap smear of cervix with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
795.03	Pap smear of cervix with low grade squamous intraepithelial lesion (SGSIL)
795.04	Pap smear of cervix with high grade squamous intraepithelial lesion (HGSIL)
795.05	Cervical high risk human papillomavirus (HPV) DNA test positive
795.06	Pap smear of cervix with cytologic evidence of malignancy
795.07	Satisfactory cervical smear but lacking transformation zone
795.08	Unsatisfactory cervical cytology smear
795.09	Other abnormal Pap smear of cervix and cervical HPV
795.10	Abnormal glandular PAP smear of vagina

Family Planning Waiver Services, continued

Reimbursable Services, continued

CPT Codes	
CPT Code	**Description of Covered Codes**
Diagnosis Codes to be used with Colposcopies, continued	
795.11	Pap smear of vagina with atypical squamous cells of undetermined significance (ASC-US)
795.12	Pap smear of vagina with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
795.13	Pap smear of vagina with low grade squamous intraepithelial lesion (SGSIL)
795.14	Pap smear of vagina with high grade squamous intraepithelial lesion (HGSIL)
795.15	Vaginal high risk human papillomavirus (HPV) DNA test positive
795.16	Pap smear of vagina with cytologic evidence of malignancy
795.18	Unsatisfactory vaginal cytology smear
795.19	Other abnormal Pap smear of vagina and vaginal HPV
Diagnosis Codes to be used with Laboratory Procedures	
054.10	Genital herpes, unspecified
054.11	Herpetic vulvovaginitis
054.12	Herpetic ulceration of vulva
079.98	Unspecified chlamydial infection
078.10	Viral warts, unspecified
078.11	Condyloma acuminatum
078.88	Other specified diseases due to chlamydiae
079.98	Unspecified chlamhydial infection
091.0	Genitial syphillis, primary
091.2	Other primary syphilis
092.0	Early syphilis, latent, serological relapse after treatment
092.9	Early syphilis, latent, unspecified
098.0	Acute gonococcal infection of the lower genitourinary tract
098.10	Gonococcal infection (acute) of the upper genitourinary tract, site unspecified
098.11	Gonococcal cystitis (acute)
098.15	Gonococcal cervitis (acute)
098.16	Gonococcal endometritis (acute)
098.17	Gonococcal salpingitis, specified as acute
099.41	Chlamydia trachomatis
099.51	Other veneral diseases due to Chlamydia trachomatis-Pharynx
099.52	Anus and rectum

Family Planning Waiver Services, continued

Reimbursable Services, continued

CPT Codes	
CPT Code	**Description of Covered Codes**
Diagnosis Codes to be used with Laboratory Procedures, continued	
099.53	Lower genitourinary sites
099.54	Other genitourinary sites
099.56	Peritoneum
099.8	Other specified venereal disease
099.9	Venereal disease, unspecified
112.1	Candidiasis of vulva and vagina
131.00	Urogential trichomoniasis, unspecified
131.01	Trichomonal vulvovaginitis
131.02	Trichomonal urethritis
622.0	Erosion and ectropion of cervix
622.10	Dysplasia of cervix, unspecified
622.11	Mild dysplasia of cervix
622.12	Moderate dysplasia of cervix
622.2	Leukoplakia of cervix (uteri)
795.00	Abnormal glandular Papanicolou (Pap) smear of cervix
795.01	Pap smear of cervix with atypical squamous cells of undetermined significance (ASC-US)
795.02	Pap smear of cervix with atypical squamous cells of undetermined significance (ASC-US)
795.03	Pap smear of cervix with low grade squamous intraepithelial lesion (SGSIL)
795.04	Pap smear of cervix with high grade squamous intraepithelial lesion (HGSIL)
795.05	Cervical high risk human papillomavirus (HPV) DNA test positive
795.06	Pap smear of cervix with cytologic evidence of malignancy
795.07	Satisfactory cervical smear but lacking transformation zone
795.08	Unsatisfactory cervical cytology smear
795.09	Other abnormal Pap smear of cervix and cervical HPV
795.10	Abnormal glandular PAP smear of vagina
795.11	Pap smear of vagina with atypical squamous cells of undetermined significance (ASC-US)
795.12	Pap smear of vagina with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
795.13	Pap smear of vagina with low grade squamous intraepithelial lesion (SGSIL)

Family Planning Waiver Services, continued

Reimbursable Services, continued

CPT Codes	
CPT Code	**Description of Covered Codes**
Diagnosis Codes to be used with Laboratory Procedures, continued	
795.14	Pap smear of vagina with high grade squamous intraepithelial lesion (HGSIL)
795.15	Vaginal high risk human papillomavirus (HPV) DNA test positive
795.16	Pap smear of vagina with cytologic evidence of malignancy
795.18	Unsatisfactory vaginal cytology smear
795.19	Other abnormal Pap smear of vagina and vaginal HPV
V72.40	Pregnancy examination or test, pregnancy unconfirmed
V72.41	Pregnancy examination or test, negative result
V72.42	Pregnancy examination or test, positive results
V76.2	Routine cervical Papanicolaou (Pap) smear
V73.81	Human Papillomavirus (HPV)
Diagnosis Code to be used for Treatment of Sexually Transmitted Infections (STI) (procedure codes 99201 and 99211)	
099.9	Venereal disease, unspecified

APPENDIX A
DIAGNOSIS CODE LIST FOR
ADDITIONAL PRENATAL SERVICES FOR PREGNANT WOMEN

DIAGNOSIS CODE LIST FOR ADDITIONAL PRENATAL SERVICES FOR PREGNANT WOMEN

Baby with Known or Suspected Genetic Disorder	655.23
Systemic Malignancy	199.0, 199.1
Age 35 years and above	659.53, 659.63
Diabetes Mellitus, Including Gestational Diabetes	648.03, 648.83
Hyperthyroidism	648.13
Asthma Requiring Medication	493.00-493.91
HIV Positive	V08
Acquired Immune Deficiency Syndrome	042
Seizure disorders	345.00-345.91
Hemoglobinopathies, Including Sickle Cell	282.0-282.9
Severe Anemia (less than 8 grams Hgb. or 24% Hct.)	648.23
Cardiac Disease	648.53, 648.63
Thromboembolic Disease	671.23, 671.33, 671.53
Pre-Eclampsia or Eclampsia	642.43, 642.53, 642.63, 642.73
Hypertension	642.03, 642.13, 642.23, 642.33
Alcohol or Drug Dependence	655.43, 648.33
Isoimmunization	656.23
Suspected Abnormality of the Fetus	655.03, 655.13, 655.23, 655.33, 655.43, 655.53, 655.63, 655.73, 655.83, 655.93
Abruptio Placenta	641.23
Premature Rupture of Membranes and/or Premature Labor with Estimated Fetal Weight of 2000 grams or less	658.13, 644.03
Multiple Gestation	651.03, 651.13, 651.23, 651.83, 651.93
Psychiatric Disorders Under Therapy	648.43
Poor Fetal Growth	656.53
Grand Multiparity	659.43
Tuberculosis	647.33
Chronic Liver Disease	646.73
Chronic Kidney Disease	646.23
Carcinoma In Situ of Cervix	233.1
Placenta Previa	641.03
Habitual Aborter	646.33
Pyelonephritis	646.63
Cervical Incompetence	654.53
Excessive Fetal Growth	656.63

APPENDIX B
DIAGNOSIS CODE LIST FOR
DELIVERY OF HIGH-RISK PREGNANT WOMEN

DIAGNOSIS CODE LIST FOR DELIVERY OF HIGH-RISK PREGNANT WOMEN

Systemic Malignancy	199.0, 199.1
Diabetes mellitus, including gestational diabetes	648.01, 648.81
Hyperthyroidism	648.11
Asthma requiring medication	493.00-493.91
HIV positive	V08
Acquired Immune Deficiency Syndrome	042
Seizure disorders	345.00-345.91
Hemoglobinopathies, including sickle cell	282.0-282.9
Severe Anemia (less than 8 grams Hgb. or 24% Hct.)	648.21
Cardiac Disease	648.51, 648.61
Thromboembolic Disease	671.21, 671.31, 671.51
Pre-Eclampsia or Eclampsia	642.41, 642.51, 642.61, 642.71
Hypertension	642.01, 642.11, 642.21, 642.31
Alcohol or drug dependence	655.41, 648.31
Isoimmunization	656.21
Suspected Abnormality of the Fetus	655.01, 655.11, 655.21, 655.31,655.41, 655.51, 655.61, 655.71, 655.81, 655.91
Abruptio Placenta	641.21
Premature Rupture of Membranes and/or Premature Labor with Estimated Fetal Weight of 2000 grams or less	658.11, 644.21, 644.03
Multiple Gestation	651.01, 651.11, 651.21, 651.81, 651.91
Psychiatric Disorders Under Therapy	648.41
Herpes Infection	647.61
Persistent Abnormal Presentation: breech, transverse, oblique	660.01
Chorioamnionitis	658.41
Grand Multiparity	659.41
Tuberculosis	647.31
Chronic Liver Disease	646.71
Chronic Kidney Disease	646.21
Carcinoma In Situ of Cervix	233.1
Placenta Previa	641.01, 641.11

APPENDIX C
DIAGNOSIS CODE LIST FOR
ADDITIONAL ABDOMINAL ULTRASOUNDS FOR PREGNANT WOMEN

DIAGNOSIS CODE LIST FOR ADDITIONAL ABDOMINAL ULTRASOUNDS FOR PREGNANT WOMEN

Baby with Known or Suspected Genetic Disorder	655.23
Systemic Malignancy	199.0, 199.1
Age 35 years and above	659.53, 659.63
Diabetes Mellitus, Including Gestational Diabetes	648.03, 648.83
Hyperthyroidism	648.13
Asthma Requiring Medication	493.00-493.91
HIV Positive	V08
Acquired Immune Deficiency Syndrome	042
Seizure Disorders	345.00-345.91
Hemoglobinopathies, Including Sickle Cell	282.0-282.9
Severe Anemia (less than 8 grams Hgb. or 24% Hct.)	648.23
Cardiac Disease	648.53, 648.63
Thromboembolic Disease	671.23, 671.33, 671.53
Pre-Eclampsia or Eclampsia	642.43, 642.53, 642.63, 642.73
Hypertension	642.03, 642.13, 642.23, 642.33
Alcohol or Drug Dependence	655.43, 648.33
Isoimmunization	656.23, 656.13
Suspected Abnormality of the Fetus	655.03, 655.13, 655.23, 655.33, 655.43, 655.53, 655.63, 655.73, 655.83, 655.93
Abruptio Placenta	641.23
Premature Rupture of Membranes and/or Premature Labor with Estimated Fetal Weight of 2000 grams or less	658.13, 644.03
Multiple Gestation	651.03, 651.13, 651.23, 651.83, 651.93
Poor Fetal Growth	656.53
Grand Multiparity	659.43
Tuberculosis	647.33
Chronic Liver Disease	646.73
Chronic Kidney Disease	646.23
Syphillis, Untreated	647.03
Placenta Previa	641.03
Excessive Fetal Growth	656.63, 653.53
Oligohydramnios	658.03
Abdominal Pain	789.01-789.09
Threatened Abortion	640.03
Missed Abortion	632
Fetal Demise	656.43
Polyhydramnios	657.03
Postmaturity	645.13, 645.23
Breech presentation without mention of version	652.23
Antepartum Hemorrhage	641.93

APPENDIX D
DIAGNOSIS CODE LIST FOR MRI AND CT SCANS

DIAGNOSIS CODE LIST FOR MRI AND CT SCANS

Upper Extremities

003.24-003.24	Salmonella osteomyelitis
015.50-015.56	Tuberculous dactylitis
095.5-095.7	Syphilis of bone, muscle, synovium, tendon, and bursa
115.10-115.19	Histoplasma infection
135-135	Sarcoidosis
140.0-208.92	Malignant neoplasm
213.4-213.5	Benign neoplasm of bone and articular cartilage of upper limb
215.2-215.2	Other benign neoplasm of connective and soft tissue of upper limb
215.8-215.8	Benign neoplasm other specified sites
232.6-232.6	Carcinoma in situ skin of upper limb
234.8-234.8	Carcinoma in situ of other specified sites
237.3-237.3	Neoplasm of uncertain behavior paraganglia
237.70-237.72	Neurofibromatosis
238.0-238.3	Neoplasm of uncertain behavior
238.7-238.8	Neoplasm of uncertain behavior
239.2-239.3	Neoplasm of unspecified nature of bone, soft tissue, skin and breast
274.00-274.03	Gouty arthropathy
353.0-353.0	Brachial plexus lesions
354.0-354.9	Mononeuritis of upper limb, and mononeuritis multiplex
356.0-359.9	Neuropathy, myopathy, and myoneural disorders
442.0-442.0	Aneurysm of artery of upper extremity
444.21-444.21	Arterial embolism and thrombosis of arteries of upper extremities
445.01-445.01	Atheroembolism of upper extremity
446.7-447.2	Takayasu's disease and other disorders of arteries and arterioles

Upper Extremities, continued

451.83-451.84	Phlebitis and thrombophlebitis of deep veins of upper extremities
457.0-457.9	Non infectious disorders of lymphatic channels
682.3-682.3	Cellulitis and abscess of upper arm and forearm
696.0-696.0	Psoriatic arthropathy
711.00-715.94	Pyogenic arthritis, and other arthropathies
716.0-716.4	Other arthropathies upper extremities
716.00-716.04	Endemic polyarthritis
716.10-716.14	Traumatic arthropathy
718.00-718.2	Derangement of joint
718.10-718.14	Loose body in joint
718.8-718.9	Other derangement of joint
718.20-718.24	Pathological dislocation
718.30-718.34	Recurrent dislocation of joint
718.40-718.44	Contracture of joint
718.50-718.54	Ankylosis of joint
718.70-718.74	Developmental dislocation of joint
718.80-718.84	Other joint derangement, not elsewhere classified
719.00-719.04	Effusion of joint
719.10-719.14	Hemarthrosis
719.20-719.24	Villonodular synovitis
719.40-719.44	Joint pain
719.50-719.54	Stiffness of joint, not elsewhere classified
719.60-719.64	Other symptoms referable to joint
719.80-719.84	Other specified disorders of joint
725-725	Polymyalgia rheumatica
726.00-726.4	Adhesive capsulitis of shoulder, and other affectations of shoulders, elbows, wrists and hands
727.00-727.05	Synovitis, tenosynovitis, and giant cell tumor of tendon sheath
727.20-727.50	Bursitis, ganglion and cysts of synovium, tendon, and bursa

Upper Extremities, continued

727.60-727.64 ..... Rupture of tendon
727.82-727.82 ..... Calcium deposits in tendon and bursa
727.89-727.89 ..... Abscess of bursa or tendon
728.0-729.2 ..... Disorders of muscle, ligament, and fascia
729.4-730.4 ..... Residual foreign body in soft tissue, and other musculoskeletal symptoms referable to limbs
730.31-730.34 ..... Periostitis
730.10-730.24 ..... Acute and chronic osteomyelitis
730.70-730.99 ..... Infection of bone
731.0-731.8 ..... Osteitis deformans; other bone involvement in diseases classified elsewhere
732.3-732.3 ..... Juvenile osteochondrosis of upper extremity
732.6-733.49 ..... Osteochondropathy, pathologic fracture, bone cysts, and aseptic necrosis of bone
733.81-733.82 ..... Malunion of fracture
733.90-733.90 ..... Disorder of bone and cartilage
736.00-736.29 ..... Acquired deformity of forearm
738.8-738.8 ..... Acquired deformity of other unspecified site
739.7-739.7 ..... Nonallopathic lesions upper extremities
747.63-747.63 ..... Upper limb vessel anomaly
755.20-755.29 ..... Reduction deformity of upper limb
756.50-756.59 ..... Osteodystrophies
756.81-756.9 ..... Other congenital anomalies of muscle, tendon, fascia, and connective tissue
759.4-759.4 ..... Conjoined twins
759.7-759.7 ..... Multiple congenital abnormalities
781.0-781.4 ..... Abnormal involuntary movements, and transient paralysis of limb
782.0-782.3 ..... Symptoms involving skin and other integumentary tissue

Upper Extremities, continued

785.6-785.6 ..... Enlargement of lymph nodes
793.7-793.7 ..... Nonspecific abnormal findings on radiological studies of musculoskeletal system
810.00-819.1 ..... Fractures of upper limbs
828.0-829.1 ..... Multiple fractures
831.00-834.12 ..... Dislocation shoulder elbow or wrist
840.0-842.19 ..... Sprains and strains of upper extremities
905.2-905.2 ..... Late effect of fracture
905.8-905.9 ..... Late effect of tendon injury or traumatic amputation
906.1-906.4 ..... Late effect of injury
906.6-906.9 ..... Late effect of burn injury
907.4-907.4 ..... Late effect of injury to peripheral nerve of shoulder girdle and upper limb
909.2-909.2 ..... Late effect of radiation
927.00-927.9 ..... Crushing injury to upper limb
959.2-959.9 ..... Injury of upper extremity
996.1-996.2 ..... Mechanical complication of other vascular device, implant or graft
996.4-996.4 ..... Complication of internal orthopedic device, implant, and graft
996.62-996.63 ..... Reaction to vascular or nervous system device.
996.66-996.67 ..... Reaction due to internal prosthetic device, implants, or graft
996.77-996.78 ..... Reaction to internal joint prosthesis, or other internal orthopedic device
996.90-996.94 ..... Complications of reattached extremity
997.2-997.2 ..... Peripheral vascular complications
997.60-997.69 ..... Amputation stump complication
999.2-999.2 ..... Other vascular complications

Lower Extremities

003.24-003.24 ..... Salmonella osteomyelitis
015.11-015.26 ..... Tuberculosis of hip

Lower Extremities, continued

015.51-015.56	Tuberculosis of bones of limbs
095.5-095.7	Syphilis of bone, muscle, tendon, and bursa
135-135	Sarcoidosis
140.0-208.92	Malignant neoplasm
215.3-215.3	Other benign neoplasm of lower limb including hip
228.09-228.1	Hemangioma, lymhangioma
237.70-237.72	Neurofibromatosis
238.0-238.1	Neoplasm of uncertain behavior bone, articular cartilage, connective, and soft tissue
239.2-239.2	Neoplasm of unspecified nature of bone, soft tissue, or skin
274.00-274.03	Gouty arthropathy
355.0-355.9	Mononeuritis of lower limb
390-390	Rheumatic fever
442.3-442.3	Aneurysm of artery of lower extremity
444.22-444.22	Arterial embolism and thrombosis of arteries of lower extremity
445.02-445.02	Atheroembolism of lower extremity
457.1-457.1	Other lymphedema
648.70-648.74	Bone and joint disorders of back, pelvis, and lower limbs during the puerperium
682.6-682.6	Cellulitis of leg
710.0-716.09	Arthropathy associated with infections
716.15-716.19	Traumatic arthropathy
716.45-716.49	Transient arthropathy
716.85-716.89	Other specified arthropathy
717.0-717.9	Internal derangement of knee
718.05-718.09	Articular cartilage disorder
718.15-718.19	Loose body in joint
718.25-718.29	Pathological dislocation of joint
718.35-718.39	Recurrent dislocation of joint
718.45-718.49	Contracture of joint
718.55-718.59	Ankylosis of joint

Lower Extremities, continued

718.65-718.65	Intrapelvic protrusion of acetabulum
718.75-718.79	Developmental dislocation of joint
718.85-718.89	Other joint derangement, not elsewhere classified
718.95-718.97	Unspecified derangement of joint of lower extremity
719.05-719.09	Effusion of joint
719.15-719.19	Hemarthrosis
719.25-719.29	Villonodular synovitis
719.35-719.39	Palindromic rheumatism
719.45-719.49	Pain in joint
719.55-719.89	Stiffness of joint, not elsewhere classified
726.60-726.91	Enthesopathy of knee, ankle and other specified sites
727.00-727.02	Synovitis and tenosynovitis, giant cell tumor of tendon sheath
727.06-727.06	Tenosynovitis of foot and ankle
727.2-727.2	Specific bursitides often of occupational origin
727.40-727.59	Ganglion and cyst of synovium, tendon, bursa, and rupture of synovium
727.65-727.89	Nontraumatic rupture of tendon and other disorders of synovium, tendon, bursa, muscle and fascia
728.0-729.9	Other disorders of muscle, ligament, fascia, and soft tissue
730.00-732.2	Osteomyelitis, Osteochondropathy, and other infections of bone
732.4-732.9	Osteochondropathy
733.00-733.29	Osteoporosis, pathologic fractures, and bone cysts
733.42-733.49	Aseptic necrosis of bone
733.7-733.99	Algoneurodystrophy and other specified bone disorders
736.40-736.99	Other acquired deformities of limbs
739.6-739.6	Nonallopathic lesions, not elsewhere classified
754.40-754.79	Congenital anomalies of lower limbs

Lower Extremities, continued

755.30-755.4 ..... Reduction deformities of lower limb
755.60-755.69 ..... Other anomalies of lower limbs
756.51-756.56 ..... Osteodystrophies
756.81-756.89 ..... Other specified anomalies of muscle, tendon, fascia, and connective tissue
781.2-781.2 ..... Abnormality of gait
793.7-793.7 ..... Abnormal finding on radiological study of musculoskeletal system
820.0-828.1 ..... Fractures involving lower limbs
835.00-838.19 ..... Dislocations involving lower extremities
843.0-845.19 ..... Sprains and strains of lower extremity
905.3-905.9 ..... Late effects of fractures, dislocations, tendon injuries, and amputations
924.0-924.9 ..... Contusions of lower limb
928.00-928.9 ..... Crushing injuries involving lower limbs
945.40-945.50 ..... Burns of lower limbs with deep tissue necrosis
956.0-956.9 ..... Injury to peripheral nerve(s) of pelvic girdle and lower limb
959.6-959.8 ..... Other injury to lower limb
996.66-996.67 ..... Infection or inflammatory reaction to internal joint prosthesis, orthopedic device, implant or graft
996.77-996.78 ..... Other complication of internal joint prosthesis, orthopedic device, implant or graft
996.95-996.99 ..... Complication of reattached extremity or body part
997.60-997.69 ..... Amputation complication

Abdomen and Pelvis

006.0-009.3 ..... Amebiasis and intestinal infection due to other organisms
014.00-014.86 ..... Tuberculous peritonitis
016.00-019.96 ..... Tuberculosis of genitourinary system

Abdomen and Pelvis, continued

017.20-017.26 ..... Tuberculosis of peripheral lymph nodes
017.60-017.66 ..... Tuberculosis of adrenal glands
017.70-017.76 ..... Tuberculosis of spleen
036.3-036.3 ..... Meningococcal adrenalitis
039.2-039.2 ..... Actinomycotic infection of abdomen
040.2-040.2 ..... Whipple's disease
070.0-070.9 ..... Hepatitis
120.0-129 ..... Other infectious and parasitic diseases affecting the GI tract
130.5-130.8 ..... Toxoplasmosis
135-135 ..... Sarcoidosis
140.00-208.92 ..... Malignant neoplasm any site
211.1-211.9 ..... Benign neoplasm of other parts of digestive system
214.3-214.3 ..... Lipoma of intrabdominal organs
215.5-215.5 ..... Other benign neoplasm of abdomen
218.0-221.0 ..... Uterine leiomyoma, and other benign neoplasm of female organs
223.0-223.9 ..... Benign neoplasm of kidney and other urinary organs
227.0-227.9 ..... Benign neoplasm of other endocrine glands and related structures
228.04-228.1 ..... Hemangioma, lymphangioma
230.1-230.9 ..... Carcinoma in situ of digestive organs
233.0-233.9 ..... Carcinoma in situ of breast and genitourinary system
235.0-236.99 ..... Neoplasm of uncertain behavior of digestive, urinary, genitourinary, and respiratory systems
237.2-237.2 ..... Neoplasm of uncertain behavior of adrenal glands
238.4-239.9 ..... Neoplasm of uncertain behavior of other sites and tissues
251.4-251.5 ..... Abnormality of glucagon and gastrin secretion

Abdomen and Pelvis, continued

251.8-251.9	Other disorders of pancreatic internal secretion
255.10-256.9	Hyperaldosteronism, adrenogenital disorders, and disorders of ovarian function
258.0-258.9	Polyglandular dysfunction and related disorders
259.2-259.2	Carcinoid syndrome
277.00-277.09	Cystic fibrosis
277.30-277.4	Amyloidosis and disorders of bilirubin excretion
282.62-282.62	Sickle-cell disease Hb-SS with crisis
282.64-282.64	Sickle cell/Hb-C disease with crisis
282.69-282.69	Other sickle-cell disease with crisis
289.2-289.59	Mesenteric lymphadenitis, hypersplenism, and other diseases of spleen
403.00-405.99	Hypertensive renal disease
441.00-442.2	Aortic aneurysm and dissection
442.83-442.89	Aneurysm of other specified artery
443.23-443.23	Dissection of renal artery
444.0-444.1	Embolism or thrombosis of abdominal or thoracic aorta
444.81-444.9	Thrombosis or embolism of other specified artery
445.81-446.29	Atheroembolism of kidney, polyarteritis nodosa, and other allied conditions
451.81-451.81	Thrombophlebitis of iliac vein
452-453.9	Portal vein and other venous embolism and thrombosis
459.0-459.0	Hemorrhage
531.00-564.9	Ulcers, hernias, surgical complications, and other functional disorders of digestive system
566-568.9	Peritonitis and other disorders of peritoneum

Abdomen and Pelvis, continued

569.5-594.9	Abscess, fistula, liver disease, and other disorders of the digestive and genitourinary systems
596.0-596.9	Bladder disorders
599.1-599.7	Urethral fistula, blood in urine, and urinary obstruction
614.0-615.9	Inflammatory disease of female pelvic organs
617.0-621.9	Other disorders of female genital tract
623.2-623.2	Stricture or atresia of vagina
654.00-654.14	Congenital disorders and tumors of uterus
654.30-654.34	Other disorders of uterus
665.50-665.90	Injury to pelvic organs during childbirth
669.30-669.44	Acute renal failure and other complications of obstetrical surgery
719.45-719.45	Disorders of pelvic joint not elsewhere classified
733.42-733.43	Aseptic necrosis of bone
750.5-750.7	Congenital anomalies of stomach
751.0-752.3	Other congenital anomalies of digestive system
753.0-753.9	Congenital anomalies of urinary system
756.6-756.79	Congenital anomalies of diaphragm and abdominal wall
759.0-759.1	Congenital anomaly of spleen and adrenal gland
759.89-759.89	Congenital malformation syndromes affecting multiple systems
785.6-785.6	Enlargement of lymph nodes
787.9-788.0	Other symptoms involving the digestive and urinary systems
789.00-789.69, 789.7-789.9	Other symptoms involving the abdomen and pelvis
793.4-793.6	Abnormal findings on radiological and other examination of body structure

Abdomen and Pelvis, continued

794.4-794.4 ..... Abnormal results of kidney function test
794.8-794.9 ..... Abnormal scan of liver and other abdominal structures
835.0-835.13 ..... Dislocation of hip
863.0-869.1 ..... Injury to gastrointestinal tract
879.2-879.8 ..... Open wound to abdominal wall
902.0-902.9 ..... Injury to blood vessels of abdomen and pelvis
908.1-908.2 ..... Late effect of internal injury to intra-abdominal organs
908.4-908.4 ..... Late effect of injury to blood vessel of thorax, abdomen, and pelvis
909.0-909.9 ..... Late effect of poisoning
926.11-926.9 ..... Crushing injury to trunk
935.1-938 ..... Foreign body in digestive system
956.0-956.8 ..... Injury to peripheral nerves of pelvic girdle and lower limb
958.4-958.5 ..... Traumatic shock and renal failure
959.12-959.12..... Injury to abdomen
996.30-996.39 ..... Mechanical complication of genitourinary device
996.62-996.62 ..... Inflammatory reaction due to other vascular device , implant of graft
996.73-996.76 ..... Other complication of internal device, implant, and graft
996.81-996.82 ..... Complications of transplanted kidney or liver
996.86-996.89 ..... Complications of other transplanted organs
997.4-997.5 ..... Complications of digestive and urinary system
998.2-998.2 ..... Accidental puncture or laceration during a procedure
998.4-998.6 ..... Foreign body left during a procedure, postoperative infection, and persistent postoperative fistula

Chest

003.22-003.22..... Salmonella pneumonia
011.0-012.86..... Pulmonary tuberculosis
031.0-031.0..... Pulmonary infection by mycobacterium
039.1-039.1..... Thoracic actinomycosis
042-042..... HIV infection
052.1-052.1..... Varicella hemorrhagic pneumonitis
055.1-055.1..... Postmeasles pneumonia
093.0-093.1..... Syphilitic aneurysm or inflammation of aorta
095.1-095.1..... Syphilis of lung
114.0-114.0..... Primary pulmonary coccidioidomycosis
115.00-115.99..... Histoplasmosis infection
117.3-117.3..... Aspergillosis
130.0-130.9..... Toxoplasmosis
135-135..... Sarcoidosis
140.00-208.92..... Malignant neoplasm
212.2-212.9..... Benign neoplasm of trachea, bronchus, lung and other chest sites
213.3-213.3..... Benign neoplasm ribs, sternum, and clavicle
214.2-214.2..... Lipoma of intrathoracic organs
215.4-215.4..... Benign neoplasm thorax
228.0-228.1..... Lymphangioma, hemangioma any site
229.8-230.1..... Benign neoplasm of other specified site, carcinoma in situ digestive organs
231.1-231.9..... Carcinoma in situ of trachea, bronchus, and lung
235.7-235.9..... Neoplasm of uncertain behavior, respiratory system
239.1-239.1..... Neoplasm of unspecified nature, respiratory system
277.02-277.02..... Cystic fibrosis, with pulmonary manifestations
277.3-277.3..... Amyloidosis
415.11-415.19..... Pulmonary embolism and infarction
416.0-417.9..... Pulmonary heart disease and other diseases of pulmonary circulation
423.2-423.8..... Constrictive pericarditis and other specified diseases of the pericardium

Chest, continued

425.0-425.9	Cardiomyopathy
429.1-429.1	Myocardial degeneration
441.00-441.2	Dissecting aneurysm
441.6-441.9	Aortic aneurysm
442.82-442.82	Aneurysm of subclavian artery
446.20-446.20	Hypersensitivity angiitis, unspecified
446.4-446.4	Wegener's granulomatosis
453.2-453.2	Venous embolism and thrombosis of vena cava
457.8-457.8	Other noninfectious disorders of lymphatic channels
459.2-459.2	Compression of vein
480.0-487.1	Pneumonias and influenza
490-496	Chronic obstructive pulmonary disease and other allied conditions
500-519.9	Lung disease due to external agents, and other diseases of the respiratory system
553.3-553.3	Diaphragmatic hernia
729.6-729.6	Residual foreign body in soft tissue
747.0-747.9	Other congenital anomalies of the circulatory system
748.4-748.69	Congenital cystic lung, other specified anomalies of lung
748.8-748.9	Other specified anomalies of respiratory system
785.6-785.6	Enlargement of lymph nodes
786.00-786.9	Symptoms involving respiratory system and chest
793.1-793.2	Abnormal findings on other exam of chest
793.7-793.9	Abnormal x-ray findings
794.2-794.2	Nonspecific abnormal results of function studies (pulmonary)
799.0-799.02	Asphyxia
807.00-807.09	Fracture of ribs, closed
860.0-862.9	Internal injury to thorax

Chest, continued

875.0-875.1	Open wound to chest wall
922.1-922.1	Contusion to trunk, chest wall
934.8-934.8	Foreign body in trachea, bronchus, lung; other specified areas in chest
959.1-959.11	Injury to chest wall
959.8-959.9	Injury of other multiple sites

Cervical Spine

015.00-015.06	Tuberculosis of vertebral column
036.0-036.9	Meningococcal infections
140.00-208.92	Malignant neoplasm
213.2-213.2	Benign neoplasm of the vertebral column, excluding sacrum and coccyx
215.4-215.4	Benign neoplasm of connective tissue of thorax
225.0-225.8	Benign neoplasm of spinal cord
228.0-228.1	Hemangioma, lymphangioma, any site
237.5-237.72	Neoplasm of uncertain behavior, brain, spinal cord and meninges, and neurofibromatosis
238.0-238.8	Neoplasm of uncertain behavior of other sites
239.0-239.9	Neoplasm of unspecified nature
252.0-253.9	Endocrine disorders
268.2-268.2	Softening of bone due to nutritional deficiency
320.0-323.8	Meningitis
324.0-324.1	Intraspinal abscess
330.0-337.9	Hereditary and degenerative diseases of the central nervous system
340-340	Multiple sclerosis
341.0-345.01	Hemiplegia, hemiparesis, and other paralytic syndromes
349.2-349.81	Disorders of meninges, spinal fluid rhinorrhea

Cervical Spine, continued

353-359.9	Nerve root and plexus disorders, neuropathy, and other myoneural disorders
430-430	Subarachnoid hemorrhage
442.89-442.89	Spinal artery aneurysm
710.0-714.9	Arthropathies associated with infections and inflammatory disorders
715.08-715.08	Generalized osteoarthrosis
715.18-715.18	Osteoarthrosis localized of other specified sites (spine)
715.28-715.29	Osteoarthrosis, localized, or secondary of other specified sites (spine)
715.38-715.38	Osteoarthrosis, localized, of other specified sites (spine)
715.88-715.89	Osteoarthrosis involving more than one site
716.00-716.09	Endemic polyarthritis
716.18-716.19	Traumatic arthropathy, multiple and other specified sites
720.0-720.9	Ankylosing spondylitis, and other inflammatory spondylopathies
721.0-721.1	Cervical spondylosis
721.5-722.4	Baastrup's syndrome, traumatic spondylopathy, and intervertebral disc disorders
722.71-722.71	Cervical intervertebral disc disorder with myelopathy
722.81-722.81	Cervical postlaminectomy disorder
722.91-722.91	Unspecified or other disorder of cervical disc
723.0-723.9	Other disorders of cervical region
727.00-732.0	Disorders of muscle, ligament, and fascia; osteomyelitis, juvenile osteochondrosis of spine, and other specified musculoskeletal disorders
732.6-733.13	Other osteochondropathy and osteoporosis

Cervical Spine, continued

733.13-733.13	Pathologic fracture of vertebrae
733.40-733.40	Aseptic necrosis of bone, site unspecified (spine)
737.10-737.9	Scoliosis, kyphoscoliosis, and other curvature of the spine
738.2-738.2	Acquired deformity of the neck
738.4-738.5	Other acquired deformity of back or spine
739.0-739.1	Nonallopathic lesions
740.0-742.9	Spina bifida and other congenital anomalies of nervous system
754.1-754.2	Congenital musculoskeletal deformities
756.13-756.17	Anomalies of spine
756.4-756.59	Chondrodystrophy and osteodystrophies
781.0-782.0	Symptoms involving musculoskeletal and nervous systems
784.2-784.2	Swelling, mass or lump in neck
792.0-792.0	Abnormal findings in cerebrospinal fluid
794.10-794.10	Abnormal response to nerve stimulation
794.17-794.17	Abnormal electromyogram
796.1-796.1	Abnormal reflex
805.0-805.18	Fracture of cervical vertebra
806.00-806.9	Fracture of vertebral column with spinal cord injury
839.00-839.18	Dislocation of cervical vertebra
847.0-847.0	Neck sprain
905.1-905.1	Late effect of fracture of spine and trunk
907.1-907.4	Late effect of spinal cord injury
925.2-926	Crushing injury of neck, and trunk
952.00-952.09	Injury to nerves and spinal cord
952.8-952.8	Injury to spinal cord, multiple sites

Cervical Spine, continued

953.0-953.1 ..... Injury to nerve roots and spinal plexus
953.8-953.8 ..... Multiple injuries to nerve roots and spinal plexus
959.01-959.09 ..... Injury to head, face, and neck

Thoracic Spine

015.00-015.06 ..... Tuberculosis of vertebral column
036.0-036.9 ..... Meningococcal infections
140.00-208.92 ..... Malignant Neoplasm
213.2-213.3 ..... benign neoplasm of the vertebral column, excluding sacrum and coccyx
214.2-214.2 ..... Lipoma of intrathoracic organs
215.2-215.2 ..... Benign neoplasm of upper limb
215.4-215.4 ..... Benign neoplasm of connective tissue of thorax
225.0-225.8 ..... Benign neoplasm of spinal cord
228.0-228.1 ..... Hemangioma, lymphangioma, any site
237.5-237.72. ..... Neoplasm of uncertain behavior, brain, spinal cord and meninges, and neurofibromatosis
238.0-238.8 ..... Neoplasm of uncertain behavior of other sites and tissues
239.0-239.9 ..... Neoplasm of unspecified nature
268.2-268.2 ..... Softening of bone due to nutritional deficiency
274.0-274.19 ..... Gouty arthropathy
320.0-323.8 ..... Meningitis, and encephalitis
324.1-324.1 ..... Intraspinal abscess
330.0-337.9 ..... Hereditary and degenerative diseases of the central nervous system
340-340 ..... Multiple sclerosis
341.0-345.01 ..... Hemiplegia, hemiparesis, and other paralytic syndromes
349.2-349.81 ..... Disorders of meninges; spinal fluid rhinorrhea

Thoracic Spine, continued

353-359.9 ..... Nerve root and plexus disorders, neuropathy, and other myoneural disorders
430-430 ..... Subarachnoid hemorrhage
442.89-442.89 ..... Spinal artery aneurysm
710.0-714.9 ..... Arthropathies associated with infections and inflammatory disorders
715.08-715.08 ..... Generalized osteoarthrosis
715.18-715.18 ..... Osteoarthrosis localized of other specified sites (spine)
715.28-715.28 ..... Osteoarthrosis, localized of other specified sites
715.38-715.38 ..... Osteoarthrosis, localized, not specified whether primary or secondary of other specified sites (spine)
715.88-715.89 ..... Osteoarthrosis involving more than one site
716.00-716.09 ..... Endemic polyarthritis
716.18-716.19 ..... Traumatic arthropathy Multiple and other specified sites
720.0-720.9 ..... Ankylosing spondylitis, and other inflammatory spondylopathies
721.41-722.31 ..... Baastrup's syndrome, traumatic spondylopathy, and intervertebral disc disorders
722.51-722.51 ..... Degeneration of thoracic disc
722.72-722.72 ..... Intervertebral disc disorder, thoracic region
722.82-722.82 ..... Postlaminectomy syndrome, thoracic region
722.92-722.93 ..... Other thoracic disc disorder
724.00-724.01 ..... Spinal stenosis, thoracic region
724.1-724.1 ..... Pain in thoracic spine
727.00-732.0 ..... Disorders of muscle ligament, and fascia, osteomyelitis, juvenile osteochondrosis of spine, other specified musculoskeletal disorders

Thoracic Spine, continued

732.6-733.10 ..... Other osteochondropathy and osteoporosis
733.13-733.13 ..... Pathologic fracture of vertebrae
733.40-733.40 ..... Aseptic necrosis of bone, site unspecified (spine)
737.10-737.9 ..... Scoliosis, kyphoscoliosis, and other curvature of the spine
738.4-738.5 ..... Other acquired deformity of spine
739.2-739.2 ..... Nonallopathic lesions, thoracic region
740.0-742.9 ..... Spina bifida and other congenital anomalies of nervous system
754.1-754.2 ..... Congenital musculoskeletal deformities
756.4-756.59 ..... Chondrodystrophy and osteodystrophies
781.0-782.0 ..... Symptoms involving musculoskeletal and nervous systems
792.0-792.0 ..... Abnormal cerebrospinal fluid findings
794.10-794.10 ..... Abnormal response to nerve stimulation
794.17-794.17 ..... Abnormal electromyogram
796.1-796.1 ..... Abnormal reflex
805.2-805.3 ..... Fracture of vertebral column (thoracic)
806.00-806.9 ..... Fracture of vertebral column with spinal cord injury
839.31-839.31 ..... Vertebral dislocations
847.1-847.1 ..... Sprain of thoracic region
876.1-876.1 ..... Complicated open wound of back
905.1-905.1 ..... Late effect of fracture of spine and trunk
907.1-907.4 ..... Late effect of spinal cord injury
922.31-922.31 ..... Back contusion
925.2-926 ..... Crushing injury of neck and trunk
952.10-952.19 ..... Injury to nerves and spinal cord
952.8-952.8 ..... Injury to multiple sites of spinal cord
953.0-953.1 ..... Injury to nerve roots and spinal plexus

Thoracic Spine, continued

953.8-953.8 ..... Injury to nerve roots and spinal plexus, or multiple sites
959.01-959.09 ..... Injury to head, face, and neck
959.11-959.19 Injury of chest wall or trunk

Lumbar Spine

015.00-015.06 Tuberculosis of vertebral column
036.0-036.9 ..... Meningococcal infections
140.00-208.92 ..... Malignant neoplasm
213.2-213.3 Benign neoplasm of the vertebral column
213.6-213.6 ..... Benign neoplasm of pelvic bones, sacrum, and coccyx
225.0-225.8 ..... Benign neoplasm of spinal cord
228.0-228.1 ..... Hemangioma, lymphangioma, any site
237.5-237.72. ..... Neoplasm of uncertain behavior, brain, spinal cord, and meninges; and neurofibromatosis
238.0-238.8 ..... Neoplasm of uncertain behavior of other sites and tissues
239.0-239.9 ..... Neoplasm of unspecified nature, bone, soft tissue, and skin
268.2-268.2 ..... Softening of bone due to nutritional deficiency
274.0-274.19 ..... Gouty arthropathy
320.0-323.8 ..... Meningitis and encephalitis
324.1-324.1 ..... Intraspinal abscess
330.0-337.9 ..... Hereditary and degenerative diseases of the central nervous system
340-340 ..... Multiple sclerosis
341.0-345.01 ..... Hemiplegia, hemiparesis, and other paralytic syndromes
349.2-349.81 ..... Disorders of meninges; spinal fluid rhinorrhea
353.0-359.9 ..... Nerve root and plexus disorders, neuropathy, and other myoneural disorders

Lumbar Spine, continued

442.89-442.89	Spinal artery aneurysm
710.0-714.9	Arthropathies associated with infections and inflammatory disorders
715.08-715.08	Generalized osteoarthrosis
715.18-715.18	Osteoarthrosis localized of other specified sites (spine)
715.28-715.29	Osteoarthrosis, localized or secondary of other specified sites (spine)
715.38-715.38	Osteoarthrosis, localized, of other specified sites (spine)
715.88-715.89	Osteoarthrosis involving more than one site
716.00-716.09	Endemic polyarthritis
716.18-716.19	Traumatic arthropathy, multiple and other specified sites
720.0-720.9	Ankylosing spondylitis and other inflammatory spondylopathies
721.0-721.3	Lumbosacral spondylosis
721.42-721.42	Lumbar spondylosis with myelopathy
721.5-721.9	Baastrup's syndrome, traumatic spondylopathy, and intervertebral disc disorders
722.10-722.10	Displacement of lumbar disc
722.2-722.30	Herniation or displacement of intervertebral disc
722.32-722.32	Schmorl's nodes, lumbar region
722.52-722.70	Degeneration of lumbar, lumbosacral, and unspecified disc
722.73-722.73	Lumbar intervertebral disc disorder with myelopathy
722.80-722.80	Postlaminectomy syndrome, unspecified region
722.83-722.83	Postlaminectomy syndrome, lumbar region
724.00-724.09	Spinal stenosis
724.2-724.6	Sciatica, lumbosacral neuritis, and other disorders of sacrum

Lumbar Spine, continued

727.00-732.0	Disorders of muscle ligament and fascia, osteomyelitis, juvenile osteochondrosis of spine; other specified musculoskeletal disorders
732.6-733.10	Other osteochondropathy and osteoporosis
733.13-733.13	Pathologic fracture of vertebrae
733.40-733.40	Aseptic necrosis of bone, site unspecified (spine)
737.1-737.9	Scoliosis, kyphoscoliosis, and other curvature of the spine
738.4-738.5	Acquired spondylolisthesis
739.3-739.4	Nonallopathic lesions of lumbar sacral region
740.0-742.9	Spina bifida and other congenital anomalies of nervous system
754.1-754.2	Congenital musculoskeletal deformities
756.13-756.17	Anomalies of spine
756.4-756.59	Chondrodystrophy, and osteodystrophies
781.0-782.0	Symptoms involving musculoskeletal and nervous systems
792.0-792.0	Abnormal cerebrospinal fluid findings
794.10-794.10	Abnormal response to nerve stimulation
796.1-796.1	Abnormal reflex
805.4-805.7	Fracture of vertebral column (lumbar, sacral)
806.4-806.5	Fracture lumbar vertebra with spinal cord injury
839.20-839.59	Vertebral dislocations
847.2-847.2	Lumbar sprain
876.1-876.1	Complicated open wound of back
905.1-905.1	Late effect of fracture of spine and trunk
907.1-907.4	Late effect of spinal cord injury
922.31-922.31	Back contusion
925.2-926	Crushing injury of neck and trunk
952.10-952.19	Injury to nerves and spinal cord

Lumbar Spine, continued

952.8-952.8 ..... Injury to multiple sites of spinal cord
953.0-953.2 ..... Injury to nerve roots and spinal plexus
953.8-953.8 ..... Injury to nerve roots and spinal plexus, multiple sites
959.01-959.09 ..... Injury to head, face and neck
959.11-959.19 ..... Injury to trunk area

Head, Brain, and Neck

003.21-003.21 ..... Salmonella meningitis
006.5-006.5 ..... Amebic brain abscess
013.00-013.96 ..... Tuberculous meningitis, tuberculoma, and tuberculous abscess of brain; other tuberculosis of central nervous system
036.0-036.9 ..... Other meningococcal infections
042-049.9 ..... HIV infection and other viral diseases of central nervous system
052.0-052.0 ..... Postvaricella encephalitis
053.0-053.13 ..... Herpes zoster with meningitis; other nervous system complication
054.3-054.3 ..... Herpetic meningoencephalitis
054.72-054.72 ..... Herpes simplex meningitis
055.0-055.0 ..... Postmeasles encephalitis
056.00-056.09 ..... Rubella with neurological complications
062.0-066.9 ..... Viral encephalitis transmitted by arthropods
070.0-070.6 ..... Viral hepatitis with encephalopathy
071-071 ..... Rabies
072.1-072.2 ..... Mumps meningitis and encephalitis
088.81-088.81 ..... Lyme disease
090.40-090.49 ..... Juvenile neurosyphilis
091.81-091.81 ..... Acute syphilitic meningitis
094.0-094.9 ..... Neurosyphilis
098.82-098.82 ..... Gonococcal meningitis
100.81-100.9 ..... Leptospiral meningitis
112.83-112.83 ..... Candidal meningitis
114.2-114.2 ..... Coccidoidal meningitis
115.01-115.01 ..... Histoplasmosis meningitis

Head, Brain, and Neck, continued

115.11-115.11 ..... Infection by Histoplasma duboisii
115.91-115.91 ..... Unspecified histoplasmosis
130.0-130.0 ..... Meningoencephalitis due to toxoplasmosis
137.1-137.1 ..... Late effects of central nervous system tuberculosis
138-138 ..... Late effects of acute poliomyelitis
140.00-208.92 ..... Malignant neoplasm, any site
213.0-213.1 ..... Benign neoplasm bones of skull and face
215.0-215.0 ..... Benign neoplasm head and neck
215.8-215.8 ..... Benign neoplasm
224.0-227.9 ..... Benign neoplasm of eye, brain, and other parts of nervous system
228.02-228.03 ..... Hemangioma of intracranial structures
229.0-229.0 ..... Benign neoplasm lymph nodes
230.0-231.9 ..... Carcinoma in situ
233.0-242.21 ..... Carcinoma in situ of other sites, neoplasm of uncertain behavior, and thyroid disorders
244.0-246.9 ..... Other thyroid disorders
250.20-250.63 ..... Diabetic coma and other neurological complications of diabetes
252.0-253.9 ..... Disorders of the pituitary and parathyroid gland
255.0-255.9 ..... Hyperaldosteronism
259.0-259.9 ..... Other endocrine disorders
290.0-290.9 ..... Organic psychotic conditions
293.0-299.90 ..... Transient organic psychotic conditions
307.20-307.23 ..... Tics
310.0-310.9 ..... Specific nonpsychotic mental due to brain damage
320.0-353.9 ..... Inflammatory, hereditary, and degenerative diseases of the central nervous system; epilepsy
358.00-358.1 ..... Myasthenia gravis

Head, Brain, and Neck, continued

360.00-379.99	Disorders of the eye and adnexa
378.50-378.9	Paralytic strabismus and other eye movement disorders
383.00-383.9	Mastoiditis and related conditions
386.0-392.9	Disorders of sense organs
430-438.9	Cerebrovascular disease
471.0-473.9	Sinus disorders
478.30-478.34	Vocal cord paralysis
527.0-527.9	Disorders of salivary glands
572.2-572.2	Hepatic coma
611.6-611.6	Galactorrhea not associated with childbirth
674.00-674.04	Cerebrovascular disorder in the puerperium
676.60-676.60	Galactorrhea
682.0-682.1	Cellulitis of face and neck
722.71-722.71	Cervical disc disorder
722.81-722.81	Cervical postlaminectomy syndrome
729.1-729.2	Myalgia and neuralgia
733.3-733.3	Hyperostosis of skull
738.10-738.2	Acquired deformity head and neck
739.0-758.3	Nonallopathic lesions, congenital anomalies of nervous system
759.2-767.9	Conjoined twins, hemartoses of brain, multiple congenital anomalies, birth trauma
768.2-770.89	Birth asphyxia, fetal distress and other conditions affecting newborn
772.10-772.2	Fetal subarachnoid hemorrhage
779.0-784.7	Cerebral irritability in newborn, neurological symptoms, and other symptoms involving head and neck
793.0-793.0	Abnormal findings on radiological or other exam of head and skull
794.00-794.19	Nonspecific abnormal results of function studies related to the brain and central nervous system

Head, Brain, and Neck, continued

794.5-794.6	Abnormal results of endocrine function study
800.00-805.18	Fracture of skull or cervical vertebra
806.00-806.19	Fracture cervical vertebra
850.0-854.19	Intracranial injury
870.3-874.9	Complicated wounds of head and neck
925.1-925.2	Crushing injury to head, face, and neck
950.0-952.09	Injury to optic nerve and pathways
959.01-959.09	Injury to head, face, and neck
996.2-996.2	Mechanical complication of nervous system device, implant, or graft
997.00-997.09	Nervous system complications

MRI Orbit, Face, and Neck

017.30-017.36	Tuberculosis of eye
017.40-017.46	Tuberculosis of ear
017.50-017.56	Tuberculosis of thyroid gland
036.81-036.81	Meningococcal optic neuritis
140.00-208.92	Malignant neoplasm any site
210.2-210.9	Benign neoplasm oral cavity and pharynx
212.0-212.1	Benign neoplasm nasal cavities, middle ear, sinuses or larynx
213.0-213.1	Benign neoplasm bones of skull and face
215.0-215.0	Benign neoplasm tissue of head, face, and neck
224.0-224.9	Benign neoplasm of eye
225.0-225.2	Benign neoplasm brain
226-226	Benign neoplasm of thyroid gland
227.1-227.5	Benign neoplasm of parathyroid gland, pituitary gland, and craniopharyngeal duct
230.0-230.0	Carcinoma in situ of lip, oral cavity, and pharynx
231.0-231.1	Carcinoma in situ of larynx and trachea
234.0-234.8	Carcinoma in situ of eye and other specified sites

MRI Orbit, Face, and Neck, continued

235.0-235.1	Neoplasm of uncertain behavior of salivary glands, lip, oral cavity, and pharynx
235.6-235.6	Neoplasm of uncertain behavior, larynx
237.0-237.1	Neoplasm of uncertain behavior of pituitary gland and craniopharyngeal duct
238.1-238.1	Neoplasm of uncertain behavior of connective and other soft tissue
433.0-433.9	Occlusion and stenosis of precerebral arteries
471.0-471.9	Nasal polyps
473.0-473.9	Chronic sinusitis
478.0-478.79	Other diseases of upper respiratory tract involving nose and throat
682.0-682.1	Other cellulitis and abscess of face and neck
719.08-719.08	Joint disorder of other specified sites
756.0-756.0	Anomalies of skull and face bones
781.0-781.4	Symptoms involving nervous system
781.6-781.6	Meningismus

MRI Orbit, Face, and Neck, continued

784.0-784.99	Symptoms involving head and neck
793.0-793.0	Abnormal findings on radiological exam of skull and head
850.0-854.19	Intracranial injury without skull fracture
870.0-874.9	Open wound of head and neck
925.1-925.2	Crushing injury of face and neck
941.30-941.39	Third degree burns of face and neck
950.0-951.9	Injury to cranial nerve
239.2-239.2	Neoplasm of unspecified nature of bone, soft tissue and skin
240.0-246.9	Disorders of thyroid gland
252.0-252.9	Disorders of parathyroid gland
350.1-352.9	Cranial nerve disorders
360.00-379.99	Disorders of eye and adnexa
382.00-382.2	Acute suppurative otitis media
383.00-389.9	Mastoiditis and related conditions, other ear disorders

APPENDIX E
DIAGNOSIS CODE LIST FOR MAMMOGRAPHY

DIAGNOSIS CODE LIST FOR MAMMOGRAPHY

Screening Mammography

DX Code	Description
V10.3	Personal History of malignant neoplasm; breast
V15.89	Other specified personal history presenting hazards to health
V16.3	Family history of malignant neoplasm; breast
V70.0	Routine general medical examination at a health care facility
V7610-V7612	Special screening for malignant neoplasms; breast

Diagnostic Mammography

DX Code	Description
V10.3	Personal History of malignant neoplasm; breast
V15.89	Other specified personal history presenting hazards to health
V16.3	Family history of malignant neoplasm; breast
V70.0	Routine general medical examination at a health care facility
V10.3	Personal history of malignant neoplasm; breast
V10.40	Personal history of malignant neoplasm; female genital organ unspecified
V10.41	Personal history of malignant neoplasm; cervix uteri
V10.42	Personal history of malignant neoplasm; other parts of uterus
V10.43	Personal history of malignant neoplasm; ovary
V10.44	Personal history of malignant neoplasm; other female genital organs
V10.45	Personal history of malignant neoplasm; male genital organ unspecified
V10.46	Personal history of malignant neoplasm; prostate
V10.47	Personal history of malignant neoplasm; testis
V10.48	Personal history of malignant neoplasm; epididymis
V10.49	Personal history of malignant neoplasm; other male genital organs
V10.71	Lymphosarcoma and reticulosarcoma
V10.72	Hodgkin's disease
V10.79	Other lymphatic and hematopoeitic neoplasms
V10.81	Personal history of malignant neoplasm; bone
V10.82	Malignant melanoma of skin
V10.83	Other malignant neoplasm of skin
V10.84	Personal history of malignant neoplasm; eye
V10.85	Personal history of malignant neoplasm; brain
V10.86	Personal history of malignant neoplasm; other parts of the nervous system
V10.87	Personal history of malignant neoplasm; thyroid
V10.88	Personal history of malignant neoplasm; other endocrine glands and related structures

Diagnostic Mammography, continued

DX Code	Description
V10.89	Personal history of malignant neoplasm; other sites
V52.4	Fitting and adjustment of breast prosthesis and implant
V71.1	Observation for suspected malignant neoplasm
V76.10-76.12	Special screening for malignant neoplasms; breast
174.0	Malignant neoplasm of female breast; nipple and areola
174.1	Malignant neoplasm of female breast; central portion
174.2	Malignant neoplasm of female breast; upper-inner quadrant
174.3	Malignant neoplasm of female breast; lower-inner quadrant
174.4	Malignant neoplasm of female breast; upper-outer quadrant
174.5	Malignant neoplasm of female breast; lower-outer quadrant
174.6	Malignant neoplasm of female breast; axillary tail
174.8	Malignant neoplasm of female breast; other specified sites
174.9	Malignant neoplasm of breast (female); unspecified
175.0	Malignant neoplasm of breast (male); nipple and areola
175.9	Malignant neoplasm of breast (male); other and unspecified sites
198.2	Secondary malignant neoplasm, skin
198.81	Secondary malignant neoplasm, breast
214.1	Lipoma, skin and subcutaneous tissue
217	Benign neoplasm of breast
233.0	Carcinoma in situ; breast
238.3	Neoplasm of uncertain behavior; breast
239.3	Neoplasm of unspecified nature; breast
457.0	Postmastectomy lymphedema syndrome
457.1	Other lymphedema
610.0	Solitary cyst of breast
610.1	Diffuse cystic mastopathy
610.2	Fibroadenosis of breast
610.3	Fibrosclerosis of breast
610.4	Mammary duct ectasia
610.8	Other specified benign mammary dysplasias
611.0	Inflammatory disease of breast
611.1	Hypertrophy of breast
611.2	Fissure of nipple
611.3	Fat necrosis of breast
611.4	Atrophy of breast
611.5	Galactocele
611.6	Galactorrhea not associated with childbirth
611.71	Mastodynia
611.72	Lump or mass in breast

Diagnostic Mammography, continued

DX Code	Description
611.79	Other signs and symptoms in breast
611.8	Other specified disorders of breast
611.9	Unspecified breast disorder
757.6	Specified anomalies of breast
771.5	Neonatal infective mastitis
785.6	Enlargement of lymph nodes
793.80-793.89	Nonspecific abnormal findings on radiological and other examination of breast
879.0	Open wound of breast, without mention of complication
879.1	Open wound of breast, complicated
926.19	Crushing injury of breast
942.11	Burn of breast
942.31	Burn of breast; full thickness skin loss (third degree, not otherwise specified)
942.41	Burn of breast; deep necrosis of underlying tissues (deep third degree) without mention of loss of a body part
942.51	Burn of breast; deep necrosis of underlying tissues (deep third degree) with loss of a body part
996.54	Complication of breast prosthesis
V15.89	Other specified personal history presenting hazards to health

APPENDIX F
DIAGNOSIS CODE LIST FOR
OUTPATIENT HYSTERECTOMY

DIAGNOSIS CODE LIST FOR OUTPATIENT HYSTERECTOMY

DX Code	Description
179	Malignant neoplasm of uterus, part unspecified
180.0	Malignant neoplasm of endocervix
180.1	Malignant neoplasm of exocervix
180.8	Malignant neoplasm of other specified sites of cervix
180.9	Malignant neoplasm of cervix uteri, unspecified
181	Malignant neoplasm of placenta
182.0	Malignant neoplasm of corpus uteri, except isthmus
182.1	Malignant neoplasm of isthmus
182.8	Malignant neoplasm of other specified sites of body uterus
183.0	Malignant neoplasm of ovary
183.2	Malignant neoplasm of fallopian tube
183.3	Malignant neoplasm of broad ligament
183.4	Malignant neoplasm of parametrium
183.5	Malignant neoplasm of round ligament
183.8	Malignant neoplasm of other specified sites of uterine adnexa
183.9	Malignant neoplasm of uterine adnexa, unspecified
184.0	Malignant neoplasm of vagina
198.6	Secondary malignant neoplasm of ovary
218.0	Submucous leiomyoma of uterus
218.1	Intramural leiomyoma of uterus
218.2	Subserous leiomyoma of uterus
218.9	Leiomyoma of uterus, unspecified
219.0	Benign neoplasm of cervix uteri
219.1	Benign neoplasm of corpus uterus
219.8	Benign neoplasm of other parts of uterus
219.9	Benign neoplasm of uterus, part unspecified
233.1	Carcinoma in situ of cervix uteri
233.2	Carcinoma in situ of other and unspecified parts of uterus
236.0	Neoplasm of uncertain behavior of uterus
236.1	Neoplasm of uncertain behavior of placenta
236.2	Neoplasm of uncertain behavior of ovary
614.4	Chronic or unspecified parametritis and pelvic cellulitis
614.6	Pelvic peritoneal adhesions, female (postoperative) (postinfective)
617.0	Endometriosis of uterus
617.1	Endometriosis of ovary
617.2	Endometriosis of fallopian tube
617.3	Endometriosis of pelvic peritoneum

Hysterectomy Diagnosis Codes, continued

DX Code	Description
617.4	Endometriosis of rectovaginal septum and vagina
617.5	Endometriosis of intestine
617.8	Endometriosis of other specified sites
618.0	Prolapse of vaginal walls without mention of uterine prolapse
618.1	Uterine prolapse without mention of vaginal wall prolapse
618.2	Uterovaginal prolapse, incomplete
618.3	Uterovaginal prolapse, complete
618.4	Uterovaginal prolapse, unspecified
618.6	Vaginal enterocele, congenital or acquired
626.2	Excessive or frequent menstruation
626.4	Irregular menstrual cycle
626.6	Metrorrhagia
626.8	Other disorders of menstruation and abnormal bleeding from genital tract
626.9	Unspecified disorder of menstruation and abnormal bleeding of genital tract
627.0	Premenopausal menorrhagia
627.1	Postmenopausal bleeding
633.8	Other ectopic pregnancy
665.10	Rupture of uterus during labor, unspecified as to episode of care
665.11	Rupture of uterus during labor, delivered, with or without mention of antepartum condition
665.20	Inversion of uterus; unspecified as to episode of care
665.22	Inversion of uterus; delivered, with mention of postpartum condition
665.24	Inversion of uterus; postpartum condition or complication
666.00	Third stage postpartum hemorrhage; unspecified as to episode of care
666.02	Third stage hemorrhage; delivered, with mention of postpartum complication
666.04	Third stage hemorrhage; postpartum condition or complication
666.10	Other immediate postpartum hemorrhage; unspecified as to episode of care
666.12	Other immediate postpartum hemorrhage; delivered, with mention of postpartum condition
666.14	Other immediate postpartum hemorrhage; postpartum condition or complication
666.30	Postpartum coagulation defects; unspecified as to episode of care
666.32	Postpartum coagulation defects; delivered, with mention of postpartum condition
666.34	Postpartum coagulation defects; postpartum condition or complication