



# **Florida Medicaid**

## **Medicaid Licensed Midwife and Birth Center Services Handbook**

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**Agency for Health Care Administration**







JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

April 1, 2005

Dear Birth Center and Licensed Midwife Services Provider:

The Florida Medicaid Birth Center and Licensed Midwife Services Coverage and Limitations Handbook was updated effective January 2005. The handbook was revised to remove the 2004 fee schedules. See Fee Schedules on this CD-ROM for the 2005 procedure codes and fees. The CD-ROM also contains the 2004 fee schedules for billing claims with dates of service prior to January 1, 2005.

The following pages were replaced in the enclosed handbook:

Updated Pages
Update Log
Table of Contents
Chapter 3, page 3-1
Appendices A and B, 2004 Fee Schedules, and Appendix C, HIPPA Crosswalk, were deleted.

The fee schedules, all the Medicaid handbooks, and additional information about Florida Medicaid are also available on the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support. Please call your area Medicaid office if you have any questions. The area offices' telephone numbers are in Appendix C of the Florida Medicaid Provider General Handbook.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Thomas W. Arnold  
Deputy Secretary for Medicaid





# UPDATE LOG

## BIRTH CENTER AND LICENSED MIDWIFE SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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### ***How to Use the Update Log***

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#### **Introduction**

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

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#### **Explanation of the Update Log**

The provider can use the update log to determine if all the updates to the handbook have been received.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

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#### **Instructions**

1. Make the pen and ink changes and file new or replacement pages.
2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in Appendix C of the Medicaid Provider General Handbook.

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UPDATE NO.	EFFECTIVE DATE
Jan2000—Revised Handbook	January 2000
Jan2001—Revised Handbook	January 2001
Update 02-1—Replacement Pages	January 2002
Update 03-1—Replacement Pages	March 2003
Jan2004 – Revised Handbook	January 2004
Errata to January 2004	January 2004
Jan2005 – Remove Appendices A, B and C	January 2005



# BIRTH CENTER AND LICENSED MIDWIFE SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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## INTRODUCTION TO THE HANDBOOK

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### Overview

#### Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells 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 the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exceptions: For Prescribed Drugs and Transportation Services, the coverage and limitations handbook and the reimbursement handbook are combined into one.

#### Legal 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, and
- Chapter 59G, Florida Administrative Code.

#### In This Chapter

This chapter contains:

TOPIC	PAGE
Handbook Use and Format	ii
Characteristics of the Handbook	iii
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***Handbook Use and Format***

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**Purpose** The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the 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.

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**Provider** The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.

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**Recipient** The term “recipient” is used to describe an individual who is eligible for Medicaid.

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**General Handbook** General information for 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. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.

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**Coverage and Limitations Handbook** Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.

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**Reimbursement Handbook** Each reimbursement handbook is named for the claim form that it describes.

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**Chapter Numbers** The chapter number appears as the first digit before the page number at the bottom of each page.

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**Page Numbers** Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.

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**White Space** The "white space" found throughout a handbook enhances readability and allows space for writing notes.

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### ***Characteristics of the Handbook***

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**Format**

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

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**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.

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**Label**

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

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**Note**

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

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**Topic Roster**

Each chapter contains a topic roster 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.

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### ***Handbook Updates***

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**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 No." and the "Effective Date."

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**Handbook Updates**, continued

**How Changes Are Updated**

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.

**Numbering Update Pages**

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

**Effective Date of New Material**

The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

**Identifying New Information**

New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

**New Label**

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

**New Label and New Information Block**

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

**New Material in an Existing Information Block**

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

**New or Changed Paragraph**

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

| Paragraph with new material. |

# **CHAPTER 1**

## **BIRTH CENTER AND LICENSED MIDWIFE SERVICES PROVIDER QUALIFICATIONS AND ENROLLMENT**

### *Overview*

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#### **Introduction**

This chapter defines who is an eligible birth center and licensed midwife and describes the provider qualifications, enrollment requirements, and general program requirements.

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#### **Legal Authority**

The federal authority governing the provisions, requirements, benefits, and service payment of the Birth Center Services Program is Title 42, Code of Federal Regulations (C.F.R.), Parts 440.50, 440.60, 440.90 and 440.165.

The federal authority governing the provisions, requirements, benefits, and service payment of the Licensed Midwife Program is Title 42, C.F.R., Part 440.60.

The state authority for maternity and infancy hygiene is Chapter 383, Florida Statutes (F.S.).

The state authority for a licensed midwife is Chapter 467, F.S.

The Florida Medicaid Birth Center and Licensed Midwife Services Programs are implemented through Chapter 409, Florida Statutes. Chapter 59G, Florida Administrative Code, implements the limitations for birthing center and licensed midwife services in Florida Medicaid.

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#### **In This Chapter**

This chapter contains:

<b>TOPIC</b>	<b>PAGE</b>
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Provider Requirements	1-4

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***Purpose and Definitions***

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**Purpose** The Florida Medicaid Birth Center Program reimburses birth centers for providing Medicaid-covered services appropriate to the care of Medicaid recipients during low-risk pregnancies, deliveries and the postpartum period. The Birth Center Program also reimburses for gynecological services, family planning services, and Child Health Check-Up screenings (newborn evaluations only).

The Florida Medicaid Licensed Midwife Program reimburses licensed midwives for providing Medicaid-covered services appropriate to the care of Medicaid recipients during low-risk pregnancies, deliveries and the postpartum period. The Licensed Midwife Program also reimburses for Child Health Check-Up screenings (newborn evaluations only).

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**Purpose of This Handbook** This handbook is intended for use by birth centers or licensed midwives, who provide services to pregnant Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program in general, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment.

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**Birth Center Services Definition** Birth center services are obstetrical, postpartum, gynecological, and family planning services and Child Health Check-Up screenings (newborn evaluations only) provided in a birth center.

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**Licensed Midwife Services Definition** Licensed midwife services are obstetrical and postpartum care and Child Health Check-Up screenings (newborn evaluations only) provided to recipients by licensed midwives.

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***Provider Qualifications***

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**Birth Center Qualifications** To enroll as a Medicaid provider, a birth center must meet all state licensure requirements pursuant to the guidelines set forth in Chapter 59A-11, F.A.C. and Chapter 383, F.S.

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**Licensed Midwife Qualifications** To enroll as a Medicaid provider, a licensed midwife must meet all state licensure requirements pursuant to the guidelines set forth in Chapter 467, F.S.

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**Provider Qualifications**, continued

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<b>Qualified at the Time of Enrollment</b>	Birth centers and licensed midwives must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.
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**Provider Enrollment**

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<b>General Enrollment Requirements</b>	Birth centers and licensed midwives must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, birth centers and licensed midwives must follow the specific enrollment requirements that are listed in this section.
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<b>Group Providers</b>	Two or more Medicaid-enrolled providers whose practice is incorporated under the same tax identification number must enroll as a Medicaid provider group. In order to receive payment from Medicaid, each member of the group must also enroll as an individual treating provider within the group. The group must have a unique location code for each location in which a group member practices as described below.
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<b>Multiple Locations</b>	Both individual and group providers who have practices at more than one location, i.e., satellite offices, must have a separate location code for each practice location. A location code is a physical location identifier that corresponds to the last two digits of the provider's Medicaid number. Providers must use the location code assigned to the practice location when billing for services provided at that location.
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The provider must notify the Medicaid fiscal agent of additional practice locations. Notification must be made in writing on an Application for a New Location code and must include an effective date for the new location. Applications for New Location Codes can be obtained from the Medicaid fiscal agent by calling 800-289-7799 or from its website at <http://floridamedicaid.acs-inc.com>.

Any closure of a practice location must also be reported to the fiscal agent, in writing on office letterhead stationery, along with the effective date of the closure.

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<b>Individual Provider Responsibility Within a Group Practice</b>	It is the responsibility of the individual treating provider to notify the Medicaid fiscal agent of all group practices for which they are affiliated.  Any individual treating provider who is terminating a relationship with a group practice must notify the Medicaid fiscal agent in writing of the termination in order to update their provider file.
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**Provider Enrollment**, continued

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**Child Health  
Check-Up  
Providers**

To be reimbursed for Child Health Check-Up screenings, the provider must enroll to provide Child Health Check-Up screenings as an additional category of service. This is category of service code 55. The provider must provide the screenings in accordance with the policies in the Florida Medicaid Child Health Check-Up Coverage and Limitations Handbook.

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**Provider Requirements**

**General  
Requirements**

In addition to the general provider requirements and responsibilities that are contained in Chapter 2 of the Medicaid Provider General Handbook, birth center and licensed midwife providers are also responsible for complying with the provisions contained in this section.

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**Provider  
Responsibility**

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). Medicaid providers, including their staff, contracted staff and volunteers, meet the definition of a covered entity according to HIPAA and must comply with HIPAA privacy requirements effective April 14, 2003, and HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

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***Provider Requirements***, continued

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**Licensed Midwives  
Employed by  
Facilities**

A licensed midwife salaried by a facility that is Medicaid reimbursed on a cost-related basis may not be reimbursed directly on a fee-for-service basis if the cost for the licensed midwife's salary is included in the facility's cost report.

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**Licensed Midwives  
Employed by Birth  
Centers**

Licensed midwives who practice at a birth center must be reimbursed through the birth center program.

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**Salaried  
Employees of a  
Birth Center**

Health care providers who are employed by or under contract to a birth center cannot be directly reimbursed for services on a fee-for-service basis that are billed by the birth center.

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## **CHAPTER 2**

# **BIRTH CENTER AND LICENSED MIDWIFE SERVICES COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS**

### **Overview**

#### **Introduction**

This chapter describes the services covered under the Florida Medicaid Birth Center Services Program and the Licensed Midwife Services Program. It also describes limited or excluded services.

#### **In This Chapter**

This chapter contains:

<b>TOPIC</b>	<b>PAGE</b>
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### ***General Service Requirements, Limitations and Exclusions***

#### **Covered Services**

Only those services designated in this chapter and listed on the Procedure Codes and Fee Schedule in Appendix A can be reimbursed by Medicaid to a birth center.

Only those services designated in this chapter and listed on the Procedure Codes and Fee Schedule in Appendix B can be reimbursed by Medicaid to a licensed midwife.

Unless otherwise specified, the services described in this chapter may be performed by birth center staff and licensed midwives who do not practice in a birth center.

**General Service Requirements, Limitations and Exclusions**, continued

**Low-Risk Pregnancy**

Medicaid reimburses birth centers and licensed midwives for providing antepartum, delivery, and postpartum care to low medical risk pregnant Medicaid recipients.

Note: See Appendix D, Glossary, in the Medicaid Provider General Handbook, for the definition of a low medical risk pregnant woman.

**Limitations**

Certain services are designated with limitations by diagnosis or other limitations in Appendices A and B. Other limitations specified in this handbook also apply.

**Medically Necessary**

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- 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; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically necessary.

**Presumptively Eligible Pregnant Women (PEPW)**

During the period of presumptive eligibility, services provided in the birth center or home prior to delivery are reimbursable. No inpatient hospital services may be reimbursed.

Note: See Chapter 3 of the Medicaid Provider General Handbook, for additional information on Presumptively Eligible Pregnant Women.

**General Service Requirements, Limitations and Exclusions**, continued

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**Aliens**

Providers can be reimbursed for only emergency services provided to aliens who are not eligible for full Medicaid benefits due to their alien status. 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 and bilateral tubal ligations are not emergencies and cannot be reimbursed for aliens who are eligible for only emergency services.

Note: See Chapter 3 of the Medicaid Provider General Handbook, for additional information on Emergency Medicaid for Aliens.

Note: See Chapter 1 of the Medicaid Provider Reimbursement Handbook, CMS-1500 for additional information on completing the emergency field (item 24 I) 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.gpoaccess.gov](http://www.gpoaccess.gov).

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**Excluded Services**

Medicaid does not reimburse birth centers or licensed midwives for the following services:

- Operative obstetrics and cesarean sections;
  - General anesthesia and conductive anesthesia;
  - Stress tests; and
  - Telephone calls.
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***Evaluation and Management Services***

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<b>Introduction</b>	Evaluation and management (E&M) services are face-to-face provider and recipient encounters.
<b>E&amp;M Office Visits</b>	Medicaid reimburses for an E&M office visit when a medically-necessary visit is provided at the birth center for a gynecological problem not related to obstetrical services.
<b>E&amp;M Home Visits</b>	Medicaid reimburses for an E&M home visit when a medically-necessary visit is provided in the recipient's private residence.
<b>E&amp;M Visit Frequency</b>	Medicaid reimbursement for E&M office visits is limited to one visit per recipient, per day.  Medicaid reimbursement for E&M home visits is limited to two visits per recipient.
<b>E&amp;M New Patient Visit</b>	One E&M new patient visit may be reimbursed once per recipient per billing provider.  A new patient is one who has not received professional services from the birth center within the past three years.
<b>E&amp;M Established Patient Visit</b>	An established patient is one who has received professional services from the birth center within the past three years.
<b>E&amp;M Visit Reimbursement Limitations</b>	The following codes are considered visit codes and are not reimbursed in addition to an office visit: 59430, 99211 FP, 99383 FP, 99384 FP, 99385 FP, 99386 FP, 99393 FP, 99394 FP, 99395 FP, 99396 FP, 99403 FP, H1000, H1001, and H1001 TG.
<b>Urinalysis, Hemoglobin and Hematocrit</b>	Manual or automated urine, hemoglobin and hematocrit tests performed as part of an evaluation and management visit are not reimbursed in addition to the evaluation and management visit. The provider may not bill for them as separate procedures.
<b>Procedure Codes and Fees</b>	See Appendixes A and B in this handbook for a list and description of procedure codes and fees.

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**Family Planning Services**

**Description**

Family planning services can be provided to Medicaid eligible persons of childbearing age who desire family planning services and supplies. The services are for the purpose of spacing children or preventing pregnancies.

Medicaid reimburses family planning services provided by birth centers. Medicaid does not reimburse family planning services provided by licensed midwives in the home setting.

**Family Planning Procedure Codes**

*Effective for dates of service on or after October 16, 2003.*

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.

**Services for Minors**

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

- Has his or her parent's or legal guardian's consent;
- Is married;
- Is a parent;
- Is pregnant; or
- Will suffer from probable health hazards if such services are not provided as determined by the physician, ARNP, or physician assistant 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.

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**Family Planning Services**, continued

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**Initial Visit Components**

Only one initial family planning visit per recipient per birth center can be reimbursed.

The following minimum 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; and
  - Post-examination interview.
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**Annual Visit Components**

The following minimum components must be provided during an annual family planning visit and documented in the recipient's medical record:

- Updating the original data in the patient record;
- Physical examination;
- Cervical pap smear, if not performed within the past three months and results are available in the medical record;
- Addressing renewal needs of contraceptive method; and
- Post-examination interview.

Annual visit reimbursements are limited to once every 365 days.

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**Recommended Laboratory Tests**

The following laboratory tests are recommended for an initial or annual family planning visit, when indicated:

- Hemoglobin or Hematocrit;
- Urinalysis;
- Screening for sexually transmitted diseases;
- Rubella titer; and
- 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.

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**Family Planning Services**, continued

**Required Laboratory Tests**

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A cervical pap smear is required for initial or annual family planning visits.

If a cervical pap smear was performed within the past three months, and the results are available, the test does not need to be repeated.

The cervical pap smear is billed by the pathologist.

No billing is allowed for the collection or handling of laboratory specimens.

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**Counseling Visit**

Counseling visits are rendered to discuss the family planning method chosen or to discuss other available methods. Counseling visits should include information on natural family planning methods.

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 applicable; and
- Identification of any problems with current birth control method.

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

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**HIV Counseling**

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 ICD-9-CM diagnosis code (V25.01 through V25.9) must be entered on the claims submitted for procedure codes 99401 and 99402.

HIV counseling sessions may be billed in addition to a family planning visit or an evaluation and management visit when all components of either visit are performed.

HIV counseling sessions are limited to four per year, per recipient acknowledging HIV risks. They are limited to two per lifetime, per recipient for preventive counseling.

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**Family Planning Services**, continued

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**HIV Documentation**

Medical records 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 such as the Department of Health's Partner Elicitation/Notification Program and community mental health agencies.

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**Supply Visit**

Supply visits are rendered to assess the recipient and to provide family planning supplies such as birth control pills or condoms.

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; and
- 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 program.

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**Natural Methods**

Training on use of natural family planning methods is not reimbursable.

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**Norplant**

Norplant services include provision of the Norplant kit and insertion or removal of the capsules.

| The Norplant System Kit is billed with procedure code A4260. |

Insertion or removal of Norplant is reimbursable in addition to a family planning initial or annual visit or an evaluation and management visit if all components of an evaluation and management visit are met and documented in addition to the Norplant services.

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**Family Planning Services**, continued

**Intrauterine Device (IUD)**

Insertion of an IUD is reimbursable in addition to a family planning initial or annual 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 appropriate J code or HCPCS procedure code. Procedure code 99070 is not an appropriate code and cannot be reimbursed for an IUD.

Removal of an IUD is reimbursable when performed as a separate procedure. No visits can be reimbursed on the same day to the same provider.

**DepoProvera and Lunelle**

Services associated with the decision to use DepoProvera or Lunelle as a contraceptive method are covered using the appropriate family planning code. Reimbursement for the medication is covered using the appropriate J code.

**Diaphragms And Cervical Caps**

Provision of diaphragms and cervical caps is by prescription and reimbursed through the Medicaid Pharmacy Program. The diaphragm or cervical cap fitting can be reimbursed to the birth center.

**Pregnancy Testing**

A pregnancy test may be indicated prior to the use of a particular contraceptive method. Reimbursement for pregnancy testing is allowed if all components of the service are provided in the office.

Specimens for pregnancy testing sent to an independent lab are billed by 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.

**Urinalysis, Hemoglobin and Hematocrit**

Manual or automated urine, hemoglobin and hematocrit tests performed as part of a family planning visit are not reimbursed in addition to the family planning visit. Providers may not bill for them as separate procedures.

**Codes and Fees**

See Chapter 3, Appendixes A and B in this handbook for a list and description of procedure codes and fees.

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## **Family Planning Waiver Services**

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### **Eligibility**

The family planning waiver extends eligibility for family planning services for 24 months to postpartum women who have had a Medicaid-financed delivery or pregnancy-related service within two years prior to the date of losing Medicaid eligibility.

Note: See Chapter 3 in the Florida Medicaid Provider General Handbook for additional information on Family Planning Waiver Services.

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### **Covered Services**

Recipients are eligible for all the Medicaid-covered family planning services listed under the “Family Planning Services” topic, family-planning related pharmacy services, antibiotics, vaginal antifungals and anti-infectives to treat sexually-transmitted diseases (STDs), sterilization, colposcopy, and transportation to family planning services.

Transportation to family planning services is billed by the Medicaid transportation provider.

Pharmaceutical services to family planning waiver recipients are billed by the pharmacy dispensing the prescription.

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### **Evaluation and Management Codes**

Evaluation and management procedure codes 99201 and 99211 are reimbursable when the recipient either returns for STD counseling and treatment or is referred for this service.

Documentation in the recipient’s medical record must include all components of the evaluation and management service and the status of the recipient related to either the initial or established visit. If initial visit (99201) is billed, the provider must state that the recipient was referred and include the name of referring provider in the recipient’s medical record.

The provider must enter diagnosis code 099.9 (venereal disease, unspecified) on the claim form.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for instructions regarding completing the claim form for referring providers.

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### **Service Exclusions**

All other Medicaid services are excluded.

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**Family Planning Waiver Services**, continued

**Service Requirements**

Claims for extended family planning services must be submitted with the following diagnosis codes:

E&M codes 99201 and 99211	099.9
Family planning	V25.01-V25.9
Colposcopy	622.1, 795.0, or 795.1
* Lab procedure for sexually-transmitted diseases	634.0-634.9, 054.0-054.9, 078.0-078.19, 079.88, 079.98, 090.3-099.9, 112.0-112.9, 131.0-131.9, or V25.09

Note: See the Medicaid Provider Reimbursement Handbook, CMS-1500 for instructions regarding completing the claim form and reference to diagnosis codes and reference pointers.

**Prescriptions**

Prescriptions to treat sexually transmitted diseases must have "FP" written on them for a recipient enrolled in the Family Planning Waiver Services program. Prescriptions are reimbursed through the Florida Medicaid Pharmacy program.



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## ***Newborn Assessment***

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### **Newborn Assessment**

A newborn assessment is performed after delivery to verify the physical status of the infant.

Medicaid reimburses only one initial newborn assessment, per recipient, per lifetime.

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### **Child Health Check-Up Services**

Child Health Check-Up, formerly called Early and Periodic Screening, Diagnosis and Treatment (EPSDT), is a comprehensive, preventive child-health screening for recipients from birth through age 20. Child Health Check-Up screenings are performed according to a periodicity schedule that ensures the recipient has health screenings on a routine basis. In addition, a recipient may be screened whenever it is medically necessary or requested by the recipient or the recipient's parent or caregiver.

If a recipient is diagnosed as having a medical problem, the recipient is treated for that problem through the applicable Medicaid program, such as physician, dental and therapy services.

To be reimbursed for a Child Health Check-Up, the provider must be enrolled in Medicaid with a Child Health Check-Up category of service. The Child Health Check-Up category of service code is 55. The screening must meet all the requirements contained in the Florida Medicaid Child Health Check-Up Coverage and Limitations Handbook. Birth centers and licensed midwives are reimbursed for only the Child Health Check-Up newborn assessment.

Note: See the Florida Medicaid Child Health Check-Up Coverage and Limitations Handbook for information on Child Health Check-Up screenings and optional forms.

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### **State Tests Made on the Newborn**

Medicaid reimburses the laboratory for state mandated tests performed on a newborn.

Medicaid does not separately reimburse a provider for obtaining a specimen for the purpose of testing.

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### **Vitamin K**

Medicaid reimburses for the purchase and injection of vitamin K into the newborn.

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***Newborn Assessment***, continued

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**Birth Center Referral for Newborn Hearing Screening**

Each state-licensed birth center that provides maternity and newborn care services must provide that prior to discharge, all newborns are referred to an authorized conductor of newborn hearing screenings. (See below for who is authorized to conduct a newborn hearing screening.)

The birth center must file written documentation of the referral in the newborn's medical chart.

Each birth center must designate a licensed health care provider to provide programmatic oversight to ensure that the appropriate referrals are being completed.

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**Licensed Midwife Referral for Newborn Hearing Screening**

For home births, the licensed midwife in attendance is responsible for the coordination and referral of the newborn to an authorized conductor of newborn hearing screenings. (See below for who is authorized to conduct a newborn hearing screening.) The referral for an appointment must be made within 30 days after the birth.

When a home birth is not attended by the licensed midwife, the licensed midwife must refer the baby for a hearing screening within the first three months after the baby's birth.

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**Who is Authorized to Conduct Newborn Hearing Screenings**

All newborn and infant hearing screenings must be conducted by an audiologist licensed under Chapter 468, F.S.; 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 directly supervised by a licensed physician or licensed audiologist.

Direct supervision means the licensed physician or licensed audiologist:

- Is on the premises when the services are rendered; and
- Reviews, signs, and dates the medical record.

Indirect supervision means the licensed physician or licensed audiologist:

- Is available, so as to be physically present to provide consultation or direction in a timely fashion as required for appropriate care of the patient; and
  - Reviews, signs, and dates the medical record.
- 

**Non-Duplication of Services**

Medicaid does not reimburse for a newborn assessment and a Child Health Check-Up screening for the same provider, same recipient, and same date of service.

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**Codes and Fees**

See Appendixes A and B in this handbook for a list and description of procedure codes and fees.

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**Obstetrical Services**

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**Description** Obstetrical services include prenatal, delivery, and postpartum care for a low medical risk pregnant Medicaid recipient.

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**Laboratory Specimens** The following are included in the reimbursement for any type of visit:

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

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**Urinalysis, Hemoglobin and Hematocrit** Manual or automated urine, hemoglobin and hematocrit tests performed as part of an obstetrical care service are not reimbursed in addition to the obstetrical care service. Providers may not bill for them as separate procedures.

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**Required Prenatal Services** 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; and
- Plan of treatment.

---

**Other Prenatal Services** 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 HIV counseling and testing; and
- Screening of all pregnant women for tobacco use with provision of smoking cessation counseling and appropriate treatment as needed.

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**Obstetrical Services**, continued

**Prenatal Visit Frequency**

Prenatal visits are limited to a maximum of 10 for low-medical risk recipients. Prenatal care is prorated, based on an average standard of 10 visits for a low-medical risk.

Effective with dates of service on or after October 16, 2003, the procedure code is H1000.

Payment for prenatal care is based on a total amount for complete care. Reimbursement for the 10 is the maximum reimbursement for the full course of prenatal care. If additional visits are provided, payment is considered already made in full. The provider may not bill the additional visits to Medicaid or the recipient.

To prevent claims denying inappropriately, 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.

**Florida's Healthy Start Prenatal Risk Screening**

*Effective with dates of services on or after October 16, 2003.*

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 10 prenatal visit limit for a low-medical risk pregnancy.

**Obstetrical 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.

Healthy Start Prenatal Risk Screening forms may be obtained from the local county health department.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for a copy of Florida's Healthy Start Prenatal Risk Screening form.

**Delivery Services**

Delivery care services include:

- Labor management;
- Fetal monitoring;
- Vaginal delivery of neonate;
- Delivery of placenta;
- Episiotomy or vaginal repair; and
- Family planning counseling.

**Delivery Services Include Postpartum Services**

Delivery procedure code 59410 includes immediate postpartum services within the delivery reimbursement.

**Supplies and Materials**

Medicaid reimburses licensed midwives for supplies and materials used in conjunction with a home delivery (procedure code S8415).

**Obstetrical Services**, continued

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**Labor Management Services**

Medicaid reimburses birth centers for labor management for recipients who labor at the birth center and are then transferred to the hospital for delivery. Medicaid reimburses licensed midwives for labor management for recipients who labor at home and are then transferred to the hospital for delivery.

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**Post-Delivery Services**

Post-delivery services are provided to the recipient immediately after delivery. The length of the service is determined by the recipient's condition and is at the discretion of the health care provider.

Medicaid reimburses only one post-delivery recovery service, per recipient, per pregnancy.

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**Postpartum Services**

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; and
  - Provision of family planning method chosen by recipient.
- 

**Postpartum Visit Frequency**

Medicaid can reimburse for two postpartum visits within 90 days following delivery when medically necessary.

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**Excluded Services**

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.

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**Codes and Fees**

See Appendixes A and B in this handbook for a list and description of procedure codes and fees.

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## CHAPTER 3

### BIRTH CENTER AND LICENSED MIDWIFE SERVICES PROCEDURE CODES

#### **Overview**

#### **Introduction**

This chapter describes the procedure codes for Medicaid reimbursable services that must be used by birth centers and licensed midwives who do not practice in a birth center.

#### **In This Chapter**

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-1
How To Read The Fee Schedule	3-3
Modifiers and Their Descriptions	3-4
Pricing Modifiers	3-5

Note: See the Florida Medicaid Provider Reimbursement Schedule for the fee schedules. The Reimbursement Schedule is available on the CD-Rom and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Fees.

#### **Reimbursement Information**

#### **Procedure and Diagnosis Code Origination**

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes, Level 1 and Level 2. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. CPT codes and descriptions are copyright 2005 by the American Medical Association. All rights reserved.

Level 1 procedure codes (CPT) are a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five digit numeric code.

Level 2 procedure codes are national codes usually used to describe medical services and supplies. They are distinguished from Level 1 codes by beginning with a single letter (A through V) followed by four numeric digits.

**Reimbursement Information**, continued

**Procedure and  
Diagnosis Code  
Origination,**  
continued

Effective with HIPAA implementation, in compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.

All previously used "local codes" can no longer be processed by the Florida Medicaid claims processing system for Medicaid payment for dates of service after HIPAA implementation. For dates of services prior to HIPAA implementation, the provider must use procedure codes that were payable at that time. Please refer to Appendixes A and B for the valid codes for Florida Medicaid services effective with HIPAA implementation.

**Diagnosis Code**

A diagnosis code is required on the CMS-1500 claim form for all medical procedures. Use the most specific code available. Fourth and fifth digits are required when available.

**Copayment**

Medicaid recipients, unless they are exempt, are responsible to pay a copayment of \$2.00, per birth center, per day, for gynecological services.

Pregnant recipients when the services relate to the pregnancy or to any other medical condition that may complicate the pregnancy or conditions or complications of the pregnancy extending through the end of the month in which the 60-day period following termination of the pregnancy ends are exempt from the copayment.

Note: See Chapter 1 in the Medicaid Provider General Handbook for categories of recipients and services that are exempt from the copayment.

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**How To Read The Fee Schedule**

**Introduction**

Specific CPT codes are reimbursed by Medicaid to birth centers and licensed midwives. These CPT codes are listed on the fee schedules. The fee schedules are described below.

Note: See Appendix A in this chapter for the Birth Center Fee Schedule. See Appendix B in this chapter for the Licensed Midwife Fee Schedule.

**Description**

The fee schedule is a table of columns listing CPT and HCPCS Level II procedure codes, their descriptors, and other information pertinent to each code. The codes are listed in numeric order. The numeric listing is followed by the J codes.

The following information explains the fee schedule columns, reading from left to right.

**Code**

The number in this column identifies the procedure being billed.

**Code Description**

The information in this column describes the service or procedure associated with the procedure code. Medicaid providers are instructed to refer to the current CPT or HCPCS Level II book for a complete description for billing purposes. The CPT and HCPCS Level II books include identifying codes and descriptions for reporting medical services and procedures.

**Max Fee**

The fee in this column is the maximum allowable amount Medicaid will pay to birth centers or licensed midwives for that procedure.

**Surgery Follow-Up Days (FUD)**

The number in this column designates the number of days following the date of surgery during which birth center or licensed midwife services are included in the surgical fee and cannot be billed separately.

**Units**

The number in this column indicates the number of units of service that may be billed on one claim line.

**R**

Identifies a 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 be submitted with the claim.

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## ***Modifiers and Their Descriptions***

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### **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 payment may be determined.

There are two different types of modifiers that birth centers and licensed midwives use: pricing modifiers and local-code modifiers. The two types of modifiers are described below.

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### **Pricing Modifiers**

The first type of modifiers is pricing modifiers. Pricing modifiers are used with the procedures listed in the fee schedule to affect the procedure code's fee or cause a claim to pend for review. The provider is required to use pricing modifiers under certain circumstances described in Chapter 2 of this handbook or in the pricing modifiers' definitions in this section.

The pricing modifiers are 22, 25, 51, and 99.

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### **Local-Code Modifiers**

The second type of modifiers is "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.

Birth centers and licensed midwives use "local-code modifiers" with procedure codes for family planning and obstetrical services.

The procedure codes with local-code modifiers are listed in Appendix C, Local Code to National Code Crosswalk and 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.

Note: Please refer to Chapter 5 in the Florida Medicaid Provider General Handbook for Medicaid policy regarding provider abuse.

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**Modifiers and Their Descriptions**, continued

**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.

Entering pricing modifiers: Enter the pricing modifier in the first Modifier field on the claim form. If more than one pricing modifier is applicable, enter the multiple pricing modifier 99. See Modifier 99 in this chapter for the full requirements.

Entering local-code modifiers: Some procedures require two local-code modifiers. Enter the first local-code modifier listed on the crosswalk in the first Modifier field on the claim form, and enter the second local-code modifier in the second Modifier field.

Entering a pricing modifier and local-code modifier: If a situation requires both a pricing modifier and local-code modifier, enter the pricing modifier in the first Modifier field on the claim form, and enter the local-code modifier in the second Modifier field.

**By Reports**

By report procedures are procedures that must be approved or manually priced. Relevant reports must be submitted with the claim. Procedure codes with 99 modifiers, procedure codes marked "R" on the fee schedules, and other procedures specified in this handbook are approved and priced by report.

**Pricing Modifiers**

**Introduction**

The modifiers listed in this section are the valid pricing modifiers, which are used with the procedures listed in the fee schedule to affect the procedure code's payment or cause the claim to pend for review.

**22 Unusual Services**

Use this modifier only when a provided service(s) exceeds the usual service as described in the CPT. Modifier 22 requires the claim to be reviewed by a Medicaid medical consultant for appropriate pricing. Documentation must be submitted that clearly indicates why modifier 22 is being used.

Additional documentation will need to be submitted along with routine documentation to indicate why additional reimbursement is being requested: examples include explanation of increased complexity of the service or unexpected complications during a service.

Failure to submit the requested documentation can result in denial of the service, request for more information, or no increase in reimbursement.

Inappropriate use of this modifier can result in claim denial or delayed reimbursement time.

**Pricing Modifiers**, continued

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**25  
Separate  
Evaluation and  
Management  
Services**

Use modifier 25 for a significant, separately identifiable evaluation and management service by the same provider or provider group on the same day of the procedure or other service. A provider may need to indicate that on the same day a procedure or service identified by a procedure code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed.

The evaluation and management service may be prompted by the symptom or condition for which the procedure or the service was provided. As such, different diagnoses are not required for reporting of the evaluation and management services on the same date. This circumstance is reported by adding the modifier 25 to the appropriate level of evaluation and management service.

This modifier is not used to report an evaluation and management service that resulted in a decision to perform surgery.

A report must be submitted with the claim. This modifier requires the claim to be reviewed by a Medicaid medical consultant for justification of the evaluation and management service and appropriate pricing.

---

**51  
Multiple  
Procedures**

Modifier 51 is used if more than one surgical procedure is performed in a single operative session. This modifier requires an operative report and documentation be submitted with the claim.

The claim will be reviewed by a Medicaid medical consultant for appropriate pricing.

The primary procedure is determined by the diagnosis and purpose of surgery. The primary procedure must be indicated first. Do not use modifier 51 with the primary procedure.

Multiple surgical procedures performed on one patient on the same day are reimbursed as follows:

- 100 percent of max allowable fee for primary surgical procedure;
- 50 percent of max allowable fee for secondary surgical procedure; and
- 25 percent of max allowable fee of all other surgical procedures.

Payment for claims submitted with only one procedure code and the modifier 51 will be reimbursed at a reduced rate.

This modifier cannot be appended to "add-on" codes.

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**Pricing Modifiers**, continued

**99  
Multiple Modifiers**

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Modifier 99 is used when two or more pricing modifiers are applicable to one procedure code line. Do not use modifier 99 when the procedure has two local-code modifiers.

When modifier 99 is used, there must be an indication made on the first page of the submitted documentation indicating the specific individual modifiers that 99 represents (Example: 99=80, 51). Absence of this indication can result in a claim line denial.

Use of this modifier requires the claim to be reviewed by a Medicaid medical consultant for appropriate pricing. Pricing will be based on the use of valid modifiers applicable to the procedure code.

Note: See Modifiers and Their Descriptions in this chapter for additional information on using modifier 99.

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## APPENDICES A, B AND C

RESERVED

Note: See the Florida Medicaid Provider Reimbursement Schedule for the fee schedules. The Reimbursement Schedule is available on the CD-Rom and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Fees.







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