



Florida Medicaid

Registered Nurse First Assistant Services Coverage and Limitations Handbook

Agency for Health Care Administration





JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

April 1, 2005

Dear Registered Nurse First Assistant Provider:

The Florida Medicaid Registered Nurse First Assistant Services Coverage and Limitations Handbook was updated effective January 2005. The handbook was revised to remove the 2004 fee schedule. 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
Appendix B, 2004 Fee Schedule, was 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

REGISTERED NURSE FIRST ASSISTANT SERVICES COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

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.

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.

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 Florida Medicaid Provider General Handbook.

UPDATE NO.	EFFECTIVE DATE
Jan2000—Revised Handbook	January 2000
Jan2001—Revised Handbook	January 2001
Update 02-1—Replacement Pages	January 2002
Update 02-02—Replacement Pages	April 2002
Jan2004—Revised Handbook	January 2004
Jan2005—Remove Appendix B	January 2005

REGISTERED NURSE FIRST ASSISTANT COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

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:

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Handbook Use and Format

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.

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.

Recipient The term "recipient" is used to describe an individual who is eligible for Medicaid.

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.

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.

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

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

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

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

Characteristics of the Handbook

Format

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

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.

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.

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.

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.

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 No." and the "Effective Date."

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

REGISTERED NURSE FIRST ASSISTANT SERVICES PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter defines who is an eligible registered nurse first assistant (RNFA) and describes the provider qualifications, enrollment requirements, and general program requirements.

Background

The federal authority governing the provisions, requirements, benefits, and service payment of the Registered Nurse First Assistant Services Program is Title 42, Code of Federal Regulations (C.F.R.), Part 440.60.

The state authority for the licensing of the RNFA providers is Chapter 464, Florida Statutes (F.S.).

The Florida Medicaid Registered Nurse First Assistant Services Program is authorized by Chapter 409, F.S., and Chapter 59G, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

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Purpose and Definition

Purpose

The Registered Nurse First Assistant Services Program reimburses registered nurse first assistants (RNFAs) for providing assistance at surgery to Medicaid recipients.

Purpose and Definition, continued

Purpose of This Handbook

This handbook is intended for use by RNFAs who provide services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General Handbook, which contain 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.

RNFA Definition

An RNFA is a health care professional who is certified in perioperative nursing to provide assistance at surgery as outlined in Chapter 464, F.S.

Provider Qualifications

RNFA Provider Qualifications

To enroll as a Medicaid provider, an RNFA must be licensed as a registered nurse first assistant as defined in Chapter 464, F.S.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for additional information on out-of-state providers and services.

Provider Enrollment

General Enrollment Requirements

RNFAs must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, RNFAs must follow the specific enrollment requirements that are listed in this section.

Qualified at the Time of Enrollment

RNFAs must meet all the provider requirements and qualifications, and their practice must be fully operational before they can be enrolled as Medicaid providers.

RNFA Group Providers

Two or more enrolled Medicaid 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.

Provider Enrollment, continued

Multiple Locations

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.

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 800-377-8216, or from its website at <http://floridamedicaid.acs-inc.com>.

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

RNFA in a Physician Group

If an 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 RNFA must enroll as a treating provider within the group.

If the services rendered by an RNFA who is employed by or under contract to a physician are billed with the RNFA as the treating provider, the services must be provided in accordance with the policies contained in this handbook.

Provider Requirements

General Requirements

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

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). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with 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 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 fiscal agent EDI help desk at 800-829-0218.

RNFA Supervision

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, and
- Reviews, signs and dates the medical record.

Services provided by an RNFA must be within the specialty of the supervising physician.

RNFAs Employed by Facilities

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

CHAPTER 2

REGISTERED NURSE FIRST ASSISTANT SERVICES COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Registered Nurse First Assistant Program. It also describes limited and excluded services.

Topic Roster

This chapter contains:

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General Services Requirements and Limitations

Covered Services

Only those services designated in this chapter and listed on the Registered Nurse First Assistant Services Procedure Codes and Maximum Fee Schedule in Appendix B can be reimbursed by Medicaid to a registered nurse first assistant (RNFA).

Limitations

Certain services are designated with limitations by diagnosis or other limitations in Appendices A and B. Other service limitations that are listed the Physician Services Coverage and Limitations Handbook also apply.

Note: The Physician Services Coverage and Limitations Handbook is available on the Medicaid fiscal agent’s website at <http://floridamedicaid.acs-inc.com>.

General Services Requirements and Limitations, continued

**Medically
Necessary**

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- 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;
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Be reflective of the level of service 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.

Medically necessary or medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

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 medical necessity or a covered service.

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

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.

Service Components

The surgical payment rate for an RNFA only includes assistance at surgery.

Surgery Authorization

Surgery that requires prior authorization when performed in any setting other than the inpatient hospital is identified in the Registered Nurse First Assistant Services Procedure Codes and Maximum Fee Schedule in Chapter 3, Appendix B by a "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 following the same procedure used for prior authorization.

If the services does not require prior authorization by the peer review organization, but is identified as "PA" in the "Spec" column, a prior authorization is still required by Medicaid for the physician claim to be reimbursed.

The RNFA may obtain prior authorization or use the same authorization number as the surgeon.

Note: Refer to Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for prior authorization procedures.

Surgery Service, continued

**Child Health
Check-Up
Referrals**

Surgery can be performed without prior authorization for recipients under age 21 if the following occurred within 12 months of the surgical procedure:

- The recipient had a Child Health Check-Up screening, and
- Was referred for the condition requiring the surgery.

Note: See the Florida Medicaid Child Health Check-Up Coverage and Limitations Handbook for information on Child Health Check-Up referrals. The handbook is available on the Medicaid fiscal agent's website site at <http://floridamedicaid.acs-inc.com>.

**Unlisted
Procedures**

Unlisted procedures or procedure codes ending in 99 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 that an operative report documenting the service provided be attached to the claim for medical consultant review and pricing.

**Incidental
Procedures**

Procedures performed as part of a surgical procedure that are secondary, minor, non-essential, and incidental surgical procedures are not separately reimbursable services.

Example: Lysis of adhesions or appendectomy is not a reimbursable service when performed incidental to an abdominal surgical procedure.

Surgery Service, continued

Assistant at Surgery

Only one assistant surgeon (physician, physician assistant or registered nurse first assistant) may be reimbursed per operative session for limited surgical procedures.

Assistant surgeons may not be reimbursed for minor procedures.

Note: See Appendix B, Registered Nurse First Assistant Services Procedure Codes and Maximum Fee Schedule, for the procedure codes that allow the use of assistant surgeons.

Gastric Bypass

Gastric bypass surgery is not reimbursable for a primary diagnosis of morbid obesity without an accompanying co-morbidity condition. Gastric bypasses require prior authorization from the Peer Review Organization prior to admission.

Note: Refer to Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for prior authorization requirements.

Surgery Services, continued

Cosmetic Surgery Cosmetic surgery is not reimbursable.

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 abortions for one of the following reasons:

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

Abortion procedures are reimbursed only for the following 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 attached to the CMS-1500 claim form.

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

Note: See Chapter 2 in the Florida Medicaid Reimbursement Handbook, CMS-1500 for a copy of the Abortion Certification Form and the instructions for completing the form.

Hysterectomies Hysterectomies are reimbursable when they are not performed for the purpose of rendering a recipient permanently sterile or incapable of reproducing. Some hysterectomy procedures must meet specific requirements before payment can be made.

Surgery Services, continued

Hysterectomy Reimbursement

To receive Medicaid reimbursement for a hysterectomy procedure code, the primary diagnosis must be listed in Chapter 3, Appendix A, Hysterectomy Diagnosis Codes.

The claim must be submitted on a paper CMS-1500 claim form, because either the Hysterectomy Acknowledgment Form or the Exception to Hysterectomy Acknowledgment Requirement Form must be attached to it.

If a recipient requires a medically necessary hysterectomy for a primary diagnosis code not listed in Appendix A, the physician must obtain prior authorization for the inpatient admission from the peer review organization in addition to all the other requirements.

If the service is performed in a setting outside the inpatient hospital, a prior authorization is required by Medicaid for the physician claim to be reimbursed.

Note: Refer to Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for prior authorization requirements.

Hysterectomy Acknowledgment Form

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

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for a copy of the Hysterectomy Acknowledgment Form.

Exception to Hysterectomy Acknowledgment Requirement Form

An Exception to Hysterectomy Acknowledgment Requirement Form may be attached to the CMS-1500 claim form in lieu of the Hysterectomy Acknowledgment Form, if any of the conditions listed below are present:

- The recipient is sterile. The cause of the sterility must be identified;
- The procedure was performed under a life-threatening situation. The doctor must describe the emergency; or
- The recipient is post-menopausal.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for a copy of the Exception to Hysterectomy Acknowledgment Requirement Form.

Surgery Services, continued

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 attached to the claim for payment.

Recipient Requirements for Non-Hysterectomy Sterilization

Sterilization procedures performed in the inpatient and outpatient hospital setting are for the purpose of rendering a recipient (male or female) incapable of reproducing and are voluntary procedures reimbursable by Medicaid. The following criteria must be met:

- The recipient must be at least 21 years old at the time of signing the consent form;
- The recipient must be mentally competent and not institutionalized in a correctional, penal, rehabilitation facility or a facility for mental diseases; and
- A Florida Medicaid Sterilization Consent Form must be correctly completed and signed at least 30 days prior to sterilization, and a copy must be attached to all claim forms for reimbursement. No other form is acceptable.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for a copy of the Sterilization Consent Form and the instructions for completing it.

Reconstructive Surgery Following Mastectomy

Medicaid reimburses reconstructive breast surgery following a medically necessary mastectomy as well as surgery to re-establish symmetry of the opposite breast. A prior authorization is not required; however, the procedure codes require the attachment of an operative report for medical review.

All procedures performed in the inpatient hospital are subject to approval from the peer review organization for the hospital stay.

Reduction Mammoplasty

Reduction mammoplasty, procedure code 19318, requires prior authorization from the Medicaid medical consultant when performed outside of the hospital setting.

Procedure Codes and Fees

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

CHAPTER 3

REGISTERED NURSE FIRST ASSISTANT SERVICES PROCEDURE CODES AND SPECIAL SITUATION CODES

Overview

Introduction This chapter describes the procedure codes for Medicaid reimbursable services that must be used by registered nurse first assistants (RNFAs) providing services to eligible recipients.

In This Chapter This chapter contains:

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Procedures Limited to Specific Diagnosis Codes	3-6
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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 Codes The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes. 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: CPT is a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five digit numeric code.

Effective October 16, 2003, 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.

Reimbursement Information, continued

Diagnosis Codes 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 Recipients, unless they are exempt, are responsible to pay a copayment of \$2.00, per provider or group provider, per day for RNFA services.

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

How to Read the RNFA Procedure Code and Maximum Fee Schedule

Introduction Specific CPT codes are reimbursed by Medicaid to RNFAs. These CPT codes are listed on the RNFA fee schedule. The RNFA fee schedule is described below.

Note: See Appendix B in this chapter for the RNFA Procedure Codes and Maximum Fee Schedule.

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 book for a complete description for billing purposes. The CPT book includes identifying numeric codes and descriptions for reporting medical services and procedures.

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

Max Fee Age 00-20 The fee in this column is the maximum allowable amount Medicaid will pay for that procedure for Medicaid recipients under the age of 21.

Max Fee 21+ The fee in this column is the maximum allowable amount Medicaid will pay for that procedure for Medicaid recipients age 21 and older.

How to Read the RNFA Procedure Code and Maximum Fee Schedule, continued

Units

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

Spec

An alphabetic code in this column indicates special requirements for submission of a claim for that procedure. Any of the alphabetic codes described below may appear in this column.

AS

Identifies a procedure code that requires billing with a modifier 80 when an assistant at surgery is requesting reimbursement. RNFAs are reimbursed only for these procedure codes.

PA

Identifies a procedure code for which written prior authorization from the Medicaid office for services performed in a setting outside of the inpatient hospital is required before performing the service. Prior Authorization forms are available from the Medicaid fiscal agent.

Note: See Surgery Services in Chapter 2 of this handbook for exceptions to the prior authorization requirement for surgery procedures.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for the prior authorization procedures.

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. A report must be submitted with the claim.

Note: See Assistant Surgeon Modifiers, By Report in this chapter for additional information on submitting a report with a claim.

A

Identifies an abortion or abortion-related code. An Abortion Certification Form must be attached to the claim. The forms are available from the Medicaid fiscal agent.

Note: See Abortion Certification Form in Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for additional information.

How to Read the RNFA Procedure Code and Maximum Fee Schedule, continued

B	Identifies a procedure code that allows billing as a bilateral procedure by using a modifier 50.
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S	Identifies a sterilization or sterilization-related procedure code. A Sterilization Consent Form must be attached to the claim. The forms are available from the Medicaid fiscal agent.
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Note: See Sterilization Consent Form in Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for additional information.

H	Identifies a hysterectomy or hysterectomy-related procedure code. The appropriate hysterectomy form must be attached to the claim. The forms are available from the Medicaid fiscal agent.
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Note: See Hysterectomy Acknowledgment Form or Exception to Hysterectomy Acknowledgement Requirement Form in Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for additional information.

Assistant Surgeon Modifiers

Introduction	<p>A modifier is a two-digit number that is placed in item 24D, Modifier, on the CMS-1500 claim form.</p> <p>To be reimbursed for providing assistance at surgery, an RNFA must attach modifier 80 to the surgery procedure code. If an additional modifier is needed, enter modifier 99 on the claim line and list the other applicable modifiers on the documentation that is attached to the claim, as described below in By Report.</p> <p><u>Note:</u> See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS 1500 for information on entering modifiers on the claim form.</p>
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By Report	<p>By report procedures are procedures that must be approved or manually priced. They must be submitted on paper claims with relevant reports attached. Procedure codes with 99 modifiers, procedure codes marked "R" on the RNFA Procedure Codes and Fee Schedule, and other procedures specified in this handbook are approved and priced by report.</p>
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Assistant Surgeon Modifiers, continued

**50
Bilateral
Procedure**

Modifier 50 is used 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. Do not bill the procedure code on one claim line and then identify the same procedure code on the next claim line with modifier 50.

For claims requiring medical review, a report must be attached documenting the service.

This modifier reimburses at 150 percent of the maximum allowable procedure code fee 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 identifies the service as “unilateral or bilateral” in the descriptor.

**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 attached to 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.

**52
Reduced Services**

Modifier 52 is used under certain circumstances when a service or procedure is partially reduced or eliminated at the physician’s discretion.

Reimbursement rate is 90 percent of the maximum allowable fee of the procedure code.

Modifier 52 must be used to report reduced services without disturbing the identification of the basic service.

Assistant Surgeon Modifiers, continued

**80
Assistant
Surgeon**

Modifier 80 is used to identify procedures that require medically necessary surgical assistant services.

Only one assistant surgeon or registered nurse first assistant may be reimbursed per surgical procedure.

Modifier 80 reimburses a registered nurse first assistant 12.8 percent of the maximum allowable fee for the procedure code.

Multiple surgical procedures are reimbursed as follows:

- 12.8 percent of 100 percent of the maximum allowable fee for primary surgical procedure (first claim line),
- 12.8 percent of 50 percent of the maximum allowable fee for the second surgical procedure, and
- 12.8 percent of 25 percent of the maximum allowable fee for all other surgical procedures.

**99
Multiple Modifiers**

Modifier 99 is used when two or more modifiers are applicable to one procedure code line.

When modifier 99 is used, there must be an indication made on the first page of the submitted documentation indicating the 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.

Procedures Limited to Specific Diagnosis Codes

**Hysterectomy
Diagnosis Codes**

Specific diagnosis codes are required for reimbursing hysterectomies.

If a recipient requires a medically necessary hysterectomy for a diagnosis code that is not listed, the provider must obtain prior authorization from Medicaid medical consultant before performing the procedure.

Note: See Appendix A in this chapter for a list of the diagnosis codes.

APPENDIX A

HYSTERECTOMY DIAGNOSIS CODES

Hysterectomy Diagnosis Codes

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
617.4	Endometriosis of rectovaginal septum and vagina

Hysterectomy Diagnosis Codes, continued

DX Code	Description
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	Post-menopausal 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

APPENDIX B REGISTERED NURSE FIRST ASSISTANT SERVICES

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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