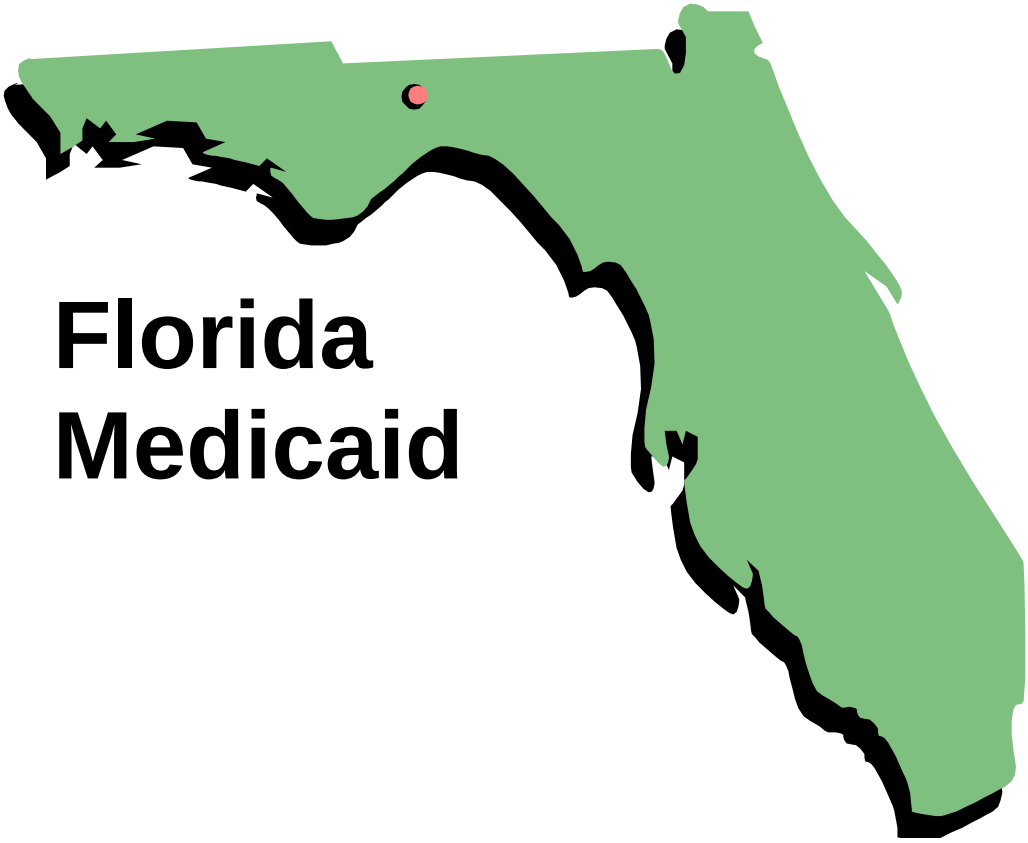

Florida Medicaid

BIRTH CENTER AND LICENSED MIDWIFE SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

May 2014

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

BIRTH CENTER AND LICENSED MIDWIFE SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
UPDATE LOG

How to Use the Update Log

Introduction

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

Obtaining the Handbook Update

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

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

Explanation of the Update Log

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

Update describes the change that was made.

Effective Date is the date that the update is effective.

UPDATE	EFFECTIVE DATE
Revised Handbook	January 2000
Revised Handbook	January 2001
Replacement Pages	January 2002
Replacement Pages	March 2003
Revised Handbook	January 2004
Errata to January 2004	January 2004
Remove Appendices A, B and C	January 2005
Replacement Handbook	May 2014

BIRTH CENTER AND LICENSED MIDWIFE SERVICES COVERAGE AND LIMITATIONS HANDBOOK TABLE OF CONTENTS

Chapter/Topic **Page**

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

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

Background

There are three types of Florida Medicaid handbooks:

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

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

Federal and State Authority

The following federal and state laws govern Florida Medicaid:

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

In This Chapter

This chapter contains:

Handbook Use

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

Characteristics of the Handbook

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

Handbook Updates

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

CHAPTER 1
QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

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

Legal Authority

Birth center and licensed midwife services are authorized by section 409.906(4), Florida Statutes (F.S.), and in Rule 59G-4.030, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

Purpose and Definitions

Medicaid Provider Handbooks

This handbook is intended for use by birth centers and licensed midwife providers that render services to eligible Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid program.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. All of the Florida Medicaid provider handbooks are incorporated by reference in Rule Division 59G, F.A.C.

Purpose and Definitions, continued

Birth Center	A licensed facility that is not an ambulatory surgical center, a hospital, or location within a hospital in which births are planned to occur away from the mother's usual place of residence following a normal, uncomplicated, and low-risk pregnancy.
Licensed Midwife	Licensed person age 21 years and older other than a licensed physician or certified nurse midwife that supervises the birth of a child.

Qualifications

Birth Center	A birth center must meet all state licensure requirements pursuant to the guidelines set forth in Chapter 408, F.S., and Rule 59A-11, F.A.C., and Chapter 383, F.S.
Licensed Midwife	A licensed midwife must meet all state licensure requirements pursuant to the guidelines set forth in Chapter 467, F.S.

Enrollment

General Requirements	Birth center and licensed midwife providers must meet the general enrollment requirements contained in the Florida Medicaid Provider General Handbook and also be responsible for complying with the provisions contained in this section. Note: For more information regarding enrollment, see the Florida Medicaid Provider General Handbook.
Child Health Check-Up	Providers must enroll in Medicaid with a Child Health Check-Up provider contract on file to be reimbursed for Child Health Check-Up screening (newborn evaluation only). Note: For more information regarding Child Health Check-Up newborn screening, see the Florida Medicaid Child Health Check-Up Coverage and Limitations Handbook.

CHAPTER 2
COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

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

In This Chapter

This chapter contains:

General Coverage Information

Medical Necessity

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

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

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

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program and not experimental or investigational;
4. 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
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

General Coverage Information, continued

Medical Necessity, continued	"(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services, does not, in itself, make such care, goods or services medically necessary or a covered service."
Exceptions to the Limits (Special Services) Process	As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). Services for recipients under the age of 21 years in excess of limitations described within this handbook or the associated fee schedule may be approved, if medically necessary, through the process described in the Florida Medicaid Provider General Handbook.
Providers Contracted with Medicaid Managed Care Plans	The service-specific Medicaid coverage and limitations handbooks provide the minimum requirements for all providers. This includes providers who contract with Florida Medicaid managed care plans (e.g., provider service networks and health maintenance organizations). Providers shall comply with all of the requirements outlined in this handbook, unless otherwise specified in their contract with the managed care. The provision of services to recipients enrolled in a Medicaid managed care plans shall not be subject to more stringent criteria or limits than specified in this handbook.
Birth Center Covered Services	Florida Medicaid reimburses birth centers for providing Medicaid-covered services appropriate to the care of Medicaid recipients including low-risk pregnancies, antepartum, deliveries, and the postpartum period.
Licensed Midwife Covered Services	Florida Medicaid reimburses licensed midwives for providing Medicaid-covered services appropriate to the care of Medicaid recipients including low-risk pregnancies, antepartum, deliveries, and the postpartum period.

General Coverage Information, continued

Presumptively Eligible Pregnant Women (PEPW)	During the period of presumptive eligibility, Medicaid will reimburse for services provided in the birth center or home prior to delivery. Medicaid does not reimburse inpatient hospital services for presumptively eligible pregnant women. Note: For additional information on Presumptively Eligible Pregnant Women, see the Florida Medicaid Provider General Handbook.
Limitations	Certain services are designated with limitations by diagnosis or other limitations in the Birthing Center Fee Schedule and Licensed Midwife Services Fee Schedule. Other limitations specified in this handbook also apply.
Reimbursement	Medicaid will reimburse practitioners including licensed midwives, licensed physicians, and certified nurse midwives separately for professional services provided in a licensed birth center or in the recipient's place of residence. Certified nurse midwives and physicians must follow the requirements in the Florida Medicaid Practitioner Services Coverage and Limitations Handbook. Medicaid will not reimburse the birth center and the treating practitioner for the same service provided to the same recipient on the same date, as this would constitute duplicate payment. Medicaid will reimburse the birth center a facility fee for deliveries provided within the birth center. The facility fee is intended to reimburse the birth center for costs related to equipment, staff, and general operational expenses incurred during a birth center delivery.

Evaluation and Management Services

Introduction	Evaluation and management (E&M) services are face-to-face provider and recipient encounters.
Office Visits	Medicaid reimbursement for licensed midwife services is limited to obstetrical services as specified on the Licensed Midwife Fee Schedule. Birth centers may not bill for other services, including evaluation and management visits and family planning services provided by a licensed midwife.
Established Patient Visit	An established patient is one who has received professional services from the provider within the past three years.

Family Planning Services

Introduction	Medicaid reimburses for covered family planning services provided in the birth center for Medicaid-eligible persons of childbearing age who desire family planning services and supplies. The services are for the purpose of enabling a recipient to voluntarily plan family size or plan the length of time between births. Medicaid recipients who choose to receive family planning services must be provided the freedom to choose any method of family planning in accordance with federal law.
Covered Service	Medicaid reimburses family planning services provided in birth centers only by qualified practitioners. Practitioners should check their practitioner-specific Medicaid fee schedule to determine reimbursement. Note: For more information on family planning services, see the Florida Medicaid Practitioner Services Coverage and Limitations Handbook.

Family Planning Services, continued

Laboratory Tests	Medicaid reimburses the following laboratory tests for a new or established family planning visit, when indicated: • Hemoglobin or Hematocrit • Urinalysis • Screening for sexually transmitted infections; • Rubella titer • Tuberculin skin test • Cervical cancer screening (for example, Papanicolaou (PAP) and human papilloma virus testing) Medicaid reimburses for a tuberculin skin test separately, in addition to the family planning service. Medicaid will reimburse the pathologist or independent laboratory providing the rubella titer, cervical cancer screening, and sexually transmitted infection screening tests. The practitioner in the birth center may not bill Medicaid for these services.
Place of Service	Medicaid does not reimburse family planning services provided at the recipient's residence.
Family Planning Waiver (FPW) Services	The family planning waiver (FPW) covers family planning services up to 24 months to eligible women, ages 14 through 55. Eligibility for the FPW is limited to family incomes at or below 185 percent of the Federal Poverty Level who are not otherwise eligible for Medicaid, Children's Health Insurance Program (CHIP), or health insurance coverage that provides family planning services; and who have lost Medicaid eligibility within the last two years. This includes women losing Medicaid managed care coverage. Note: For more information on family planning waiver services, see the Florida Medicaid Provider General Handbook and the Practitioner Services Coverage and Limitations Handbook.
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.
Licensed Midwife	Medicaid does not reimburse family planning services provided by licensed midwives.
Natural Methods	Medicaid does not reimburse for training on use of natural family planning methods.

Medication Services

Introduction	Medicaid coverage for medication services for practitioners include injectable, implanted, and other pharmaceutical services purchased and provided by the practitioner.
Covered Service	Medicaid will reimburse for medications purchased and administered in the birth center or in the recipient's home during home deliveries. The provider must bill using the appropriate National Drug Code (NDC) and Health Common Procedure Coding System code billing units. Birth center providers must check their respective fee schedules to ensure Medicaid coverage of medications.
E&M Services	Medicaid will reimburse an E&M service in addition to the administration of an injectable or implanted medication, if the visit is for a separate and identifiable service and the services are documented in the medical record.
Service Limitations	Medicaid will only reimburse medications for which the manufacturer has a federal rebate agreement per section 1927 [42 U.S.C.1396r-8]. The current list of manufacturers who have rebate agreements is available at www.ahca.myflorida.com. From the Site Menu, under the Division of Medicaid, select Pharmacy Services. Medicaid may exclude or otherwise restrict coverage of a drug in accordance with section 1927 of the Social Security Act. Outpatient-administered medications fall under the jurisdiction of the Pharmaceutical and Therapeutics Committee and their recommendations, and AHCA's decisions associated with the Preferred Drug List (PDL). See the Florida Medicaid Prescribed Drug Services Coverage and Limitations Handbook for further clarification.
Off-label, and Investigational Medications	Medicaid does not reimburse for investigational or experimental drugs as defined in Rule 59G-1.010, F.A.C.
Clinical Trials	Medicaid does not cover any aspect of clinical trials, including radiology follow-up scans, laboratory procedures and any other medical testing, if the drugs are provided free of charge to the recipient.

Newborn Assessment Services

Introduction	A newborn assessment is performed after delivery to verify the physical status of the infant.
Covered Service	Medicaid reimburses only one initial newborn assessment, per recipient, per lifetime.
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.
Vitamin K	Medicaid reimburses for the purchase and injection of vitamin K into the newborn.
Birth Center Referral for Newborn Hearing Screening	The newborn hearing screening is for the purpose of testing all Medicaid-eligible newborns for hearing impairment to alleviate the adverse effects of hearing loss on speech and language development, academic performance, and cognitive development. Each state-licensed birth center that provides maternity and newborn care services must ensure that prior to discharge, all newborns are referred to an authorized conductor of newborn hearing screenings according to Chapter 383, Florida Statutes. 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. Note: For more information on newborn hearing screening, see the Florida Medicaid Hearing Services Coverage and Limitations Handbook.
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. The licensed midwife must refer the baby for an appointment 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.

Obstetrical Services

Introduction

Obstetrical services in a birth center or provided by a licensed midwife include prenatal, delivery, and postpartum care for a low medical risk pregnant Medicaid recipient.

Covered Services

Reimbursement for prenatal care is prorated based on a total amount for complete care. Reimbursement for the ten visits is the maximum reimbursement for the full course of prenatal care, for a pregnancy that continues to be determined low-risk. 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.

Both birth centers and licensed midwives providers are required by their respective licenses to initially determine through an assessment that a woman is expected to have a low-risk pregnancy and delivery. Providers shall regularly evaluate the pregnancy to assure that the outcome is expected to remain a low-medical risk. If at any time during the antepartum, intra-partum or postpartum period, it is determined that the woman or fetus is considered at risk, the provider must refer the patient to a physician for continued care.

Limitations

Medicaid does not reimburse for a prenatal visit and a delivery service on the same day, same recipient, same practitioner.

Providers may not bill office visit codes for routine prenatal care.

Laboratory Specimens

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

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

Obstetrical Services, continued

Documentation Requirements Per Visit

The following components must be provided at each prenatal visit and documented in the recipient's medical record:

- Physical examination
- Recording of weight and blood pressure
- Recording of fetal heart tones when clinically appropriate
- Urinalysis and collection of specimens (for the laboratory once per pregnancy and at subsequent visits, if appropriate)
- Hemoglobin or hematocrit (once per pregnancy and at subsequent visits, if appropriate)
- Recipient education (if appropriate)
- Plan of treatment

Documentation Requirements During Pregnancy

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

- Initial and subsequent history
- Florida's Healthy Start Prenatal Risk Screening or documentation of refusal
- Offer of testing for sexually transmitted infections (At a minimum to include, chlamydia, gonorrhea, hepatitis B, HIV, counseling and testing syphilis. The provider must offer testing during the initial visit, and again at 28 to 32 weeks gestation. The provider must document a recipient's refusal of testing in the medical record.)
- Screening of all pregnant women for tobacco use (with provision of tobacco cessation counseling and appropriate treatment, as needed)

Florida's Healthy Start Prenatal Risk Screening

The Healthy Start Prenatal Risk Screening should be offered at the first prenatal visit. The prenatal visit that includes completion of the Healthy Start Prenatal Risk Screening is reimbursed once per pregnancy.

Note: For more information on Florida's Healthy Start Prenatal Risk Screening, see the Florida Medicaid Practitioners Coverage and Limitations Handbook.

Obstetrical Services, continued

Florida's Healthy Start Prenatal Risk Screening Form	The practitioner 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 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 in the Florida Department of Health Web site for a copy of the Healthy Start Prenatal Risk Screening available in English, Spanish, and Creole. The Department of Health Web site is www.doh.state.fl.us. Select Floridians and Visitors, then under section Children, Adults and Families and Communities select Healthy Start, scroll down to Healthy Start Screening Forms and Brochures and select the desired form.
Labor Management Services	Medicaid reimburses birth centers for labor management for recipients who labor at the birth center or at home and are then transferred to the hospital for delivery.
Delivery Services	Delivery care services include: • Labor management • Fetal monitoring • Vaginal delivery of neonate • Delivery of placenta • Episiotomy or vaginal repair

Obstetrical Services, continued

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 practitioner.
Postpartum Visit Frequency	Medicaid will reimburse for two postpartum visits within 90 days following delivery.
Postpartum Documentation	The following components of a postpartum office visit must be provided and documented in the recipient's medical record: • Subsequent history and physical exam • Counseling regarding family relationships • Education regarding breast self-exam • Referrals and counseling as indicated • Provision of family planning method (chosen by the recipient)

Excluded Services

General Services	Medicaid does not reimburse birth centers or licensed midwives for the following services: • Operative obstetrics and cesarean sections • General anesthesia and conduction anesthesia • Telephone calls
Urinalysis, Hemoglobin, and Hematocrit	Medicaid does not reimburse for manual or automated urine, hemoglobin, and hematocrit tests performed as part of an evaluation and management visit. The provider may not bill for these as separate procedures.
Infertility	Medicaid does not reimburse for infertility evaluation and treatment.

CHAPTER 3
REIMBURSEMENT AND FEE SCHEDULE

Overview

Introduction

This chapter describes reimbursement and fee schedule information for birth centers and licensed midwives who do not practice in a birth center.

In This Chapter

This chapter contains:

Reimbursement Information

Procedure Codes

The procedure codes listed in this handbook or the Birthing Center Fee Schedule and Licensed Midwife Services Fee Schedule are Healthcare Common Procedure Coding System (HCPCS) Levels I and II. Both levels are part of the nationally standardized code sets.

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

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

Reimbursement Information, continued

Diagnosis Code	A diagnosis code is required on the claim form for all medical procedures. Use the most specific code available.
Birth Center Reimbursement	A Medicaid enrolled birth center will be reimbursed directly from Medicaid according to the Birthing Center Fee Schedule. The birth center may bill code 59409 TC for facility reimbursement. Note: The Birthing Center Services Fee Schedule is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and then select Fee Schedules.
Licensed Midwife Reimbursement	A Medicaid enrolled licensed midwife may be employed by or under contract with a birth center and will be reimbursed by Medicaid directly according to the Licensed Midwife Fee Schedule. In accordance with Title 42, Code of Federal Regulations, section 447.10(g), the practitioner's fee may be reimbursed by Medicaid to the center on behalf of the practitioner, if the center requires that as a condition of the contract or employment. Medicaid licensed midwife covered services are limited to procedures listed on the Licensed Midwife Fee Schedule. Note: The Licensed Midwife Fee Schedule is located on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules.
Prenatal Period	Conditions related to the prenatal period must be billed as prenatal visits using procedure code H1000.
Healthy Start Prenatal Risk Screening	Billing of procedure code H1001 indicates that the recipient agreed to the screening, the provider performed the complete screening, and included the complete screening documentation in the recipient's medical record. If the practitioner completes the Healthy Start Prenatal Risk Screening during the first trimester, the provider should bill procedure code H1001 with modifier TG. H1001 is included in the 10 prenatal visit limit for a low-medical risk pregnancy.

Reimbursement Information, continued

Labor Management Services	Birth centers must bill S4005 for the facility labor management fee when labor management services do not result in a delivery. Practitioners must bill 99354 and 99355 for the professional labor management fee when labor management services do not result in a delivery in the birth center or at home.
Delivery and Postpartum Services	Delivery procedure code 59410 includes immediate postpartum services within the delivery reimbursement.
Post-delivery Services	Medicaid reimburses a facility fee to the birth center when the delivery occurs at the birth center. The birth center may bill for this service using procedure code 59409 TC (birth center facility fee). The facility fee includes post delivery services. Birth centers must not bill 59409 TC when the delivery occurs at another place of service. Medicaid reimburses only one post-delivery recovery service for practitioners who provide services for home births. Practitioners may bill for this service by using procedure code 59430 TH.
Supplies and Materials for Home Delivery	Medicaid reimburses licensed midwives for supplies and materials used in conjunction with a home delivery (procedure code S8415).
Copayment	Medicaid recipients, unless they are exempt, are responsible for a $2.00 copayment, for practitioner services. Note: For more information on copayment, see the Florida Medicaid Provider General Handbook.

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 tables of columns listing CPT and HCPCS Level II procedure codes, their descriptors, and other information pertinent to each code.
Code	The number in this column identifies the procedure being billed.
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.
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.
Fee	The fee in this column is the maximum allowable amount Medicaid will pay to birth centers or licensed midwives for that procedure.
Units	The number in this column indicates the number of units of service that may be billed on one claim line.
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.

Procedure Code Modifiers

Introduction

The modifiers listed in this section are valid pricing modifiers used with the procedure codes listed in the appropriate fee schedule which affect reimbursement or cause the claim to pend for review.

Local Code Modifiers

The Health Insurance Portability and Accountability Act 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 as listed on their respective fee schedules.

The procedure codes with local-code modifiers are listed on the fee schedules. Local-code modifiers can only be used with the procedure codes listed. Use of local-code modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

25 Separate Evaluation and Management Services

Use modifier 25 to indicate a separately identifiable evaluation and management service on the same day of a procedure or other service, by the same provider or provider group.

Providers may also use modifier 25 to bill for an evaluation and management service that results in the decision to perform a surgical procedure on the same day as the surgical procedure.

51 Multiple Procedures

Use modifier 51 for multiple procedures, other than evaluation and management services, when procedures are performed at the same session by the same provider.

The primary procedure or service may be reported as listed. The additional procedures may be identified by appending the modifier 51 to the additional procedure. This modifier should not be appended to designated ''add-on'' codes.

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
- 25 percent of max allowable fee of all other surgical procedures