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State/Territory Name: Florida

State Plan Amendment (SPA) #: 12-014

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

December 11, 2012

Justin M. Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Re: Florida (FL) Title XIX State Plan Amendment, Transmittal FL12-014

Dear Mr. Senior:

We have reviewed Florida State Plan Amendment (SPA) 12-014, which was submitted to the Atlanta Regional Office on September 10, 2012. The purpose of this SPA is to limit reimbursement for general physician visits to two per month for non-pregnant adults. This limit also applies to Nurse Practitioners (ARNP) and Physician Assistants (PA).

The state added language to the SPA pages allowing exceptions to the monthly limits based on medical necessity.

Based on information provided and the state's agreement to collaborate with CMS on the development of the notices to Medicaid beneficiaries and providers, we are now ready to approve Florida SPA 12-014 as of December 11, 2012. The effective date of this amendment is August 1, 2012. The signed CMS-179 and the approved plan pages are enclosed.

If you have any questions regarding this amendment, please contact Etta Hawkins at (404) 562-7429.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: 2012-014	2. STATE Florida
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE August 1, 2012	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440	7. FEDERAL BUDGET IMPACT: (in thousands) FFY 2011-2012 $ (364) FFY 2012-2013 $ (2,176)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A pages 24, 25 and 59 Attachment 3.1-B pages 24, 28 and 59	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A pages 24, 25 and 59 Attachment 3.1-B pages 24, 28 and 59

10. SUBJECT OF AMENDMENT: Physician Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//	16. RETURN TO: Mr. Justin M. Senior Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308 Attention: April Cook
13. TYPED NAME: Mr. Justin M. Senior	
14. TITLE: Deputy Secretary for Medicaid	
15. DATE SUBMITTED: 09/10/12	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/10/12	18. DATE APPROVED: 12/11/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 08/01/12	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Opns

23. REMARKS:

Approved with the following changes to items 7, 8, and 9 as authorized by state agency e-mail dated 09/11/12 and 12/04/12:

Block # 7 changed to read: FFY 2012-2013 $2,039,348.

Block #8 changed to read Attachment 3.1-A pages 24, 25, and 59; Attachment 3.1-B pages 24, 28 and 52, Attachment 4.19-B pages 28 and 29.

Block #9 changed to read Attachment 3.1-A pages 24, 25, and 59; Attachment 3.1-B pages 24, 28 and 52, Attachment 4.19-B pages 28 and 29.

10/1/90
(5)

PHYSICIAN SERVICES: Limits visits outside the hospital to not more than one per recipient per day per physician (except for emergencies) and initial consultations outside the hospital to one per medical specialty per recipient per medical condition per year (except for emergencies). Limits general visits to two visits per month provided by physicians, advanced registered nurse practitioners, and physician assistants for non-pregnant adults. Exceptions to the limits will be authorized based on medical necessity. A consultation includes services rendered by a physician whose opinion or advice is requested by another physician or agency in the evaluation or treatment of a patient's illness or problem. Also limits one physician visit per recipient per month in all types of long term care facilities (except for emergencies). Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity. Excludes clinically unproven procedures and cosmetic surgery. Sterilization procedures which meet federal requirements and abortion procedures meeting federal requirements are allowed. Health screening examinations for non-EPSDT recipients 21 years of age and older are limited to one per recipient per year. Health screening examinations are provided under EPSDT for EPSDT participants.

Elective surgical procedures require prior authorization or EPSDT screening for inpatient hospital services. For purposes of the plan, elective surgery is defined as those surgical procedures' that can be safely deferred without:

1. Threatening the life of the recipient, or
2. Causing irreparable physical damage, or
3. Resulting in the loss or serious impairment of a bodily function, or
4. Resulting in irretrievable loss of growth and development.

Medicaid program medical consultant staff will make individual patient decisions as appropriate regarding whether a patient's procedure meets the above criteria on either a prior or postauthorization basis.

ADVANCED REGISTERED NURSE PRACTITIONERS (ARNP):

8/1/12

New patient office, home or hospital visits are limited to one per recipient per provider every three years. Subsequent office, home or hospital visits are limited to one per day per recipient, except for emergency services. Visits for general services are limited to two visits per month provided by physicians, advanced registered nurse practitioners, and physician assistants for non-pregnant adults. Exceptions to the limits will be authorized based on medical necessity. Routine physical examinations are provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program or Adult Health Screenings.

8/1/12
(6d)

PHYSICIAN ASSISTANT:

New patient office, home or hospital visits are limited to one per recipient per provider every three years. Subsequent office, home or hospital visits are limited to one per day per recipient, except for emergency services. Limits general services visits to two visits per month provided by physicians, advanced registered nurse practitioners, and physician assistants for non-pregnant adults. Exceptions to the limits will be authorized based on medical necessity. Routine physical examinations are provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program or Adult Health Screenings. Assistant at surgery fees are limited to surgical codes that allow an assistant surgeon.

10/1/90 (5) PHYSICIAN SERVICES: Limits visits outside the hospital to not more than one per recipient per day per physician (except for emergencies) and initial consultations outside the hospital to one per medical specialty per recipient per medical condition per year (except for emergencies). Limits general visits to two visits per month provided by physicians, advanced registered nurse practitioners, and physician assistants for non-pregnant adults. Exceptions to the limits will be authorized based on medical necessity. A consultation includes services rendered by a physician whose opinion or advice is requested by another physician or agency in the evaluation or treatment of a patient's illness or problem. Also limits one physician visit per recipient per month in all types of long term care facilities (except for emergencies). Exceptions to the limits will be authorized on a case by case basis and will be evaluated based on medical necessity. Excludes clinically unproven procedures and cosmetic surgery. Sterilization procedures which meet federal requirements and abortion procedures meeting federal requirements are allowed. Health screening examinations for non-EPSDT recipients 21 years of age and older are limited to one per recipient per year. Health screening examinations are provided under EPSDT for EPSDT participants.

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PHYSICIAN ASSISTANT:

New patient office, home or hospital visits are limited to one per recipient per provider every three years. Subsequent office, home or hospital visits are limited to one per day per recipient, except for emergency services. Limits general services visits to two visits per month provided by physicians, advanced registered nurse practitioners, and physician assistants for non-pregnant adults. Exceptions to the limits will be authorized based on medical necessity. Routine physical examinations are provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program or Adult Health Screenings. Assistant at surgery fees are limited to surgical Codes that allow an assistant surgeon.

Amendment 2012-014
Effective 08/01/12
Supersedes 94-15
Approval 12-11-12

METHODS USED IN ESTABLISHING PAYMENT RATES

8/1/12 INDIVIDUAL PRACTITIONERS SERVICES - (Doctors of Medicine, Chiropractic, Osteopathy, Dentistry, Optometry and other individual Practitioners services) -
Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of physician, chiropractic, osteopathic, dental, optometric, and podiatric services. The agency's fee schedule rate is in effect for services provided on or after August 1, 2012. All rates, including current and prior rates, are published and maintained on the agency's website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at www.MyMedicaid-Florida.com.

1/1/01 Medicaid will only reimburse doctors of medicine, osteopathy, and other individual practitioner services for mobile services under contractual agreement with a Federally Qualified Health Center or a County Health Department. Medicaid will only reimburse those practitioners whose mobile Rural Health Clinic (RHC) units are certified by Medicare as mobile RHCs in accordance with Title 42 Code of Federal Regulations.

Medicaid will only reimburse doctors of optometry for mobile services under contractual agreement with a Federally Qualified Health Center. Medicaid will only reimburse those practitioners whose mobile Rural Health Clinic (RHC) units are certified by Medicare as mobile RHCs in accordance with Title 42 Code of Federal Regulations.

7/1/01 Medicaid will only reimburse doctors of dentistry for mobile services under contractual arrangement with a Federally Qualified Health Center, County Health Department, state approved dental educational institution, or for services rendered to recipients age 21 and over at nursing home facilities.

Reimbursement for mobile services is made directly to the CHD, FQHC or RHC on a cost-based reimbursement method. Reimbursement to the individual practitioners contracting with these entities is made directly by the CHD, FQHC or RHC with whom they contract the services provided.

Medicaid will not reimburse for mobile services for radiology procedures or interpretations if the service was provided by a mobile provider.

Amendment 2012-014
Effective 8/1/2012
Supersedes 2004-012
Approval 12-11-12

METHODS USED IN ESTABLISHING PAYMENT RATES

8/1/12

OTHER PRACTITIONER SERVICES
Advanced Registered Nurse Practitioner, Nurse Midwife, Licensed Midwife, Physician Assistant and Registered Nurse First Assistant Services:

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of advanced registered nurse practitioner, nurse midwife, licensed midwife, physician assistant and registered nurse first assistant services. The agency's fee schedule rate is in effect for services provided on or after August 1, 2012. All rates, including current and prior rates, are published and maintained on the agency's fiscal agent website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at www.MyMedicaid-Florida.com.