PROPOSED ADDITIONS TO THE PHYSICIAL HEALTH FEE SCHEDULE
FOR PUBLIC COMMENT
Proposed to Be Effective January 1, 2019

Comments may be made through January 20, 2019. For any changes made based on comments, claims will be adjusted retroactively as appropriate.

Notes on interpreting the fee schedule:
1. The payment rates, rendering provider requirements, the units, and the max units are subject to public comments at this time.
2. FQHC's, Indian Health Service, and PL 638 Tribal Healthcare Providers may also be authorized to perform some services but encounter rates may apply.
3. This feeschedule is for services provided to Medicaid fee-for-service recipients. Managed care provider rates are determined between the provider and the MCO and may differ from the fee-for-service fee schedule. Managed care rates are not subject to the public comment process.

RENDERING PROVIDER REQUIRED	CPT or HCPCS code	FEE SCHEDULE AMOUNT EFFECTIVE JANUARY 1, 2019	CODE DESCRIPTION	ACTION	COMMENT
INSERTION, REMOVAL AND REINSERTION OF LONG ACTING REVERSIBLE CONTRACEPTIVES (LARC) DRUG IMPLANTS and INSERTION OF IUDS					
rendering required	11981	$149.34	Refer to Current Procedural Coding CPT© Manual	The payment is currently $119.47. The change represents a 25% increase over the current rate.	The payment amounts were reviewed based on comments received from various providers and other interested parties regarding the need to increase payment for the service in order to provide reasonable recipient access to the service. The current rates were deemed inadequate to reasonably compensate a provider for the services.
rendering required	11983	$256.46	Refer to Current Procedural Coding CPT© Manual	The payment is currently $205.17. The change represents a 25% increase over the current rate.	
rendering required	58300	$119.07	Refer to Current Procedural Coding CPT© Manual	The payment is currently $39.69. The change represents a 200% increase over the current rate.	
REIMBURSEMENT FOR NEUROLOGICAL and NEUROSURGICAL TELEMEDICINE CONSULTATIONS TO HOSPITALS USING "ACCESS" REMOTE NEURO CONSULT EXPERTS (ACCESS PROGRAM)					
rendering required which may be the onsite provider at the hospital	95999 U1	$850 per episode	Refer to Current Procedural Coding CPT© Manual	The payment is made to a designated hospital professional component number using the CMS1500/837P billing format.	The rate is set at the amount the hospital contracted to the ACCESS program typically pays for the ACCESS consultants.
rendering required which may be the onsite provider at the hospital	95999 U2	$1,200 per episode	Refer to Current Procedural Coding CPT© Manual	The payment is made to a designated hospital professional component number using the CMS1500/837P billing format.	The rate is set at the amount the hospital contracted to the ACCESS program typically pays for the ACCESS consultants.
COMPLEX CHRONIC CARE MANAGEMENT SERVICES and COMPREHENSIVE ASSESSMENT AND CARE PLANNING and TRANSITIONAL CARE MANAGEMENT					
rendering required	**99487**	$85.31	Refer to Current Procedural Coding CPT© Manual	All of the conditions specified in the CPT manual must be met in order to bill for the service.	The proposed rate is 94% of the Medicare Fee Schedule.

rendering required	**99489**	$28.99	Refer to Current Procedural Coding CPT© Manual	All of the conditions specified in the CPT manual must be met in order to bill for the service.	The proposed rate is 94% of the Medicare Fee Schedule.
rendering required	**99490**	$37.27	Refer to Current Procedural Coding CPT© Manual	All of the conditions specified in the CPT manual must be met in order to bill for the service.	This is the current rate already paid by Medicaid which is about 92% of the Medicare Fee Schedule. It is included here in order to make it known that this is a covered service.