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# Florida Medicaid Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION



## CRITICAL CHANGES FOR NPI ON FLORIDA MEDICAID CLAIMS



Changes are coming in Florida Medicaid that will impact most providers who submit claims to the Florida Medicaid program. The Health Insurance Portability and Affordability Act (HIPAA) of 1996 mandated the implementation of a National Provider Identifier (NPI). Most health care providers must register with the National Plan and Provider Enumeration System and receive a unique NPI. The intent of the HIPAA regulations was to require all health plans to convert their claims processing systems to use only the NPI for claims processing and reporting for providers required to obtain an NPI. Because of the complexities of this conversion by health care plans and providers, the use of the NPI has not yet been strictly enforced. However, Medicaid claims submitted on and after January 1, 2011, will have new requirements for the use of the NPI.

### Starting January 1, 2011

In order to enhance Medicaid efforts to ensure that the program is providing quality, affordable health care for all Americans, the United States Congress included provisions in the Patient Protection and Affordable Care Act of 2010 that mandates changes in Medicaid rules for enrolling providers and submitting claims. Starting January 1, 2011, Medicaid will require that all providers who must obtain an NPI include their NPI on all claims submitted to Medicaid. This will include all claims from these providers, whether submitted

on paper or electronically. The Medicaid provider number will be allowed to accompany the NPI on claims; however, claims that do not contain the NPI will be denied. Look for further instructions in the near future for these new requirements.

### Starting April 2011

The X12 transactions mandated by HIPAA are being modified with a new version, known as 5010. As Florida prepares to convert electronic transactions to the new version of HIPAA, further changes in the electronic claims are needed for the use of NPI for providers who must obtain an NPI. The 5010 version of the claims transactions will no longer allow providers to include the Medicaid provider number as part of the transaction and will allow only the NPI. This affects only electronic claims. Consequently, in preparation for the 5010 implementation, Florida Medicaid will no longer accept X12 claim transactions that contain the Florida Medicaid provider number starting in April 2011. Electronic claims that contain the Medicaid provider number will be denied. Florida Medicaid will provide further instructions in the near future on the 5010 implementation and associated changes that will be required later in 2011.

For details on how to complete your claims and what to expect in claim processing when these changes take effect, please refer to the [NPI Quick Reference Guide](#).



The use of Agency throughout this publication refers to the Agency for Health Care Administration.



Articles with this graphic contain links to more information on the Internet.



Articles with this graphic contain important Medicaid provider handbook information.



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# A MESSAGE FROM INTERIM SECRETARY ELIZABETH DUDEK

Dear Medicaid Provider:

As you may know, the Agency will be undergoing several changes in the upcoming months due to changes in administration. This change should be seamless for you. Your continuous commitment to serving Medicaid recipients is critical to the Agency's mission to provide better health care to all Floridians. In our last edition, I mentioned that the Agency had submitted an extension request to CMS to allow Florida to continue the Florida Managed Care Pilot Waiver program until 2014 and that CMS notified the Agency that it will review and process our request under an authority that calls for continued negotiation with the Agency. Since then, we have met with CMS on several occasions and are anticipating further feedback and direction from them in the near future.

In addition, recent estimates and projections regarding Medicaid expenditures and enrollment indicate that Medicaid costs will contribute to a budget shortfall for next year of \$3.5 billion or more. With so many people depending on Medicaid and the state facing a challenging economic situation, we know some difficult decisions will have to be made regarding the Florida budget to ensure program efficiency while maintaining needed services. We hope that you will continue to work with us to make sure Medicaid recipients receive the best care.

I know with your help and dedication we can solve the issues affecting the Medicaid program and make a difference in our state. Your commitment to serving the Medicaid population is appreciated. Happy Holidays!

Sincerely,



Interim Secretary  
Elizabeth Dudek



## MEDICAID COMPLIANCE CORNER: INCREASED OVERSIGHT INITIATIVES

The Agency for Health Care Administration continues to implement increased oversight initiatives geared specifically to detect and deter fraud, abuse, and overpayments. These efforts will continue to increase throughout the year. While the Agency aggressively pursues fraud prevention through prepayment efforts, we are also increasing post-payment reviews which lead to determinations of provider non-compliance with Medicaid policy and other governing laws.

As was discussed in the [Fall 2010 Provider Bulletin](#), Medicaid providers have an obligation to ensure that claims submitted to the Medicaid program are correct and properly reimbursed. Providers should conduct “self-audits” and repay overpayments that they identify. For more information about conducting self-audits, providers should contact the Agency’s Office of Inspector General, Bureau of Medicaid Program Integrity’s Self Audit Coordinator, Pam Fante, at [Pam.Fante@ahca.myflorida.com](mailto:Pam.Fante@ahca.myflorida.com) or the Division of Medicaid Fraud and Abuse Liaison, Kelly Bennett, at [Kelly.Bennett@ahca.myflorida.com](mailto:Kelly.Bennett@ahca.myflorida.com).

These reviews will result in overpayment recovery efforts and the application of sanctions. Additionally, the Agency is in the process of increasing awareness among its own employees about the Medicaid sanctioning process to ensure that we increase referrals to other government regulatory and law enforcement agencies. Due to the increased sanctions that may be imposed, providers should review practices to ensure compliance with Medicaid Requirements.

Providers who are the subject of a review by the Agency should feel free to ask the auditor/investigator questions about the process but should not use the question and answer process as a means to delay furnishing requested records or information to the Agency. In fact, a provider who does not furnish requested records or information, or who refuses to grant access to records or the provider’s office, will be subject to sanctions for the infraction. These sanctions are in addition to sanctions for non-compliance with programmatic policies and often result in the provider being suspended from participation in the Medicaid program.

Providers with review findings that are indicative of fraud or abuse are referred to MPI for review and likely referral to the Attorney General’s Medicaid Fraud Control Unit. Significant potential overpayments are also referred to MPI to conduct more comprehensive investigations, recover overpayments, and issue sanctions. Providers with continued non-compliance will be the subject of increased sanctions as well as further comprehensive reviews. Administrative sanctions are applied in accordance with Rule 59G-9.070, F.A.C., and can include fines, suspension, or termination from the Medicaid program, and may be issued by any of the Agency’s organizational units.

In March 2010, the Office of Program Policy Analysis and Government Accountability (OPPAGA) released Report No. 10-32 which outlined several recommendations that the Agency could implement

to strengthen its Medicaid fraud and abuse program. One of the recommendations directed MPI to strengthen the sanctioning process to impose higher fines based on the provider’s identified overpayment. The enactment of Senate Bill (SB) 1986, which was passed in the 2009 Legislative Session, affected multiple sections of law administered by several agencies. Amendments to existing laws and rules were required to enhance the activities and authority of the various agencies in combating fraud and abuse in the delivery of health care services. One such rule was the Administrative Sanction Rule, Rule 59G-9.070, F.A.C. The Agency amended the rule to comply with the OPPAGA recommendation and to meet the legislative intent of SB 1986 to reduce and prevent fraud in the Medicaid program. As a deterrent for violating laws governing the Medicaid program, monetary sanctions were significantly increased by the amended rule which became effective September 7, 2010. The following is a link to the rule as amended: [Administrative Sanction Rule, Rule 59G-9.070](#).

As amended, the sanction rule now mandates termination for providers with egregious billing practices from the Medicaid program and increases fines as a deterrent from repeated misbillings. Fines for first violations have more than doubled. For example, the fine under Rule 59G-9.070(7)(c), F.A.C., for failure to furnish records, has increased from \$1,000 per record request to \$2,500 per record request and suspension until the records are made available at the first violation. Another example, under Rule 59G-9.070(7)(e), F.A.C., for failure to comply with Medicaid laws, subjects the provider to an increased fine from \$500 per provision to a \$1,000 fine per claim found in violation up to 20% of the overpayment amount for the first offense; for a second violation the fine increases to \$2,500 per claim found in violation up to 40% of the overpayment amount; and upon a third violation a \$5,000 fine per claim up to 50% of the overpayment amount. Termination from the program may occur as early as the first violation in some instances, and in most situations is definite at the second or third violation.

As an example, two recent audits performed on pharmacy providers found violations of Rule 59G-9.070(7)(n), F.A.C., for shortages of goods or time. Both cases found shortages of goods, which carries a \$1,000 fine per type of good found to be short for the first violation. The first provider had a total overpayment of \$109,545.94 and an applied sanction of \$21,909.19. The sanction was capped at 20% of the overpayment since this was a first offense. The second provider had a total overpayment of \$231,112.79, and the Agency applied the full sanction of \$24,000—a \$1,000 fine for each of the 24 types of goods found to be short. For each of these cases, the sanction amount under the prior version of the rule would have been \$5,000.

These sanctions will be imposed in addition to the full recoupment of the overpayment.



## ARE YOU READY? MEDICAID EHR INCENTIVE PAYMENTS BEGIN THIS YEAR!

Over the past few years, health care providers have widely discussed making the switch to electronic health record (EHR) technology. EHR ensures that patients spend less time filling out forms and doctors spend less time writing medical histories, tracking down x-rays, and repeating expensive tests. It's a win-win situation that ultimately results in better care for patients and more efficient operations for providers. Yet, only two in ten doctors and one in ten hospitals use even a basic electronic record system.

Many doctors and hospitals are hesitant to change because they view the process as cost prohibitive. However, the Centers for Medicare and Medicaid Services (CMS) will soon offer a program providing incentive payments to eligible professionals (EPs).

EPs who adopt, implement, or upgrade and demonstrate meaningful use of certified EHR technology can receive more than \$63,000 over a six year period. Payments to hospitals are based on a formula with a base incentive amount modified by the number of Medicaid patient discharges, as well as other factors. Incentive payments will begin in August 2011.

### Who is Eligible?

- Physicians (not hospital-based)
- Pediatricians (special rules)
- Nurse practitioners and certified midwives
- Dentists
- Physician assistants who practice at Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC) that are led by a physician assistant
- Acute care, critical access, and children's hospitals



### What are the Requirements?

- Over a 90-day period, applicants must meet the following Medicaid patient volume:
  - » Providers: 30%
  - » Pediatricians: 20%
  - » Acute care and critical access hospitals: 10%
  - » Children's hospitals: no requirement.
- EPs are also eligible when practicing predominantly in an FQHC or RHC seeing 30% "needy individuals" (receiving medical assistance or uncompensated care).

### You Can Start Preparing Now.

- Contact your [Regional Extension Center](#).
- Read about "Meaningful Use" and more at the [CMS EHR Incentive Programs Web site](#).
- EPs may receive payments from only one program. Both Medicare and Medicaid will offer incentive payments and providers must select one (but can change from one program to the other once).



## PAYMENT ERROR RATE MEASUREMENT PROJECT (2011)

The Improper Payments Information Act of 2002 (HR 4878) requires federal government agencies to provide an estimate of their improper payments annually. The Centers for Medicare and Medicaid Services (CMS) has tested the process and methodology, and will implement a nationwide effort to measure improper payments in the Medicaid program. The Agency for Health Care Administration is the single state agency responsible for administering the Medicaid program in Florida.

CMS will measure the accuracy of Medicaid and Children's Health Insurance Program (CHIP) payments made by states

for services rendered to recipients through the Payment Error Rate Measurement (PERM) program. Under the PERM program, CMS will use three national contractors to measure improper payments in Medicaid and CHIP. One contractor will provide statistical support to the program by selecting a sample of claims to be reviewed, and calculating Florida's error rate. Another will provide the documentation/database support by collecting medical policies from the state and medical records from the providers. The third contractor will conduct medical and data processing reviews of the sampled claims.

Medical records are needed to support medical reviews that the contractor will conduct on the fee-for-service Medicaid and CHIP claims to determine if the claims were correctly paid. If a claim is chosen in the sample for a service rendered by you, the contractor responsible for the collection of medical records will contact you for a copy of your medical records to support the medical review of the claim. Once CMS has notified the state Medicaid agencies as to who the contractor will be for the 2011 PERM cycle, we will provide that information in a future provider bulletin.

### Consequences of Non-Response

If requested supporting medical documentation is not submitted, the claim will be coded as an error and monies paid will be recouped. Since dollars estimated as being paid in error are projected to the total claims universe, the actual impact of each claim error will be magnified several times, resulting in an overall negative impact on the Florida Medicaid program. If the error rate is excessive, the Agency may have to add controls or other limitations to address problem areas that are identified. It must be restated that even small dollar claim amounts identified as payment errors can have a significant impact on how a particular service area is perceived.

### Medical Record Requests

Please note that providers are required by **Section 1902(a)(27) of the Social Security Act** to retain records necessary to disclose the extent of services provided to individuals receiving assistance, and to furnish CMS with information regarding any payments claimed by the provider for rendering services, which includes medical records.

In addition, the collection and review of protected health information contained in individual-level medical records for payment review purposes is permissible by the Health

Information Portability and Accountability Act of 1996 (HIPAA), as stated in the following at 45 Code of Federal Regulations, parts 160 and 164:

...a covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits...or other activities necessary for the appropriate oversight of (1) the health care system; (2) government benefit programs for which health information is relevant to beneficiary eligibility; (3) entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or (4) entities subject to civil rights laws for which health information is necessary for determining compliance.

Medicaid providers are required to comply with a medical records request from any authorized Medicaid employee. Please review subsequent provider bulletins for additional details regarding the 2011 PERM cycle, which begins October 2010 for Federal fiscal year 2010-2011. We will be sending out more specific information that pertains to medical record requests when this information has been given for the 2011 cycle.

Florida Medicaid wants to remind all providers to bill in accordance with the billing procedures outlined in the Provider General Handbook, and within the specific program policy handbook for the procedure being billed.

Please note, if you have changed your address or telephone number and have not updated your information with the Agency, this is a good opportunity to do so, since you are required to report the change of address to the Agency ([Provider General Handbook](#), page 2-44).

If you would like more information related to PERM and your role in this process, please visit the [CMS PERM web site](#).

We appreciate your participation in the Florida Medicaid program. If you have any questions, please contact Jason Ottinger, Government Analyst II, Office of Medicaid Program Oversight, by telephone at (850) 412-4695, or via e-mail at [Jason.Ottinger@ahca.myflorida.com](mailto:Jason.Ottinger@ahca.myflorida.com).



## DOCUMENTATION REQUIREMENT FOR CMS 1500 CLAIMS FOR NON-CITIZEN SERVICES

The Medicaid program reimburses providers for emergency services rendered to needy persons who are non-citizens (aliens). However, Medicaid eligibility is only for the duration of the emergency and reimbursement applies only to the services rendered during the emergency. Federal law prohibits any Medicaid payment from the point at which the emergency has been alleviated and the patient is stabilized.

Therefore, when submitting emergency services claims for aliens enter "Y" for YES in item 24C on the CMS 1500 form. No claim should be submitted for services to aliens unless the services were rendered in an emergency.

**DO NOT SEND** any paper attachments or medical records to the Medicaid fiscal agent with the CMS 1500 claim form. Regardless of place or dates of service, attachments for alien claims are not required. All CMS 1500 claims for alien emergency services will be processed per these instructions.

If you have any questions, please call your local Medicaid area office.



## 10 TIPS FOR SUCCESSFUL DURABLE MEDICAL EQUIPMENT (DME) HOSPITAL BED PRIOR AUTHORIZATION SUBMISSIONS

- To obtain authorization for hospital beds, the provider submits the Florida Medicaid Authorization Form (PAO1) and required authorization documentation directly to the Medicaid fiscal agent, not to the local Medicaid area office or Medicaid Headquarters.
- Hospital Bed types that require prior authorization (with procedure code):
  - Fixed height hospital bed (E0250).
  - Adjustable height hospital bed (E0255).
  - Heavy duty hospital bed for recipients weighing in excess of 350 pounds (E0303).
- Hospital Bed types that do not require prior authorization, but are limited to recipients under the age of 21:
  - Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress (E0260).
  - Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress (E0265).
- The length of need for the bed and the description of the diagnosis and symptoms should be included in the prior authorization request. The use of the [Certificate of Medical Necessity \(CMN\) form](#) is strongly encouraged to help ensure all required information is provided.
- If an eligible recipient has an urgent need for a hospital bed, the DME provider may deliver the hospital bed to the recipient's place of residence prior to submitting the post-authorization request to the Medicaid fiscal agent for processing.
- For post-authorization requests, the provider must obtain a prescription or CMN that is signed and dated by the recipient's treating physician, ARNP, or physician assistant within 21 days from the date the bed was delivered to the recipient's home.
- Please make sure the practitioner's name, address, phone number, license number, Florida Medicaid Provider number, and UPIN or National Provider Identifier (NPI), is included.
- To avoid denial due to a duplicate request, please return any additional information needed with the original prior authorization packet to the Medicaid fiscal agent.
- When medically necessary, Medicaid may reimburse for the replacement of a hospital bed or hospital bed rails every eight (8) years.
- Please review the *DME and Medical Supply Services Coverage and Limitations Handbook* Hospital Bed Documentation section (page 2-52) for all required documentation.



# EXCITING NEWS FROM THE MEDIPASS PROGRAM!

MediPass has a new Web page! Go to [www.ahca.myflorida.com/Medicaid/MediPass/](http://www.ahca.myflorida.com/Medicaid/MediPass/) and check out our new look. You will find many interesting, interactive features with helpful information for providers and members. Medicaid providers interested in MediPass can find a history of the program, download the Agreement for Participation in MediPass, and obtain information on the Florida Medicaid Health Information Network. Need to find a specialty provider for your patients? With the click of a button you can link to the local Medicaid area office Web site where you will find a list of specialists in your area. Interested providers can also find links to the MediPass Quick Reference Guide, provider alerts and information about disease management services available to patients. The Quick Links on each page provide easy access to the fiscal agent Web site where providers can review Medicaid handbooks and provider reports.

The new Web page also provides the following information for MediPass members:

- How to change providers
- How to replace a lost or stolen MediPass or Medicaid card
- How to access care in case of an emergency
- How to manage their health records
- Member rights and responsibilities

Members can also find advice on how to plan healthy meals on a budget as well as information about "The Get Active Challenge" where they can join the challenge to eat right and become more active.

Parents will find the new Web page useful for updated information on Child Health Check Ups and recommended immunization schedules. In addition, expectant mothers can find information about eating healthy during pregnancy and how to track their baby's growth and health history with the eBaby Book. Related Web sites are listed under the Quick Links on each page.

These are just a few of the exciting new features of the MediPass Web page. We value your opinion, so please visit the Web site and give us your feedback at: [MediPass@ahca.myflorida.com](mailto:MediPass@ahca.myflorida.com). Also, be sure to let your patients know about the new Web page.

## MediPass providers, have you enrolled with the Medicaid Web Portal?

If you have not already registered on the Medicaid Web Portal, today is a great time to do so! There are many advantages to using the Web Portal such as free Medicaid eligibility verification and receiving enrollment reports electronically, which makes information quickly available when you need it. You can also receive notices regarding Medicaid policy changes, review remittance vouchers, submit electronic claims and much more! As a MediPass provider, we encourage you to register with the Web Portal by going to [MyMedicaid-Florida.com](http://MyMedicaid-Florida.com).



## BILLING VACCINES FOR MEDIKIDS

MediKids is a Children’s Health Insurance Program (CHIP) for children ages 1 through 4. Children enrolled in CHIP are not eligible to receive vaccines through the Vaccines for Children Program. Providers will need to use vaccines from their private stock.

Children with MediKids coverage will either be enrolled with a Medicaid Health Maintenance Organization (HMO) or enrolled with a MediPass provider. The child’s managed care enrollment will determine the way you bill.

### For MediKids Children Enrolled in MediPass or Fee-for-Service

- Use the CMS-1500 claim form to bill Medicaid for the vaccine and the cost of administering the vaccine.

### For MediKids Children Enrolled in an HMO

- Use the CMS-1500 claim form to bill Medicaid for the vaccine.
- Bill the HMO (follow billing instructions from the HMO) for the cost of administering the vaccine.

The vaccine codes and fees for MediKids can be found on the [MediKids Publications Web page](#). Look under “Current Codes and Fees” and you will see two links:

1. [Title XXI Immunization codes, 1st quarter 2011](#) - These are the codes and fees to use when a MediKids child is assigned to a MediPass provider or Fee-for-Service. The fee includes both the cost of the vaccine and the cost of administering the vaccine.
2. [Immunization codes for HMOs, 1st quarter 2011](#) – These are the codes and fees to use when a MediKids child is assigned to a Medicaid HMO. The fee only includes the cost of the vaccine.

If you are unsure if a child has MediKids coverage, just look at the benefit plan when checking eligibility for the month. The benefit plan for MediKids is **MKIDS**. Also, the MediKids aid categories are **MKA, MKB or MKC**.

Please refer to the Medicaid Reimbursement Handbook CMS-1500 for instructions about submitting claims to Medicaid.



# Critical Reminder to Child Health Check-Up (CHCUP) Providers

As licensed health care professionals, you are aware that performing a blood test for lead is a federal requirement at specific intervals during the “Child Health Check-Up” (CHCUP). This note is to remind you how important it is to document the blood tests you are performing in compliance with this federal mandate. Failure to provide documentation can lead to a federal audit and the requirement to repay Medicaid for fees received. The federal regulation as referenced in the Child Health Check-Up Coverage and Limitations Handbook, October 2003, pages 2-13 and 2-14, and page 3-6, requires that all Medicaid children receive a screening blood lead test at the ages of 12 months and 24 months, and between the ages of 36 months and 72 months if they have not been previously screened for lead poisoning.\* The procedure code for blood lead testing is 83655. The Child Health Check-Up Coverage and Limitations Handbook can be accessed by visiting [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select **Public Information for Providers**, then **Provider Support**, then **Provider Handbooks**, and then the **Child Health Check-Up Handbook**.

\*The Florida Department of Health has announced the publication of the Childhood Lead Poisoning Screening and Case Management Guide. The guide provides valuable updated information for health care providers about childhood blood lead screening and case management requirements. The guide is available by calling (850) 245-4444 ext. 2694 or by visiting the Florida Department of Health’s [Florida Childhood Lead Poisoning Prevention Program](#) Web site.

Please also note:

- CHCUP providers may only bill for one visit, per Medicaid child, per provider, per day. The visit may be a CHCUP visit or a sick visit. Provider discretion in evaluating the degree of illness should determine if a CHCUP should be performed. This policy is explained in the Child Health Check-Up Coverage and Limitations Handbook, October 2003, page 2-3. Medicaid may recoup overpayments if medical record audits indicate that a provider has been reimbursed for a CHCUP and a sick visit on the same day, for the same child.
- A CHCUP referral code is required on the claim form in order to be reimbursed for a CHCUP.
- It is critical that the federally required referral code be appropriate for the diagnosis code on CHCUPs. For example, a diagnosis code of V20.2 (routine infant or child health check) would be appropriate with a referral code of “U” or “NU” (complete normal/no referral). A diagnosis code of V20.2 (routine infant or child health check) is not appropriate with a referral code of “T” or “ST” (abnormal, patient referred). For the required referral codes see page 3-4 of the Child Health Check-Up Coverage and Limitations Handbook, October 2003.
- CHCUP providers are responsible for referrals and follow-up on a Medicaid child as a result of a CHCUP. This is referenced in the Child Health Check-Up Coverage and Limitations Handbook, October 2003, page 2-2.
- Dental referrals are required beginning at 3 years of age; earlier as medically indicated. CHCUP providers must refer Medicaid children who are 3 years old and older for an assessment by a dentist and document this referral in the child’s medical record. The provider may refer a younger child if it is medically necessary. Following the initial dental referral, subsequent visits to a dentist are recommended every 6 months, or more frequently as prescribed by a dentist or other authorized provider. If a dental provider is not available, providers should notify the local Medicaid area office that the child needs a dental visit and still complete the referral.



HP Enterprise Services, LLC  
Florida's Medicaid Fiscal Agent  
P.O. Box 7070  
Tallahassee, FL 32314-7070

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