

- Volume XI
- Issue 2
- Spring 2011

Florida Medicaid Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION



ATTENTION: MAY 1, 2011 NPI REPLACES MEDICAID ID FOR CLAIMS PROCESSING



Florida Medicaid is changing requirements for including the Medicaid ID on electronic claims from providers who are required to obtain a National Provider Identifier (NPI). Please note the following regarding this change:

Florida Medicaid, beginning May 1, 2011, will no longer accept X12 claim transactions that contain the Florida Medicaid ID from providers who are required to obtain an NPI. Affected providers are encouraged to work with their billing agents or billing software support staff to ensure they are submitting compliant transactions that contain only the NPI and not the Medicaid ID. **Starting May 1, 2011, electronic claims that contain the Medicaid ID will be denied, except as noted below.**

- If providers submit X12 837 claim transactions but are not required to obtain an NPI, Medicaid IDs are still allowed in the provider identifier in claim transactions.
- If providers directly enter their claims on the HP secure web portal (direct data entry), Medicaid IDs are still allowed in the provider identifier in claim transactions.

NPIs are issued at the national level by the National Provider Enumerator (NPES) as part of the HIPAA legislation that required health care providers and payers to use standard transactions and code sets. Providers must register their NPI with Florida Medicaid to create a link to the corresponding Medicaid ID. In cases where a provider has multiple Medicaid IDs, a crosswalk is required that can include taxonomy and/or ZIP+4. Claim transactions must include the exact same combination of NPI, taxonomy, and/or ZIP+4 code as registered on the Medicaid provider file to guarantee the transactions are associated with the correct Medicaid ID.

Please reference the public Provider Web portal for information to help you register your NPI correctly at <http://portal.flmmis.com/FLPublic/>. Select Provider Support, then FAQ, and then National Provider ID (NPI).



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.



INSIDE THIS ISSUE:**ALL PROVIDERS**

- 1) Attention: Coming Changes in NPI
- 2 A Message from Secretary Elizabeth Dudek
- 3 Medicaid Compliance Corner
- 4 Medicaid EHR - Going Digital
- 6 Are You Signed Up for Medicaid Health Care Alerts?
- 8 Payment Error Rate Measurement Project (2011)
- 9 New Medicaid Quality Improvement Organization
- 10 Outpatient Hospital Reimbursement Outside the Hospital Line Item Rate for Intrathecal Baclofen Pump

MEDIKIDS

- 11 Eyeglass Limits for Adults

CHILD HEALTH CHECK-UP

- 12 Critical Reminder to Child Health Check-UP (CHCUP) Providers

A MESSAGE FROM SECRETARY ELIZABETH DUDEK

Dear Medicaid Provider:

The 2011 Legislative session is well underway, and as we anticipated, the House and the Senate are considering some changes to the Medicaid program to ensure its longevity. Our hope is that the new proposals will improve care, encourage more providers to participate in the Medicaid program, provide more budget predictability, and reduce fraud and abuse.

In addition to changes to the Medicaid program, we are preparing to launch the Florida Medicaid Electronic Health Records (EHR) Incentive program. The program will begin in August 2011, but we encourage you to start preparing to go digital now. EHRs will play an important role in the future of health care and we want to make sure Florida is at the frontline of the health IT transition to ensure better coordinated care for all health care consumers.

The Agency has also undergone several changes in management over the last several months, but most of our Agency management team will remain in their current posts, including myself and Deputy Secretary for Medicaid Roberta Bradford. We welcomed Jim Boyd as our new Inspector General, Michelle Dahnke as our new Communications Director and Chris Chaney as our new Legislative Affairs Director.

We look forward to your support and input as we lead the nation in changing the Medicaid program. Together, we can make a difference.

Sincerely,



Secretary
Elizabeth Dudek



MEDICAID COMPLIANCE CORNER

Providers in the Florida Medicaid program may begin to notice a recurring theme within Agency for Health Care Administration (Agency) communications about compliance efforts and provider-conducted internal reviews, which the Agency calls “self-audits.” This article continues that theme and further describes self-audits.

Previous “Compliance Corner” articles have addressed the fact that both federal and state laws obligate providers to ensure the claims they submit are correct and properly reimbursed. Routine self-audits as a part of a well-developed compliance program will help satisfy that obligation, and allow providers to maintain more control over the return of improper payments to the Agency. A compliance program helps providers prevent, detect, and report non-compliance to the Agency. Voluntarily reporting non-compliance and repaying the improper payments will also save providers money; when the Agency initiates the review and identifies the non-compliance, investigative costs and administrative sanctions for the non-compliance can be recovered from providers as well.

The Department of Health and Human Services, Office of Inspector General, has established guidance about the components of an effective compliance program. However, this article is not intended to describe all aspects of an effective provider compliance program. Rather, it is intended to provide guidance specific to self-audits. Providers should look to their governing handbooks as a first step in compliance efforts, and are also expected to comply with regulations that govern the practice of their profession. Providers should be prepared at all times to demonstrate that services were rendered, and/or goods dispensed properly and in accordance with Medicaid program rules.

Provider information and resources, including training materials to assist with compliance efforts, are available on the Agency’s Medicaid website: <http://ahca.myflorida.com/Medicaid>. Providers are also welcome to contact Kelly Bennett, the Medicaid Director’s liaison regarding compliance matters and information about additional training on self-audits: Kelly.Bennett@ahca.myflorida.com.

The term self-audit means an audit of claims that the provider conducts (as opposed to the Agency) and then provides the results (identified non-compliant claims) to the Agency. A self-audit should be a review of reimbursements for a specified period of time, which we refer to as the “audit period.” The audit should be a detailed evaluation of either all claims (referred to as a “comprehensive review”), or particular services, procedure codes, or revenue codes (referred to as a “focused review”) within the audit period.

While the Agency wishes to encourage all providers to submit self-audits, it is better for the provider and the Agency if the provider will first submit a written plan describing the audit period, focus of the review, and how they intend to conduct

the audit. This will help ensure the provider is given any needed guidance, thereby increasing the likelihood that the Agency can validate the audit and accept the findings. Additionally, providers with a voluminous claims history subject to the self-audit may wish to use the Agency’s statistical methodology to conduct a review of a sample of claims only.

The basic principle of how to conduct a self-audit is simple—evaluate claims for reimbursement, and, for any reimbursement determined to be in excess of the amount that should have been paid (based upon Medicaid reimbursement and coverage policies), return the improper amount to the state with supporting documentation.

Most providers who complete self-audits submit the results in a spreadsheet that identifies the claims that were reviewed (by including identifiers such as date of service, date of payment, procedure, units of service, name and identification for the treating provider, pay to provider and recipient, as well as the claim number. The Agency will also need to know whether the claims were found to be in compliance with program rules or not; and, for the non-compliant claims, will need to know (in general terms) why the claims were non-compliant. Some examples of reasons for finding a claim non-compliant include:

- The services were not rendered.
- The coding level was in error.
- The claim was for brand drugs when a generic was dispensed.
- The level of staff performing the services was not proper under Medicaid rules or the provider’s practice standards.
- The claim referenced the wrong date of service or an incorrect recipient.
- The claim was for services that were reimbursed under another code or claim.
- Claims were billed for unbundled services that should have been billed using a global code or panel.
- The services were not documented in accordance with Medicaid requirements.

Providers who would like more information about conducting self-audits should contact

Pam Fante, Self-Audit Coordinator, in the Agency’s Office of Inspector General, Bureau of Medicaid Program Integrity: Pam.Fante@ahca.myflorida.com.





GOING DIGITAL:

MAKING THE MOVE FROM PAPER TO PRACTICAL

Our nation's health care system is undergoing a transformation to improve quality, safety, and efficiency of care for every patient—making it easier for you as a provider to deliver care rather than delivering mounds of paperwork.

When You Switch to EHR You Can:

- + **Quickly** access a patient's current and complete health information.
- + **Conveniently** order prescriptions and file insurance claims.
- + **Spend more time seeing patients** and less time writing medical histories, tracking down x-rays and repeating expensive tests.
- + **Get incentive payments** (up to \$63,750). The Health Information Technology for Economic and Clinical Health Act, or the "HITECH Act," established programs under Medicaid to provide incentive payments for "meaningful use" of certified EHR technology. Incentive payments will begin Fall 2011.

Are You Eligible to Participate?

Eligible professionals include:

- + Physicians (not hospital based)
- + Pediatricians
- + Nurse practitioners and certified midwives
- + Dentists
- + Physician assistants (when practicing at Federally Qualified Health Centers and Rural Health Centers led by a physician assistant)

How do Providers Qualify to Receive a Medicaid EHR Incentive Payment?



To qualify for an incentive payment under the Florida Medicaid EHR Incentive Program, an eligible professional must be a fully enrolled Medicaid provider and meet one of the following criteria:


- + Have a minimum 30% Medicaid patient volume (over a 90-day period).
- + Have a minimum 20% Medicaid patient volume, if a pediatrician. (Qualifying with a lower volume reduces the incentive payment by two-thirds of the maximum incentive payment, totalling \$42,500.)
- + Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals.
- + Registration begins August 2011.

Regional Extension Centers

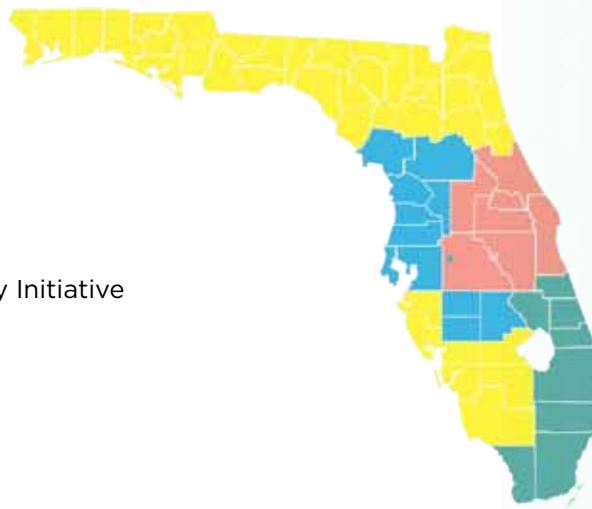
REC services vary to meet the needs of their provider communities, but generally include education, training, workflow study, certified electronic health record consultation, and more. Some work predominantly with primary care providers, while others incorporate services for Eligible Professionals who provide specialty care. Contact the REC in your area for further information.

 The Center for the Advancement of Health IT
(727) 573-2422 ext. 300
info@advanceHealthIT.org
www.AdvanceHealthIT.org

 PaperFree Florida (University of South Florida)
(813) 974-7742
tlang@health.usf.edu
www.PaperFreeFlorida.org

 Central Florida Health Information Technology Initiative
(407) 882-0727
info@ucf-rec.org
www.ucf-rec.org

 South Florida Regional Extension Center
1-866-628-9193
southfloridainfo@southfloridarec.org
www.southfloridarec.org



For more information on how you can start the process and be a part of the Medicaid EHR Incentive program, visit www.AHCA.MyFlorida.com/MedicaidEHR.

Join the interested parties list for e-mail alerts about the program.
Questions? E-mail MedicaidHIT@ACHA.myflorida.com.

ARE YOU SIGNED UP FOR MEDICAID HEALTH CARE ALERTS?

We are making it easier for you to keep up-to-date with changes in Medicaid. Sign up for "Medicaid Health Care Alerts" in three easy steps at: www.ahca.myflorida.com.

Instructions for subscribing are listed below. Once signed up, you will receive updates with policy, billing, and news for the provider type(s) and geographic areas you select. You will control what you wish to receive and will be able to easily update your email address and preferences.

Here's how:

1. Go to: www.ahca.myflorida.com to sign up for **Medicaid Health Care Alerts**.
2. Click on the [Sign Up for Medicaid Health Care Alerts](#) located at the bottom of the page.

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for All Floridians

Home About Us Dashboard Public Records Publications Find a Facility Contact Us **REPORT FRAUD**

Elizabeth Dudek
Secretary
email

FloridaHealthFinder.gov

Florida Health Information Network

Welcome to the Agency for Health Care Administration's Web site. Our mission is Better Health Care for All Floridians, and together we are responsible for the administration of the Medicaid program, for the licensure and regulation of health facilities and for providing information to Floridians about the quality of the health care they receive in Florida... [more information](#)

Every day we look for ways to improve health care in this state, and we appreciate your partnership in that effort. Thank you for the opportunity to serve you.

Agency Alerts Agency News Public Meetings Boards and Councils

- [Emergency Rule Repeals](#) (379 kb)
- [Emergency Rules as Filed](#) (5mb): 59GER11-01, Developmental Disabilities Waiver Provider Rate Table; 59GER11-02, Developmental Disabilities Waiver Services Procedure Codes; 59ER11-03, Developmental Disabilities Waiver Residential Habilitation Services in a Licensed Facility Provider Rate Table; 59GER 11-04 Family and Supported Living Waiver Provider Rate Table; and, 59GER11-05 Family and Supported Living Waiver Services Procedure Codes.
- [Health Alerts](#) – Alerts provided by the US Food and Drug Administration (FDA), Department of Health and Human Services Centers for Disease Control and Prevention (CDC), and other entities regarding food, pharmacy, and provider health problems.
- [Provider Emergency Actions](#) – a listing of all regulated health facilities that have been placed under a moratorium on admissions, has had their license suspended, and/or have had any other restriction or limitation on their license.
- [Sign Up for Medicaid Health Care Alerts](#) –The Florida Medicaid program has an e-mail alert system to supplement the present method of receiving Provider Alerts information and to notify registered providers or interested parties of "late-breaking" health care information.

ARE YOU SIGNED UP FOR MEDICAID HEALTH CARE ALERTS?

3. The Florida Medicaid Health Care Alerts page allows you to subscribe to the automated alert system. To subscribe, complete the online form shown below. A confirmation email will be sent to your mailbox to avoid fraudulent subscription requests.

Note: You must return the confirmation email to complete your subscription.



HCBS Waivers
HIPAA
Intergovernmental Transfer (IGT) Workgroup
Long-Term Care Partnership
Medicaid Encounter Data System (MEDS)
Medicaid HMOs
Medicaid Privacy Notice
Medicaid Procurements
Medicaid Reform
Medicaid Research Contracts and Evaluations
Medicaid State Plan
MediKids
MediPass
Newborn Eligibility
Nursing Facility Provider Information
Nursing Home Transition
Organ Transplant Advisory Council
Payment Error Rate Measurement (PERM)
Pharmacy Services
Preferred Drug List
Provider Service Network (PSN)
Quality in Managed Care
Recent Presentations
Reimbursement Workgroups Meetings
Report Medicaid Fraud
Substance Abuse Services
Utilization Review

your selected provider type.

To subscribe to the automated alert system, complete the online form below. A confirmation e-mail will be sent to your mailbox to avoid fraudulent subscription requests. **Subscribers must return the confirmation e-mail to complete their subscription.**

If you would like to search or view health care alerts now, please click [here](#).

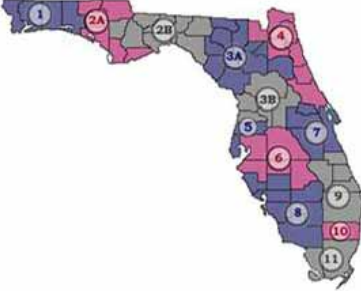
*Email

First Name

Last Name

*Area

All Areas
 Area 1
 Area 2
 Area 3
 Area 4
 Area 5



*Provider Type

00 - All Messages/Provider Types
 01 - General Hospital
 04 - State Mental Hospital
 05 - Community Behavioral Health Services
 06 - Ambulatory Surgical Center
 07 - Mental Health Practitioner
 08 - District Schools
 09 - Skilled Nursing Unit
 10 - Skilled Nursing Facility/Nursing Home
 11 - State ICF/DD Facility
 12 - Private ICF/DD Facility
 13 - Swing Bed Facility

* = Required Field

You can check 00- All Messages/Provider Types or as many individual provider types as you wish. You will receive information via email as soon as Medicaid Health Care Alerts are sent from AHCA. You can unsubscribe or add/change email addresses at any time.

SPRING 2011

7

PAYMENT ERROR RATE MEASUREMENT PROJECT (2011)

The Improper Payments 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 to implement a nationwide effort to measure improper payments in the Medicaid program. As the single state agency responsible for administering the Medicaid program in Florida, the Agency for Health Care Administration (Agency) will be participating in this effort.

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 two national contractors to measure improper payments in Medicaid and CHIP. The first contractor will provide statistical support to the program by selecting a sample of claims to be reviewed and then calculating Florida's error rate. Once CMS has notified the Agency as to who this contractor will be for the 2011 PERM cycle, we will be relating this information in subsequent Provider Bulletin articles. The second contractor, A Plus Government Solutions, will provide documentation/database support by collecting medical policies from the state and by collecting medical records from the providers. This contractor will also conduct medical and data processing reviews of the sample claims.

Medical records will be needed for medical reviews by A Plus Government Solutions to determine if fee-for-service Medicaid and CHIP claims were correctly paid. If a claim for a service that you rendered to either a Medicaid or CHIP recipient is selected to be in the sample, A Plus Government Solutions will contact you for a copy of your medical records to support the medical review of that claim. You will need to submit these medical records within 75 days from the date they contact you.

Consequences of Non-Response

If the requested supporting medical documentation is not submitted, the claim will be coded as an error and any monies paid will be recouped. Since dollars estimated as being paid in error from the sample will be projected to the total claims, the actual impact of each claim error will be magnified several times. This will result in an exponentially 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 emphasized that even small 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 the 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. Furnishing information includes submitting medical records for review.

In addition, the collection and review of protected health information contained in individual-level medical records is permissible for payment review purposes via the Health Information Portability and Accountability Act of 1996 (HIPAA), as stated in 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."

Additionally, 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 is underway for Federal fiscal year 2010-2011. Medical reviews by A Plus Government Solutions will begin in July 2011. We will continue to send out specific information that pertains to medical record requests by A Plus Government Solutions when this information becomes available. If your claim is sampled, your billing and treating provider offices will be notified by letter from AHCA that your claim has been selected and you will need to provide medical records when requested by A Plus Government Solutions.

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

Please also 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 any 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 at <http://www.cms.hhs.gov/perm/>. All documentation specific to 2011 participating states will be located under "Cycle 3." General state provider information will be located under "Providers."

We appreciate your continued cooperation with Florida Medicaid. 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 email at Jason.Ottinger@ahca.myflorida.com.



NEW MEDICAID QUALITY IMPROVEMENT ORGANIZATION

The Agency for Health Care Administration (Agency) has entered into a contract with eQHealth Solutions, Inc., formerly known as Louisiana Health Care Review, for utilization management, including prior authorization of the following Medicaid services:

- Inpatient Medical and Surgical Services
- Home Health Services (includes private duty nursing, personal care services, and home health visits)
- Prescribed Pediatric Extended Care (PPEC) Services
- Therapy Services

The primary purpose of the utilization management program is to safeguard against the provision of unnecessary medical services or inappropriate use of Medicaid services.

eQHealth Solutions has been the Centers for Medicare & Medicaid Services' Quality Improvement Organization for the State of Louisiana for over 23 years, and has contracts for utilization management and peer review activities for the Medicaid programs in Mississippi and Illinois. eQHealth Solutions is also accredited through the Utilization Review Accreditation Commission.

eQHealth Solutions will replace Keystone Peer Review Organization, Inc. (KePRO) as the Medicaid vendor for prior authorization of inpatient medical and surgical services and home health services, beginning June 1, 2011. eQHealth Solutions will begin prior authorizing PPEC and therapy services beginning November 1, 2011.

eQHealth Solutions will be hosting face-to-face training sessions around the state for inpatient and home health service providers beginning April 2011. Training sessions for PPEC and therapy providers will begin in September 2011.

The Agency will provide periodic updates through the Florida Medicaid Web Portal, provider bulletins, provider notification letters, and Medicaid Health Care Alerts. Additional information and communication from eQHealth Solutions will follow.

Please visit <http://fl.eqhs.org> for more information about eQHealth Solutions



OUTPATIENT HOSPITAL REIMBURSEMENT OUTSIDE THE HOSPITAL LINE ITEM RATE FOR INTRATHECAL BACLOFEN PUMP

Prior authorization for the Intrathecal Baclofen Therapy (ITB) pump must be requested from the Agency for Health Care Administration (AHCA) by the physician. The hospital must have this prior authorization form before payment of the ITB device can be made.

The physician should submit all prior authorization requests for ITB to:

Agency for Health Care Administration
ATTN: ITB Coordinator
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308

No facsimile prior authorizations are accepted.

If Medicaid approves the device, the Medicaid ITB coordinator will fax the coversheet of the prior authorization request to the requesting provider. Reimbursement will be made through the gross adjustment process.

Note: The physician's procedure of inserting the device is already covered by Medicaid and requires no prior authorization. Only the device requires prior authorization and must be requested by the physician, not the hospital.

Requesting physician must provide the following documentation for reimbursement:

- Medical records, including report of operation, showing the date of the surgery and that implantation of the ITB pump was performed.
- A copy of the prior authorization page that was faxed to the physician.



Submit all requests for reimbursement and supporting documentation to:

Agency for Health Care Administration
ATTN: ITB Coordinator
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida 32308

Note: When the ITB pump is reimbursed through this method, the cost of the device must not be included in the hospital's cost report.



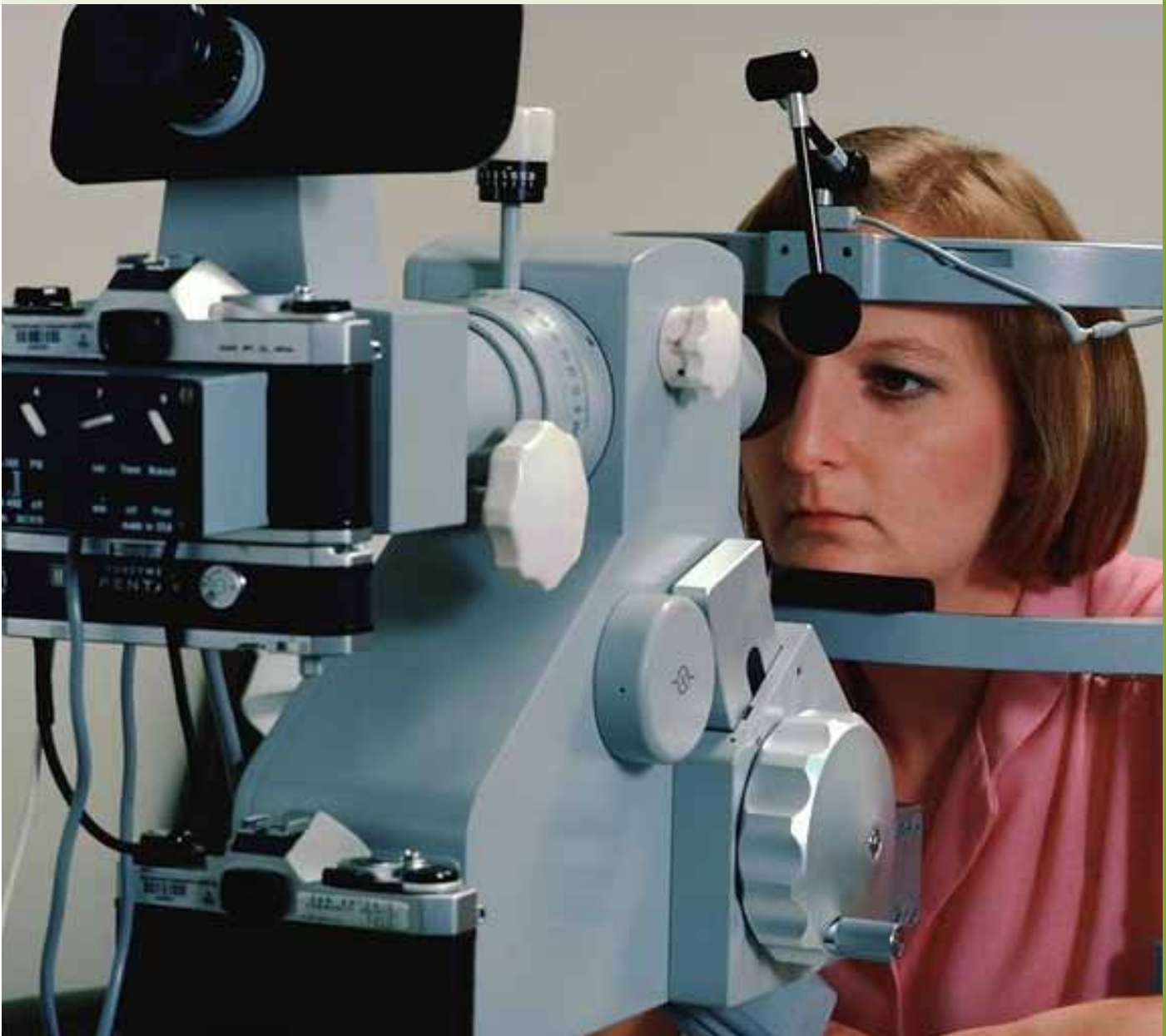
EYEGLOSS LIMITS FOR ADULTS

As a reminder to all visual services providers, since January 1, 2010 the adult eyeglass provision has been limited to one pair of eyeglasses (frames and lenses) every two years. Lenses may be provided every 365 days. If more than one pair of eyeglasses is needed before the two years have elapsed, the provider may submit a Prior Authorization Request form (available on our Web site), giving justification for the request to exceed the limit. Limits are counted from date of service rather than per calendar or fiscal year.

No changes have been made to the limits for children through age 20. Children may have one pair of eyeglasses per year, and if a second pair is medically

necessary within that year it may be provided without Prior Authorization. The reason for a second pair of glasses must be documented in the patient's records.

Eyeglass repairs are a covered service, and complete information on coverage and limitations is found in the following handbooks: Provider General Handbook (which has information on recipient eligibility, co-pays and other vital information), the Physician's Coverage and Limitations Handbook (for ophthalmologists), the Optometric Handbook (for optometrists) and the Visual Services Handbook (for opticians).



Child Health Check-Up (CHCUP)

Early Periodic Screening, Diagnosis and Treatment AND.....

As licensed health care professionals, you understand the importance of preventive care. Although Child Health Check-Ups (CHCUP) include comprehensive physical exams, developmental assessments and anticipatory guidance; this is a reminder of other important components to include:

Fluoride Varnish

Oral evaluation and fluoride varnish application are preventive services which should be provided to high risk patients, preferably within six months of eruption of the first primary tooth. Medicaid covers the application of fluoride varnish when provided to Medicaid-eligible children in a physician's office. Physicians, physician assistants, and advanced registered nurse practitioners may provide this service and bill Medicaid using CPT procedure code 99499.

Fluoride varnish may be applied to a child's teeth at the time of the CHCUP visit. Medicaid reimbursement for 99499 is \$27.00 for both the application of fluoride varnish and the oral evaluation for a child 0 to 3 years of age.

The fluoride varnish application should include counseling of the child's caregiver.

Dental Referrals

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 physician needs assistance locating a dentist, the physician should notify the local Medicaid Area Office that the child needs a dental visit and still complete the referral.

Blood Lead Testing

Performing a blood test for lead is a federal requirement at specific intervals during the 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. Select **Public Information for Providers**, then **Provider Support**, then **Provider Handbooks**, and then the **Child Health Check-Up Handbook**.

