

Medicaid Bulletin

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The Agency for Health Care Administration champions accessible, affordable, quality health care for all Floridians.

Medicaid Budget Proposals

The Legislature's chief job during its annual session is to pass a budget. Medicaid represents a major portion of the budget, involving \$8 billion in state and federal funds. In his FY 2000-01 recommended budget, Governor Bush proposes improvements to the Medicaid program.

Program Enhancements

Florida KidCare. Governor Bush has two main goals for Florida KidCare, the state's Title XXI children's health insurance program: (1) to ensure that eligible children have access to health benefits; and (2) to maximize the state's use of its annual \$270 million federal Title XXI block grant. For FY 2000-01, Governor Bush recommends \$214 million in additional funding to:

- ◆ Fully fund the Title XXI estimated unmet need for children's health insurance — about 81,000 additional children under age 19 with incomes at or below twice the federal poverty level in FY 2000-01;
- ◆ Provide dental benefits to all Title XXI Florida KidCare enrollees and increase Medicaid fees for children's dental services;
- ◆ Extend Florida KidCare benefits to approximately 7,725 children whose status as non-citizens excludes them from Title XXI programs by federal law. The funding for this issue is state-only and contingent upon local matching funds of 40 percent of total costs; and
- ◆ Initiate presumptive eligibility for Medicaid for children under age 19, allowing these children to have temporary eligibility for Medicaid while their full eligibility determinations are being completed.

Physician Fee Increases. In addition to increasing provider fees for Medicaid children's dental services, the Governor also recommends \$42 million to increase reimbursement for physicians by about 7.6 percent, which should help improve access to care.



Ruben J. King-Shaw, Jr., Executive Director. His extensive background in health care includes executive positions with Neighborhood Health Care, John Alden, and JMH Health Plan.



Gary L. Crayton, Deputy Director for Medicaid. A Medicaid veteran, he returned to the program last year after 18 months with the Florida Health Care Association. He has worked with Medicaid since 1982.

(continued on page 4)

MediPass Disease Management

The Agency for Health Care Administration initiated a disease management program last summer and has now contracted with organizations to provide disease management services to MediPass recipients who have been diagnosed with diabetes, AIDS, asthma, or hemophilia. The Agency is in contract negotiations to provide disease management services for congestive heart failure and end stage renal disease. These services should begin in the second quarter of 2000. Disease management services may also be implemented in the future for MediPass recipients who have been diagnosed with sickle cell anemia, cancer, or hypertension.

Who is Eligible?

The Medicaid disease management projects are available only to Medicaid recipients enrolled in the Primary Care Case Management Program (MediPass). The MediPass population represents over 524,000 of the more than 1.5 million Florida Medicaid recipients. The Agency has determined that 19 percent of the MediPass population meets the criteria for the six disease states the Agency currently manages or will manage by Spring 2000. All eligible MediPass recipients are automatically enrolled in the disease management program but can disenroll at any time.

Why Disease Management?

Results of disease management studies conducted around the country indicate that closely managing patients with chronic diseases can reduce the higher cost services these patients often require and at the same time improve quality of life for the patient. Disease management also can prevent or delay the onset of the more severe stages of a disease.

Design and Objectives

In 1997 the Florida Legislature authorized the disease management program and directed the Agency to “select methods for implementing the program that included best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools.” The Florida disease management program has been designed to promote and measure: health outcomes, improved care, reduced inpatient hospitalization, reduced emergency room visits, reduced costs, and better educated providers and patients. It is also expected that the disease management

program will bring an enhanced connection between the patient and the provider, making a significant impact on health outcomes and improved quality of life for patients with chronic diseases.

The Enrollment Process

The Agency identifies potential MediPass disease management recipients through paid claims. Prospective recipients are notified by the Agency and the appropriate disease management organization that they are eligible for participation in the program and are advised of the additional care management benefits that are a part of the disease management program.

Provider Involvement

The Agency also notifies the MediPass primary care physicians of the recipients in their MediPass patient caseloads who meet the criteria for disease management services. Providers may also refer their MediPass patients who are not already enrolled and who may benefit from a program. The disease management care managers become an extension of the physician’s services by helping enrolled patients better understand their diseases and make necessary life style changes with the goal of self-management. Providers are informed of their enrolled patients’ progress through ongoing reports. In addition, providers receive clinical practice guidelines developed by leading experts in the treatment of each disease state.

The Future

The Agency encourages MediPass physicians and entities to work closely with the disease management organizations to make this program a success. Ultimately the disease management program should prove to be beneficial to the patient, the provider, and to Medicaid. The expected benefits of this program are improved health and well being of MediPass patients, additional resources to MediPass providers, and reduced costs associated with patients who have a chronic disease.

**For more information, please visit the
AHCA website at:
<http://www.fdhc.state.fl.us/medicaid>
Click on Disease Management.**

Program Under Way

Disease Management Organization	Disease Group	Medicaid Areas Covered
<p>Accordant Health Services 4900 Koger Boulevard, Suite 300 Greensboro, NC 27407 (800) 948-2497</p>	Hemophilia	7, 8, 9, 10, 11
<p>Caremark, Inc. 2211 Sanders Road Northbrook, IL 60062 (800) 225-5967</p>	Hemophilia	1, 2, 3, 4, 5, 6
<p>Coordinated Care Solutions 210 N. University Drive, Suite 700 Coral Springs, FL 33071 (888) 721-9797</p>	Diabetes Congestive Heart Failure	Statewide 8, 9, 10, 11
<p>Integrated Therapeutics Group 2000 Galloping Hill Road Kenilworth, NJ 07033 (800) 498-1079</p>	Asthma	Statewide
<p>LifeMasters Supported SelfCare 450 Newport Center Drive, Suite 410 Newport Beach, CA 92660*</p>	Congestive Heart Failure	1, 2, 3, 4, 5, 6, 7
<p>Renal Management Strategies Inc. 1620 Waukengan Road, Building R McGraw Park, IL 60085*</p>	End Stage Renal Disease	Statewide
<p>Positive Healthcare 10199 Southside Blvd., Suite 203B Jacksonville, FL 32256 (800) 832-0778</p>	HIV/AIDS	1, 2, 3, 4, 5, 6, 7, 8, 9 and Monroe County
<p>South Florida Community Care Network 1801 NW 9 Avenue, Suite 700 Miami, FL 33136*</p>	HIV/AIDS	Broward and Dade Counties

*Contact phone numbers pending contract negotiations.

**The Florida Disease Management Program promotes:
improved care, reduced inpatient hospitalization,
reduced emergency room visits, reduced costs,
and better educated providers and patients.**

All Providers

(continued from page 1)

Hospital Fee Increases. The Governor recommends \$131.3 million to increase the hospital outpatient cap for adults from \$1,000 to \$1,500 annually, and eliminate inpatient and outpatient reimbursement caps for teaching, specialty, and community hospital education program hospitals. These recommendations are intended to provide some relief for these providers of indigent and charity care.

New Coverages

Psychiatric Services for Children. Governor Bush recommends \$23 million to initiate Medicaid coverage for psychiatric hospital services for children under age 21, also called institutions for mental diseases, or IMDs. This service will allow Medicaid to cover psychiatric residential services for children, thereby decreasing the number of admissions and readmissions to higher-cost inpatient facilities.

Universal Newborn Hearing Screening. The Governor recommends \$1.4 million to initiate Medicaid coverage for hearing screenings for newborns. Since Medicaid pays for 55 percent of all births in Florida, this is an important health service to help identify and treat infant hearing problems as early as possible. The Governor also recommends additional funding in the Department of Health's budget to screen newborns who are not eligible for Medicaid.

Waiver Services for Medically Fragile Young Adults. Currently, children with complex medical needs may receive services from the Department of Health's Children's Medical Services (CMS) program until age 21, when they are no longer eligible for services. This issue provides \$1.4 million, \$610,000 of which is General Revenue transferred from CMS to Medicaid, to create a specialized home and community-based services waiver for technology dependent, medically fragile young adults.

Continuation Funding

The Governor recommends \$625.2 million in additional funding for FY 2000-01 to continue the Medicaid program under current benefits and eligibility criteria, and to fund an increase in the average monthly caseload of almost 80,000. Almost \$394 million — or 63 percent of the total increase — is due to higher costs for prescribed drug services.

Cost Containment Initiatives

The Governor recommends several issues to contain costs in the Medicaid program. The largest of these issues is the prescribed medicine cost containment initiative.

Prescribed Medicine Cost Containment Initiative. The 1999 Legislature authorized several prescribed drug measures to help control growing costs. Even with these measures, Medicaid prescribed drug spending is expected to grow by 25.4 percent in FY 2000-01 over FY 1999-00. By comparison, Medicaid expenditures for all service categories excluding prescribed drugs, is only expected to grow by 6.4 percent. The Governor's FY 2000-01 initiative, which would reduce Medicaid prescribed medicine expenditures by \$240 million, includes the following major provisions:

- ◆ Implementing a preferred drug designation program for selected therapeutic categories, including anti-hypertensive, gastrointestinal and asthmatic agents;
- ◆ Initiating prior consultation requirements for any drug not on the preferred drug designation list;
- ◆ Securing additional supplemental rebates from pharmaceutical manufacturers;
- ◆ Expanding disease management organization contracts to help control prescribed drug costs;
- ◆ Capitating drug coverage for Medicaid-eligible nursing home patients; and
- ◆ Establishing a monthly limit of four "brand name" prescriptions for adult Medicaid beneficiaries while permitting unlimited access to multi-source (generic) prescriptions.

Other Cost Containment Measures. The Governor also recommends reducing nursing home institutional service costs by diverting individuals to other non-nursing facility settings and covering additional people under the Assisted Living Facilities waiver, realizing additional savings by further improving MediPass case management and disease management strategies, and modifying disproportionate share program expenditures.

Prescriber Patterns Reviewed

The state of Florida is experiencing unprecedented increases in the cost of the pharmacy benefit component of Medicaid. In the next fiscal year, the cost of prescription drugs for Medicaid in Florida will exceed \$1.5 billion—and is increasing at a rate of over 20 percent per year. To address this issue, the Legislature created the Prescriber Pattern Review Panel. Members are active practitioners appointed by the Governor, Speaker of the House and President of the Senate. This panel will work with the Drug Utilization Review Board to communicate with prescribers.

We are asking your help as a Medicaid prescriber. While some factors, such as the high cost of new therapies and the pressures of direct-to-consumer advertising for expensive drugs, cannot be controlled within the program, there are efforts prescribers can make to reduce some costs while maintaining high quality of care. Appropriate and thoughtful prescribing can reduce costs in many areas. This panel of practicing physicians and pharmacists has a legislative mandate to help educate Medicaid prescribers about the costs of our program and prescribing guidelines that optimize quality of care while controlling costs. The law specifies that practitioners who continue to prescribe inappropriately be subject to prior authorization for specific drugs.

Consultec has contracted with Heritage Information Systems to design communications similar in purpose to those you are receiving from managed care and HMO pharmacy benefit managers comparing physicians within their medical specialties. This panel is cognizant of the *overall* cost of the Medicaid program, and is *not* suggesting a reduction in pharmacy costs without concern for outcomes. To this end, Medicaid medical claims data as well as Medicaid pharmacy claims data will be used by Heritage Information Systems in each analysis.

An initial review of claims data for the past four months indicates that a relatively small percentage of Medicaid prescribers (less than 10 percent) account for nearly 85 percent of the prescription dollars in the program. Some providers treat Medicaid patients with serious and complex diseases; therefore, we would expect their prescription dollars to be higher. Other providers in this group have extremely high costs *per patient* when compared to others within their medical specialties but without indication of medical complexity. Data was reviewed by therapeutic class, within specialties as reported by the physician on annual licensing information. Physicians identified as having prescribing patterns outside the norm, within specific therapeutic classes, have been sent an informative analysis of their prescribing patterns compared to other physicians within their specialty.



The cost of prescription drugs for Medicaid in Florida (in the next fiscal year) will exceed \$1.5 billion, and is increasing at a rate of over 20% per year.



Appropriate and thoughtful prescribing can reduce costs in many areas.



For more information on the Prescriber Pattern Review Panel, see AHCA's Medicaid Internet site at: <http://www.fdhc.state.fl.us/Medicaid>

All Providers

Newborn Eligibility Policy

On October 1, 1999, the Department of Children and Families and the Agency for Health Care Administration's Medicaid Office started issuing Medicaid identification numbers and gold cards to pregnant women for their unborn children. Providers are now able to inquire about the unborn baby's eligibility with the card control number; however, the Medicaid number will not be active until after the baby is born. Providers can activate the coverage by following the instructions listed below:

- 1 Look up the baby's eligibility record on MEVS, FAXBACK, or AVRS.

If the message tells you that the baby is eligible, no further action is required. Be sure to write down the baby's Medicaid identification number for billing purposes.

If MEVS, FAXBACK, or AVRS tells you the baby's number is inactive, you will need to fax an Unborn Activation Form to Consultec at 877-231-2170 to have the coverage activated. You can obtain the form by calling Consultec at 800-289-7799. Making copies of this form is acceptable.

- 2 Look up the mother's number on MEVS, FAXBACK, or AVRS.

Consultec will not add coverage if the mother is not eligible, if her eligibility category is MU (Presumptively Eligible Pregnant Woman) or FP (Family Planning Services only), or the form is incomplete.

- 3 Complete an Unborn Activation Form and fax it to Consultec at 877-231-2170.

Within two working days, Consultec will add the newborn's name and birth date and activate the

coverage. Please be sure to fill out the form completely. Incomplete forms will be returned to you.

If the mother is in a Medicaid HMO, the baby will be retroactively enrolled in the same HMO as the mother for the first three months of life unless the mother voluntarily enrolls the baby in a different managed care plan.

If you know the mother is pregnant, Medicaid eligible, and her unborn child does not have a number, you may have the baby added by sending a CF-ES 2039, Medical Assistance Referral Form to the district office of Department of Children and Families. A copy of the referral form is in the Medicaid Provider Reimbursement Handbook, Chapter 3. This chapter also contains instructions to follow for completing and mailing the form.

Following this process will expedite the addition of newborns' eligibility to the Medicaid file and allow you to submit your bills more timely. If you have any questions, please call your area Medicaid office.

**The Unborn Activation Form
on the next page
is also available on AHCA's
Medicaid Internet site at:**

<http://www.fdhc.state.fl.us/medicaid>

Unborn Activation Form



This form is used by providers to **activate** a newborn's Medicaid Identification Number only. All of the information **MUST** be completed to activate the Medicaid I.D. number. Please print clearly. FAX this form to Consultec at 1-877-231-2170.

MOTHER		Fiscal Agent Use Only
MEDICAID ID NUMBER: _____ - _____		Mom Eligible _____
FIRST NAME: _____		HMO Enrolled _____
LAST NAME: _____		If yes, attach screen.
MOTHER'S SSN: _ _ _ - _ _ - _ _ _ _		

NEWBORN		Fiscal Agent Use Only
MEDICAID ID NUMBER: _____ - _____		Date Entered on FMMIS _____
FIRST NAME: _____		Operator ID _____
LAST NAME: _____		
DATE OF BIRTH: / /		
SEX (M or F): _____		

PROVIDER	
PROVIDER'S ID NUMBER: _ _ _ _ _ - _ _	
PROVIDER NAME: _____	
ADDRESS: _____	
TELEPHONE NUMBER: _ _ _ - _ _ _ - _ _ _ _	
CONTACT NAME: _____	

Fiscal Agent Use Only	
HMO Provider Number: _____ - _____	Recipient ID: _ _ _ _ _ - _
From Date: _____	To Date: _____
Allowed Charges: _____	

All Providers

Internet Access Can Save Time and Money

We encourage all providers to take advantage of the Consultec Florida Medicaid Website, <http://floridamedicaid.consultec-inc.com>. This website is available 24 hours-a-day, 7 days-a-week. The site is user-friendly and offers important, up-to-date information at no cost to you.

The Florida Medicaid website was designed to help providers search for and retrieve information instantaneously. For easier navigation, the website is divided into three areas: the Public page, the Provider Only page, and the Data Exchange page.

The Public page contains provider support information such as handbooks, provider enrollment applications, and forms. Also available are Medicaid Bulletins, EDI service information and office and field representative contact data.

The Provider Only page contains information that is applicable only to Medicaid providers. A valid Florida Medicaid provider number allows you access to this area. EOB codes and resolution and electronic claims submission software are a few of the resources available to providers.

The Data Exchange page is a secured site that contains Electronic Remittance Vouchers (ERVs). If you choose to receive RVs over the Internet, you will be assigned a Logon ID and password. This ID and password give you secure access to your RVs.

The Florida Medicaid website can save you time and money because the information provided is instant and free of charge. The Internet will enable you to get there. There are several free Internet service providers available. Call the EDI Support Unit for more information at 1-800-829-0218.

Florida MEDICAID

Welcome to the Florida Medicaid Fiscal Agent home page

Consultec is pleased to welcome the Florida Medicaid Community to our Website. The following pages contain information and links that will assist you through much of the Medicaid process.

Provider Payment Note: Please make all checks payable to Consultec. If your check or money order is not made out to Consultec, it will be returned with your correspondence, asking you to correct it.

The following menu options are available:

Menu Option	Included Information
Provider Support	<ul style="list-style-type: none">Provider NoticesEnrollment applicationFee schedule

Chlamydia Epidemic and Screening Alert

There is a chlamydia epidemic in the United States. The Centers for Disease Control and Prevention (CDC) estimate an annual incidence of about 4.5 million new chlamydia cases, with the highest rates among women younger than 25 years. It is the most common treatable sexually transmitted disease in the country. Many women are asymptomatic (showing no symptoms) and the infection may persist for extended periods of time. Reducing the high prevalence of chlamydial infection requires that health care providers be aware of the high prevalence of chlamydia and recognize chlamydial illness, screen asymptomatic patients, and counsel all sexually active patients about the risks of chlamydial infections.

Screening

Screening for chlamydia is especially important because 60 to 70 percent of people with chlamydia do not experience any symptoms. Many women undergo pelvic examinations during visits for routine health care or because of illness. During these examinations, specimens can be obtained for chlamydial screening tests. Sexually active adolescent females have the highest risk, with as many as 1 in 10 adolescent females testing positive for chlamydia. Female patients of adolescent care providers should be screened for chlamydial infection too. Chlamydia screening at family planning and prenatal care clinics is particularly cost-effective because of the large number of sexually active young women who undergo pelvic examinations.

Recent studies finding a high prevalence of chlamydia have led several researchers to recommend that all sexually active adolescent females be screened for chlamydia every 6 months (Burstein, G.R., Gaydos, C. et al., 1998; Gaydos, C., Howell, R.M. et al., 1998). The CDC currently recommends yearly screening (CDC, MMWR, 1998, 47:RR-1; MMWR, 1993, 42:RR-12). Chlamydia screening is a new performance measure in the HEDIS 2000 specifications.

Consequences

Chlamydia is the leading preventable cause of pelvic inflammatory disease (PID), an often painless infection that can result in internal scarring. Infertility or tubal pregnancies occur after 1 in every 10 chlamydia cases. Other possible long-term consequences include chronic pelvic pain and lingering infection.

Risk Reduction Counseling

In addition to screening and treatment, health care providers should:

- Educate sexually active adolescent females regarding HIV and STDs;
- Assess the adolescent's risk factors for infection;
- Offer at-risk adolescents advice about behavior changes to reduce the risk of infection; and
- Encourage the use of condoms.

For additional information about chlamydia screening and the HEDIS 2000 performance measures, please visit the following web sites:

<http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000222/entire.htm>

<http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000480/entire.htm>

<http://www.ncqa.org>

Provider Service Networks

Newest Managed Care Option - Provider Service Networks

The 1997 Florida Legislature authorized the Agency for Health Care Administration to create and contract with up to four Provider Service Networks (PSNs) through a competitive process. These networks serve as demonstration projects offering integrated systems of health care for Medicaid recipients and are managed by health care providers.

Until now Medicaid has offered recipients three managed care options, MediPass, Health Maintenance Organizations (HMOs), and the Children's Medical Services Network. PSNs will provide recipients with a fourth managed care option. PSNs are similar to MediPass in fee structure since PSN primary care providers are paid a monthly case management fee of \$3 per enrollee, and providers are reimbursed on a fee-for-service basis for medically necessary services.

Each PSN will function as a separate managed care entity with its own provider network. Like an HMO, the PSN is responsible for contracting with primary care providers, hospitals, specialists, and ancillary service providers to create a comprehensive provider network.

In February 1998, the Agency released an Invitation to Negotiate and held a bidders conference for potential PSN demonstration applicants. After a review and evaluation process of the seven submitted proposals, contract negotiations began with the highest-ranked applicant, the South Florida Community Care Network (SFCCN).

The SFCCN is composed of the Public Health Trust of Miami-Dade County, Memorial Healthcare System, and the North Broward Hospital District. This PSN will service Miami-Dade and Broward counties. The contact person

for the network is Stephanie Schmidt, Project Manager, 1801 N. W. 9 Avenue, Suite 700, Miami, FL 33136. Her telephone number is (305) 575-3659.

The Agency and SFCCN have completed contract negotiations and preparations for implementation. At bulletin deadline, SFCCN was on schedule to begin enrolling its first recipients in March.

When providers check the managed care information for a recipient through the Medicaid Eligibility Verification System (MEVS), they will see the letter "S" when a recipient is enrolled in a PSN. In addition, they will see the telephone number of the assigned PSN primary care provider for the recipient.

PSN enrollees will receive the majority of their health care through the PSN. Out-of-network care provided to PSN enrollees (for PSN-managed services) must be authorized by the PSN in order for the claims to be paid by the Medicaid fiscal agent. All Medicaid-covered services will be available to PSN enrollees. However, the PSN will not manage community mental health, targeted case management, family planning, hospice, nursing facility, dental, transportation, or waiver services. PSN enrollees may obtain these services from any Medicaid provider.

It is anticipated that Medicaid recipients will benefit from the PSNs' comprehensive integrated health care delivery system of specialists, hospitals, and other providers. The demonstration project is expected to produce positive results for the Medicaid recipient, the providers involved, and the Agency.



Using MEVS for Claims Inquiry

Consultec is pleased to announce the addition of a new MEVS CICS transaction that provides Florida Medicaid claim status information. This feature is available to all Medicaid providers through authorized Florida Medicaid switch vendors. Providers can inquire on the status of their claims using either a TCN, a provider number, or a recipient number and date of service.

Providers may access only their own claims that are up to two years old based on the pay-to provider number submitted on the claims. Information provided through MEVS CICS will inquire directly against the Medicaid claim files and provide claim adjudication status.

By using MEVS for claims inquiry, providers can save time and money by helping their offices run more efficiently. Providers who are interested in using this new feature should contact one of the MEVS vendors listed on this page.

OCR for Paper Claims

Here is how to make your claims legible for Optical Character Recognition (OCR) automated processing, the fastest way to get paper claims processed.

- ✓ Only use the red-printed HCFA 1500 and UB-92 forms available through Consultec or from your forms supplier.
- ✓ Use BLACK (or dark) ink only. Red ink will “drop out” or disappear on the imaged claim documents.
- ✓ Check your print output to ensure readability. The data must also be inside the correct boxes. If hand-printing the claim form, print legibly and within the correct boxes. Remember, if you have trouble reading the information on the claim, so will the data entry processor, whether clerk or machine.
- ✓ For crossover claims, circle the corresponding recipient information on the EOMB form in black ink (not red ink or highlighter). It is not necessary to mark through other recipients’ information.

NOTICE OF CHANGE

Vendors for Medicaid Eligibility Verification Services (MEVS)

Authorized Vendors

*Please update your records and
other materials now!*

Consultec EDI Gateway Services
1-800-829-0218

ENVOY Corporation
1-800-366-5716

Healthcare Data Exchange Corporation
1-610-219-1600

HealthNet Data Link, Inc.
1-800-486-7352

Insurance Benefit Spot Check, Inc.
1-800-233-7768

Healtheon/WebMD
(formerly MedE America Corporation)
1-888-633-3888

MediFAX /The Potomac Group, Inc.
1-800-444-4336

National Data Corporation
1-800-218-1500

All Providers

Electronic Remittance Vouchers (ERVs) Secure on Internet

Consultec now delivers Electronic Remittance Vouchers (ERVs) over a secure Internet site for Florida Medicaid providers. Billing agents and clearinghouses have already taken advantage of this service. There are two different formats of the ERV files available via the Internet.

The most popular format is known as the “report” file. This file looks exactly like what you would receive in the mail. The second option is known as the “dataset” file. This file is a stream of data that can be integrated into the practice management systems. The dataset file is in the exact format used by the previous fiscal agent and is a popular way to automatically post payments. *Caution- once enrolled, you will receive the “dataset” ERV file and will no longer receive a hardcopy of your RV or tapes in the mail. You will, however, be able to print the “report” version from the Internet site.*

For providers and others who wish to receive ERVs over the internet, call the EDI Support Unit at 1-800-829-0218 to obtain a registration form. Complete one registration form for each billing provider number that you wish to register. Each form must be notarized and mailed back to Consultec at:

Consultec
Attn: ERV Registration
1801 Hermitage Blvd., Suite 460
Tallahassee, FL 32308

Consultec strongly encourages all providers to download their remittances from the Internet each Monday morning. This will give you time to correct denied claims and resubmit them by Wednesday for the payment cycle that week.

Frequently Asked Questions about Electronic Remittance Vouchers

Q

What is a “report” ERV?

This file is on the Internet and looks exactly like your hardcopy RV that you receive in the mail. It will be available each Monday morning by 10:00 am. You may print this file from the Internet site at any time.

Q

What is a “dataset” ERV?

This file is on the Internet and follows a specific set of data parameters with multiple variable length records.

Q

Can I view the “dataset” file in Access or Excel?

No. Unless you have a practice management system that is capable of automatically posting payments using an input file, you will not be able to use this file. Only the report file can be viewed using Access or Excel.

Q

How long will ERV files remain on the Internet?

“Report” files will be available for two months (24 hours a day, 7 days a week). “Dataset” files will not be available until an agreement has been received and processed. A maximum of two months of ERV information for both types will be available.

Q

What should I name the file when I download it?

You may name the file whatever you like, but as a default, always add a .txt extension after the filename. If you need to rename the file to comply with a practice management system, please do so after downloading the file with a .txt extension.

FAQs about ERVs (continued)

Q Can I still get a hardcopy version of my RV in the mail if I sign up for RVs via the Internet?

No. If you complete an ERV agreement and mail it back to Consultec, you will receive the “report” and “dataset” file only via the Internet.

Q If I sign up for ERVs via the Internet, will I still get my RVs via tape?

No.

Q Is the tape format different from the ERV “dataset” format?

Yes. You will need to reprogram your system to be able to handle the ERV format. Call the EDI Support Unit for information on how to do this at 1-800-829-0218.

Q Why doesn't my “report” RV via the Internet page-break correctly when I try to print it?

The file is a flat text (html) file and the page break will depend on your individual browser and printer settings.

Q Can I get a report older than two months placed back out on the Internet?

No. You will need to submit a special request to the Provider Inquiry unit at 1-800-289-7799 for a mailed copy.

Q Can I fax the agreement back to Consultec?

No. Consultec needs an original notarized agreement for processing.

Conversion to National Standard Format/UB 92 Formats

Note: If you or your agent is using Consultec's WINASAP 2000 product for electronic claim submission, please ignore this message.

Beginning June 1, 2000, all electronic claims submitters for Florida Medicaid will be required to submit claims in either the NSF version 3.1 or UB 92 version 5 formats. Consultec will no longer accept or support the current proprietary format. The new formats are national standards produced by the Health Care Financing Administration (HCFA). These formats support a four-digit century date, where the proprietary format does not. The NSF (version 3.1) format includes practitioner, dental, public transportation, private transportation, NIO, and Child Health Checkup. The UB 92 format is for institutional claims only.

Please be advised that if you currently submit electronic claims through a vendor, billing agent, or clearinghouse, they will be responsible for executing this conversion. Before being permitted to submit production claims, your vendor, billing agent or clearinghouse must test its new product with Consultec. If you have any questions about your electronic claims submission, or are not sure of your current format, please call EDI Technical Support at 1-800-829-0218.

Consultec highly encourages submitters to convert claim formats as soon as possible. Format specifications can be downloaded from the Internet at: <http://floridamedicaid.consultec-inc.com>

If you have specific format or conversion questions, please call our EDI Analysts at 1-850-201-1171.

All Providers

EDI Frequently Asked Questions

Here are some frequently asked questions (FAQs) concerning electronic claims:

Q: How can I submit my claims electronically?

A: The provider must have an active provider number with Florida Medicaid. You need to fill out the Electronic Claims registration forms that include the Electronic Claims Information Sheet and the Electronic Claims Submission Agreement. These forms can be downloaded at <http://floridamedicaid.consultec-inc.com>. After completing the forms, please mail the original signed copies to:

Consultec
Attn: EDI Enrollment
1801 Hermitage Blvd., Suite 460
Tallahassee, FL 32308

Once we receive and process your forms you will be issued a personal logon and password by either fax or mail. Upon request, you will also receive a copy of the WINASAP2000 software.

Q: When can I start transmitting claims?

A: If you have completed your enrollment as an electronic claims submitter and are using the WINASAP2000 or ASAP-LTC software, you will receive your logon form within 3 working days. At that time, you can begin transmitting claims; testing is not required. If you have vendor or third-party software, you need to also register and send in agreements for Electronic Claims submission to receive your login information. Your software vendor needs to successfully test its program with our EDI Analysts. If the software has been tested and approved by our analysts, you can begin submitting claims.

Q: I submit electronic claims. Can you clarify when I need to call EDI, Provider Inquiry, or Provider Enrollment?

A: Call **EDI** with questions regarding registering for electronic claims, Faxback, Enrollment for Electronic Data Exchange services, support for installation of WINASAP 2000 and ASAP-LTC software, technical support for transmission of electronic claims, and claims that were transmitted but did not show up on the RV. Call **Provider Inquiry** with questions regarding billing, claims adjudication and payment questions, EOB code clarifications and eligibility information.

Call **Provider Enrollment** with questions regarding EFT, enrollment of new Medicaid providers, and changes in enrollment (address, tax-ids, categories of service).

Q: When is the weekly payment cycle deadline for electronic claims submission?

A: In order to receive payment the week that you submit your claims, you need to submit no later than midnight on Wednesday.

Q: I submit my electronic claims with Consultec's new software, WINASAP2000. While searching the Florida Medicaid Website, I noticed that there was a software update. Do I need this update?

A: We always recommend installing the latest update to ensure proper application of WINASAP2000.

Q: I am a software vendor interested in programming for electronic claims. Where can I get a copy of the Florida Medicaid Specifications Manual?

A: Our specifications manual can be downloaded from the Consultec Florida Medicaid Website located at <http://floridamedicaid.consultec-inc.com>.

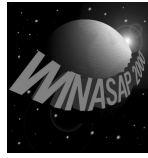
Q: In addition to receiving my weekly remittance voucher, I received a reject report. What is this report?

A: As a service to the provider community, EDI mails the provider a copy of the rejected claim information pertaining to a particular file. This is to inform the provider of a possible rejected claim prior to receiving your remittance voucher. If you have questions regarding this reject report, please contact an EDI Analyst at 850-201-1171.

Q: For some reason I have not been receiving my reject report. Who can I contact to ensure that you have my correct address?

A: Rejects are mailed to the address listed on the provider master file. If you need to update your mailing address or telephone number, please contact the Provider Enrollment department at 1-800-377-8216 for instructions on how to update your information.

Tips for Billing Adjustments and Voids Using WINASAP 2000



Many providers are using WINASAP 2000 to send electronic claim adjustments and voids. To ensure that your claim adjustments and voids are processed correctly, please follow the easy steps below.

Adjustments

To adjust a PAID claim:

- Enter the TCN of the paid claim in the TCN field in the upper right hand corner of the claim.
- Enter the code that reflects the reason you are adjusting the claim. The code is entered in the Reason Code field in the upper right hand corner of the claim.
- If the claim you are adjusting was NOT originally submitted using WINASAP 2000, enter the claim exactly as it was originally submitted. Change only the field that you are correcting. *Note: Remember that you cannot adjust a provider number or recipient number.*

Voids

If you are submitting a void, the TCN should reflect the claim that was paid. You can only void a PAID claim.

CATTS Claims Submissions Discontinued June 1, 2000

On June 1, 2000, CATTS claims submission software will not be distributed and CATTS electronic claims transmissions will be disconnected at the host. All providers using CATTS need to convert to WINASAP2000 or other compliant vendor software.

WINASAP2000 software can be downloaded from the internet at <http://floridamedicaid.consultec-inc.com>. Call the EDI Support Unit at 1-800-829-0218 for information on WINASAP2000 or other compliant software vendors.

Medicaid Overview Training in Area 4



Medicaid Overview Training for HCFA-1500 users in Duval, Clay, St. Johns, Nassau and Baker Counties will be held April 11, 2000. Hospital providers in the same counties will receive training on April 12, 2000.

HCFA-1500 users in Volusia and Flagler counties will receive training on May 1 and 3, 2000. Hospital providers in these counties will receive training on May 2, 2000. Please call (904) 353-2100 at extension 129 or 149 for more information and registration.



As of February 1, 2000, you can purchase the HCFA-1500 and UB 92 claim forms through Consultec. An order form can be downloaded from the Medicaid website at:
<http://floridamedicaid.consultec-inc.com>



Please do not punch holes in claim forms. Transaction Control Numbers (TCNs) cannot be assigned and your claim will either be returned or delayed by manual processing.

Dental, Health Care Practitioners

Expanded Adult Dental Services



The 1999 Florida Legislature approved \$4.5 million to expand the Medicaid adult dental program to include preventive and emergency services. Since the additional funding is somewhat limited, there is one new adult preventive service, an oral prophylaxis (D1110), to be performed once per year.

Emergency services are limited to extractions and incision and drainage (I&D) procedures, as needed for relief of pain or infection. Procedure codes used for adult emergency services are already covered with the adult denture program. Medicaid dental policy is now revised to allow the extraction of teeth without the stipulation that a complete denture must replace the extracted teeth.

New Dental Procedure Codes



On January 1, 2000, the Medicaid Dental Program began coverage of nine new CDT-3 dental procedure codes. The new codes and fees are as follows:

D0350	\$7.00
D2337	\$72.00
D3221	\$30.00
D3331	\$50.00
D3333	\$31.00
D8692	\$63.00
D9241	\$50.00
D9242	\$20.00
D9248	\$40.00

On January 1, 2000, Medicaid also began covering two and three surface resin restorations for posterior primary and permanent teeth, codes D2381, D2382, D2386 and D2387. Fees for multi-surface posterior resins are the same as comparable surface amalgam restorations.

Procedure codes D0471, D9240 and W5301 are being discontinued and will cease paying for dates of service after March 31, 2000.

Proper Billing Procedures When Using Modifiers

Multiple Modifiers

When billing for procedures with multiple modifiers, use modifier -99 only and submit a paper claim with supporting documentation of each service provided. At the top of the documentation please provide a statement, clearly marked for the medical consultants, which shows what modifiers were intended for review.

Example: modifier 99 = 78 and 80. This will ensure proper review and pricing.

Modifier -25

Modifier -25 requires a paper claim and supporting documentation of the evaluation and management service. The documentation must support that a significant and separate identifiable evaluation and management service was performed on the same date as the surgery. Medicaid does not reimburse for pre-operative visits on the same date of surgery. Please refer to the appropriate Medicaid Coverage and Limitations Handbooks, which contain guidelines for Global Surgical Package Components and the description for using modifier -25.

Modifier -22

Use modifier -22 only when a provided service exceeds the usual service as described in the CPT handbook. A report must be attached that documents the additional service and describes the unusual circumstances. This report must be submitted in addition to the operative report or physician documentation of the actual service provided. Omission of this documentation will cause the claim to deny.

CORRECTION

**On page 8 of the October 1999 Medicaid Bulletin, the telephone number for Bay county was incorrect. It should have read:
1-800-226-7690**

Child Health Check-Up, Birth Centers, Licensed Midwives

Child Health Check-Ups (formerly called EPSDT)



Reminders:

Blood lead testing is required for children at 12 months and at 24 months of age, and between the ages of 36 months and 72 months of age if they have not been previously screened for lead poisoning.

Blood lead tests reimbursable by Medicaid are:

- W9979 Blood lead (capillary) using collection tube or finger stick filter paper, and
- 83655 Blood Lead (venous).

Refer to the Laboratory Services Coverage and Limitations Handbook for further information.

For any abnormal findings found during a Child Health Check-Up, providers must enter the appropriate diagnosis code and exam code on the Child Health Check-Up 221 claim form. This information is critical for case management.

Your patients may be eligible for free nutritious foods and nutrition counseling through the Women, Infants and Children (WIC) Program. Please refer all pregnant, postpartum and breast-feeding women, infants, and children under five years old to a WIC office or have them call the WIC toll-free number at 1-800-342-3556.

Changes for Birth Center Program

Effective January 1, 2000, the following changes occurred in the birth center program:

- J2590, Oxytocin, is covered at \$1.00 for up to 10 IUs. Maximum 2 units for a total of 20 IUs.
- J2210, Methergine, is covered at \$3.28 for up to 0.2 mg. Maximum 1 unit.
- J0550, PCN G, is covered at \$24.62 for up to 2.4 mu. Maximum 14 units.
- Clindomycin is covered at invoice price under the code 99070, unclassified drugs. (You must bill for this code on a paper claim with an invoice attached documenting the drug amount used for the recipient.)

Changes for Licensed Midwife Program



Effective January 1, 2000, the following changes occurred in the licensed midwife program.

- J2590, Oxytocin, is covered at \$1.00 for up to 10 IUs. Maximum 2 units for a total of 20 IUs.
- J2210, Methergine, is covered at \$3.28 for up to 0.2 mg. Maximum 1 unit.
- J0550, PCN G, is covered at \$24.62 for up to 2.4 mu. Maximum 14 units.
- Clindomycin is covered at invoice price under the code 99070, unclassified drugs. (You must bill for this code on a paper claim with an invoice attached documenting the drug amount used for the recipient.)
- Birth kit reimbursements increased from \$30 to \$45.

Durable Medical Equipment, Home Health

DME, Home Health

Customized And Motorized Wheelchairs For Recipients 21 And Over

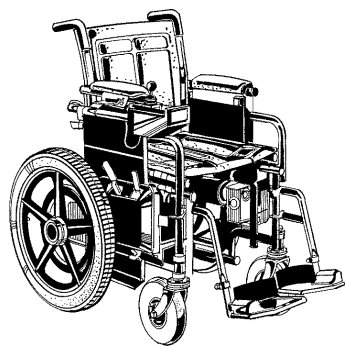
Medicaid now covers customized manual and motorized wheelchairs for Medicaid recipients age 21 and over. To be reimbursed, a provider must submit a prior authorization request to the local area Medicaid office. The request for customized wheelchairs must include:

- Medical necessity or Certificate of Medical Necessity (CMN).
- Evaluation by Physical or Occupational Therapist.
- Written documentation describing the physical status of the recipient with regard to mobility, self-care status, strength, cognitive abilities, coordination, and activity limitations.
- A description of what physical improvement(s) can be anticipated or what physical deterioration can be prevented.
- A list of each customized feature required for unique physical status.
- A description of the medical benefit of each customized feature.
- A list of the principal places of use.
- An itemized invoice with actual cost for parts and labor.
- A list of the source(s) of purchased accessories and modifications.

Prior authorization is not a requirement for standard motorized wheelchairs; however, the recipient must meet all of the following conditions:

- Be documented as having a severe abnormal upper extremity dysfunction or weakness.
- Have sufficient eye/hand perceptual capabilities to operate the chair and the cognitive skill to guide it independently.
- Be capable of some activity to which the motorized chair will provide access.
- Have an environment conducive to the use of a motorized wheelchair.

Prior authorization is not required for dually-eligible recipients who request customized wheelchairs. Dually eligible recipients are defined as individuals who are receiving both Medicare and Medicaid benefits.



Home Health

Patient Responsibility

Patient responsibility is that portion of the hospice care payment, determined by the Department of Children and Families (DCF), for which the recipient is responsible. The patient responsibility amount may be zero or any dollar amount. The DCF notice of approval, sent to the hospice provider, indicates if any patient responsibility is due for the client. Providers should contact DCF if they do not receive a notice of approval.

When billing for Medicaid hospice services, the patient responsibility amount **MUST** be entered in field 57 on the UB-92 claim form. It is the hospice's responsibility to collect the patient responsibility amount. That amount must be entered on the claim form whether or not the payment is collected, even if the amount equals zero.

Medicaid pays up to the approved Medicaid rate that remains after the amount of patient responsibility has been deducted by the Florida Medicaid Management Information System (FMMIS) claims processing system.

Providers must ensure their software identifies a field for patient responsibility. If you have further questions regarding the reporting of patient responsibility, please contact your area Medicaid office.

Home Health Retrospective Review

During the contract period of July 1, 1998 – June 30, 1999, Florida Medical Quality Assurance, Inc. (FMQAI) reviewed 814 records (a review period of 7/1/97 – 6/30/98) for utilization and quality review of home health services received by Medicaid recipients.

Positive Findings:

- 93 percent of records reviewed documented performance of an initial or annual assessment.
- 95 percent of all ordered services were obtained in a timely manner.
- 96 percent of records reviewed documented that the plan of care was specific for duration and frequency of services ordered.
- 97 percent of records reviewed documented that patient status was periodically recorded by the nurse.

Areas for Improvement:

Ninety-one home health agencies had billing errors. The top three billing errors are below.

- Unordered visits billed and reimbursed for 22.16 percent of records reviewed.
- LPN visits billed inaccurately for 8.76 percent of records reviewed.
- Aide visits billed inaccurately for 29.64 percent of records reviewed.

Of the 224 records that went to physician review for lack of medical necessity, 108 were denied.

Other Notes:

- 31 percent of the recipients were 66 years of age and older.
- Recipients had an average number of 59.5 visits per certification period with an average of 1.7 certification periods per recipient.

Home Health Pre-Certification

Effective October 1, 1999 through June 30, 2000, KePRO of Harrisburg, Pennsylvania will review home health pre-certification requests for Medicaid. Please send all home health pre-certification, modification and reconsideration requests to:

KePRO
Attn: State Contracts Pre Cert
P.O. Box 8310
Telephone: (877) 763-7720
Facsimile: (877) 763-7721

Pre-Certification Modification Requests

When submitting a modification request to the PRO, please send a copy of the pre-certification approval letter for the certification period being modified, along with a completed request form and a copy of the physician orders.

HMO PRO Review Activity

The Peer Review Organization (PRO) reviewed 6,462 HMO records (dates of service 7/1/97 through 6/30/98) for quality of care and services provided by HMO providers to Medicaid recipients. During the contract period July 1, 1998 — June 30, 1999, the quality of care and services evaluated included visits conducted in the primary care physicians' (PCPs) offices, annual family planning visits, initial prenatal visits, and postpartum visits.

The review included evaluating the documentation provided in the record related to:

- Allergies, advanced directives, medications, past health history, and risk factors;
- Appropriateness of diagnostic tests, treatment, referrals to specialists, ancillary services, and follow-up; and
- Coordination of follow-up care after a hospitalization or emergency room visit.

The second review cycle showed improvement over the first review cycle in medical services documentation to Medicaid recipients.

Positive findings:

- Primary Care Physicians (PCPs) are addressing chief complaints.
- PCPs are conducting appropriate diagnostic tests and follow-up.
- PCPs are implementing aspects of primary prevention, e.g., comprehensive physical exams are occurring in 94 percent of the encounters and health screens for adults are occurring in 73 percent of the encounters.
- The overall quality of care for antepartum visits was excellent.

Areas for improvement:

- There was a general lack of attention when documenting risk factors and associated recipient education and interventions that would prevent illnesses.
- PCPs did not make referrals to specialists in 42 percent of the encounters in which a specialist referral was indicated.
- PCPs failed to provide ancillary services for recipients who needed these services in 49 percent of the encounters.
- Absence of Healthy Start Prenatal Risk Screenings in 32 percent of the encounters.
- Histories related to postpartum visits revealed nutrition information was missing in 66 percent of the encounters; a pelvic exam was not conducted in 54 percent of the encounters; and patient teaching regarding infant care did not occur in 71 percent of the encounters.

MediPass PRO Review Findings

The PRO reviewed 4,040 MediPass records (dates of service 7/1/97 through 6/30/98) for quality of care and services provided by MediPass providers to Medicaid recipients. During the contract period July 1, 1998 through June 30, 1999, the quality of care and services evaluated included visits conducted in physicians' offices, annual family planning visits, initial prenatal visits, and postpartum visits.

Positive findings:

- MediPass providers are addressing chief complaints.
- MediPass providers are conducting appropriate follow-up related to an illness.
- Women are receiving cervical pap smears and mammograms according to state policy.

Areas for improvement:

- Documentation concerning allergies and medications.
- Documentation of risk factors.
- Absence of referrals to specialists in 21 percent of the encounters.

The findings for this review cycle are similar to the previous review cycle for: completed physician exams, treatment regimens appropriate for chief complaints, and well documented plans of treatment. Providers performed better regarding the provision of mammograms and pap smears. However documentation indicates a difference in referrals to specialists: 21 percent of the encounters for this review sample were not referred when a referral was indicated compared to 8 percent in the previous sample. This preliminary finding may suggest the MediPass provider's reluctance to refer to specialists or that access to specialists is not considered.

Sacred Heart PRO Pilot Project

Each year the Peer Review Organization (PRO) requests 40,000 medical records from hospitals across the state. Linda Hoover, Utilization Review Coordinator at Sacred Heart Hospital in Pensacola, requested that the Agency for Health Care Administration perform a pilot project on submission of abstracted records in lieu of records in their entirety. An abstracted record is about one-fourth the size of a complete medical record. The contents of an abstracted record include: demographics, admission history and physical (H&P), discharge summary, physicians' orders and notes, OP reports and all diagnostics (labs, x-rays, EKGs, etc.).

Sacred Heart hypothesized that an abstracted record would provide a clear clinical picture of medical necessity for most admissions. For the few cases in which the abstract would not provide sufficient information or in

which there were potential quality concerns, the PRO could request the complete medical record. The Agency agreed that the PRO would review abstracts on the next selection for Sacred Heart Hospital, which consisted of a total of 99 records.



From those 99 records, the nurse reviewer approved 69 cases based on the information provided. Thirty records were sent to a physician advisor for first level review. Of the 30 cases, 27 were approved and three were denied. Of the 99 cases, none were denied on the basis of inadequate documentation. All the reviewers found the information

provided was sufficient to make a medical necessity determination.

Based on the findings of this study, the Agency will recommend to the next PRO that record abstraction be considered when hospitals submit records to the PRO.

Search for New Peer Review Organization

On September 30, 1999, Florida Medical Quality Assurance, Inc. (FMQAI) terminated its contract for utilization review with Florida Medicaid. Hospitals, home health agencies, HMOs, MediPass physicians, clinics, hospices, and Project AIDS Care waiver providers were notified that all reviews and communications with FMQAI would terminate at the conclusion of the contract.

The Agency for Health Care Administration is in the process of procuring a new vendor to provide peer review service.

An Invitation to Negotiate was issued December 17, 1999. The Agency intends to contract with a new PRO effective April 3, 2000. When a new contractor is selected, the Agency will notify all affected providers. The new PRO will conduct orientation seminars across the state prior to beginning reviews.

Hospitals, Hospice

PRO Review Activities - Hospitals

During fiscal year 1998-1999, the Peer Review Organization (PRO) reviewed 35,528 hospital records (dates of service 7/1/97 through 12/31/99) for medical necessity, appropriate setting, and quality of care provided by hospital providers to Medicaid recipients. The random sample of records focused on chest pain diagnoses and on diagnoses for which a regressive sampling methodology indicated a high potential for denial in specific hospitals. The PRO also reviewed a random selection of cases from providers with low denial rates to assure a minimum of five cases per provider. (A low denial rate was defined as less than 14 percent admission denials, less than 5 percent length of stay denials, and less than 0.70 days denied per case.)

The focused review of chest pain cases revealed a high denial rate (15.9 percent) on length of stay. It appeared from the review data that overall admissions were appropriate (2.2 percent denial rate), but hospitals tended to keep the patient in the hospital 1-2 days longer than medically necessary.

The overall denial rate for the year was 17 percent, based on cases denied. However, it is significant that since FMQAI terminated the contract with AHCA prior to finalizing many requests for reconsiderations, the denial rate is preliminary. Historically, the reconsideration rate is approximately 39 percent and reversal rate on reconsiderations is approximately 50 percent. The historically high rate of reconsiderations and reversals is due to only one level of physician review being necessary to issue a denial.

Implemented by PRO during the fiscal year was an intensified review of 12 hospitals with the probability of high denial rates. The PRO requested that those hospitals provide a corrective action plan, which addressed the reason for high denial rates with actions to correct the deficiencies. Follow-up on intensified review was aborted because of the termination of the PRO contract.

AHCA expects that the new PRO contract will include reviews of reconsideration completions and pending initial reviews prior to the initiation of new reviews.

Hospice Retrospective Review

FMQAI reviewed 992 Hospice medical records for services rendered from July 1, 1998 to June 30, 1999. The significant findings are listed below:



Top 5 Diagnosis

- Carcinoma of the lung
- Debility
- Cerebral degeneration
- Alzheimer's
- HIV



Key Findings

- 57 percent of recipients included in the sample resided in a nursing facility.
- 20 percent of the records reviewed did not contain documentation of a terminal illness.

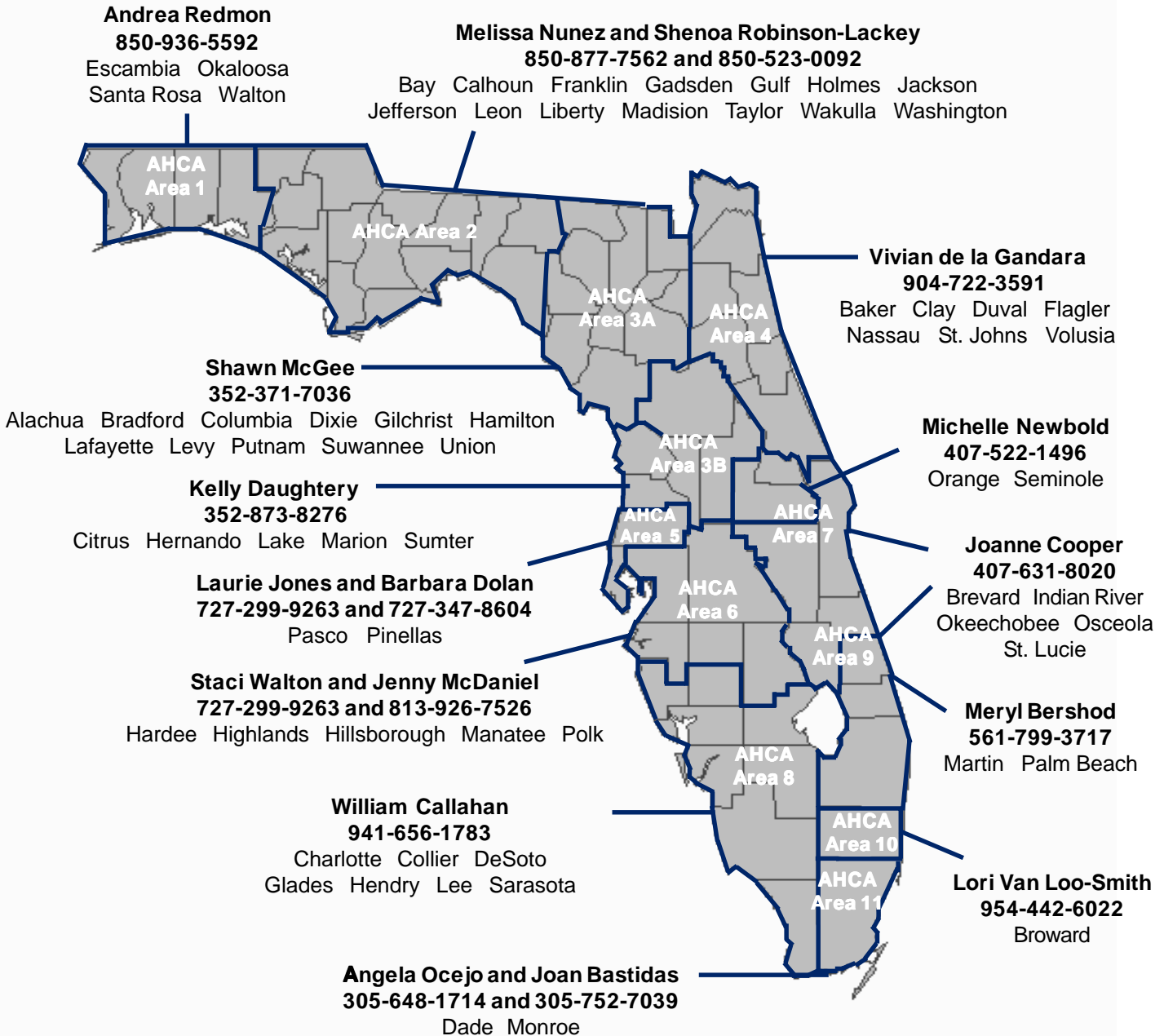


Positive Findings

- 99 percent of records reviewed indicated that the pain management plan was administered as planned.

CONSULTEC Field Representative Map

Field Representatives, Counties Covered and Telephone Numbers



Dialing the number "1" before the area code may be necessary to complete your telephone call.

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Articles carrying this graphic contain important Medicaid Provider Handbook information.



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