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Florida Medicaid

Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION

Florida Medicaid Transition to HIPAA 5010 Transactions

Claims submitted to Florida Medicaid in the 4010 version of HIPAA standard transactions after December 31, 2011 will not be processed. All trading partners will be deactivated for HIPAA standard 4010 X12 transactions effective January 1, 2012. Providers and vendors who submit or receive electronic files from Florida Medicaid or its fiscal agent must be prepared for the expiration of the 4010 version of HIPAA standard transactions on December 31, 2011. **Failure to prepare for this deadline will result in delayed Medicaid payments.**

Florida Medicaid has provided communication and transition planning assistance for this project since August 2010. It is coming close to the time this mandatory change will occur. If you have not made preparations yet, you should:

1. Contact your software/practice management vendor, billing agent, or clearinghouse immediately regarding the HIPAA 5010 standard.
2. Refer to the [EDI-Submission Information](#) page on the Florida Medicaid Public Web Portal for guidelines for testing and moving to the 5010 version of HIPAA transactions.



Medical claims submitted to Florida Medicaid in a method other than the HIPAA standard electronic batch format (i.e., paper, Secure Web Portal Direct Data Entry) are not affected by this transition.

For questions regarding Florida Medicaid's 5010 implementation, please contact the Medicaid fiscal agent at 1 (866) 586-0961.

Inside This Issue:**All Providers**

1. Florida Medicaid Transition to HIPAA 5010 Transactions
2. A Message from Secretary Elizabeth Dudek
3. Medicaid Compliance Corner
4. The Statewide Medicaid Managed Care Program
6. Payment Error Rate Measurement Project (2011)
7. ICD-10 Transition Plans
8. Going Digital to Achieve Meaningful Use

Physicians and Hospitals

9. Unborn Activation Tips

FQHCs and RHCs

9. Revised Wraparound - Supplemental Submission Worksheet

Dental Providers

10. Florida Medicaid Statewide Prepaid Dental Health Expansion

Child Health Check-Up (CHCUP) Providers

12. Child Health Check-Up

A Message From Secretary Elizabeth Dudek

The Agency for Health Care Administration is working to implement the Statewide Medicaid Managed Care (SMMC) program. As you may have heard, the intent of the program is to provide a more efficient and effective service delivery system that enhances quality of care and health outcomes in the Florida Medicaid Program. We are in regular communication with the Centers for Medicare and Medicaid Services regarding our waiver submissions for this program and will keep you abreast of new information as it becomes available.

Under the SMMC program, managed care plans will be required to establish a system that encourages recipients to build a relationship with their primary care provider. This system will afford better coordination of care and supply information to each enrollee about the importance of having a primary care provider. I hope you will support the Agency and Medicaid recipients as we work through this implementation.

Information regarding the SMMC program implementation and managed care can be found in this and future provider bulletins. In addition, details regarding the timeline for procurements, plan selection and contracting, plan network requirements and future public meetings will be posted on the Agency's website as they become available at www.ahca.myflorida.com/Medicaid/statewide_mc. You may also sign up at this website to receive SMMC program alert notices via email.

In closing, this is the time of year we pause to reflect and give thanks for the important people in our lives. As a Florida Medicaid Provider, I am thankful to each of you for the much needed services you provide to Florida's Medicaid recipients. May your holidays be cheerful and safe!

Sincerely,



Elizabeth Dudek
Secretary

Medicaid Compliance Corner

An internet search using any major search engine with the term “Health Care Fraud” yields millions of articles. Inevitably, there will be articles describing some form of action by federal or state law enforcement that took place perhaps only hours earlier. The search will also result in numerous articles about investigations in major metropolitan cities, including those here in Florida.

Over the past several years, the Agency for Health Care Administration (Agency) has increased its communication and coordination with other state agencies, as well as local, state and federal law enforcement and private-sector partners, in the effort to fight fraud within Florida health care and the Florida Medicaid program. It is no surprise that there has also been a significant increase in law enforcement and regulatory activity to address health care fraud.

This increased communication means a greater likelihood that would-be fraudsters will be detected earlier, investigated more efficiently, and punished more swiftly. It also means the Agency is able to be more proactive at managing areas of potential risk. We are better able to focus investigatory efforts more directly on areas of high risk, and focus education and monitoring on more providers using fewer resources.

Recently, we have made more policy and compliance-related training available on our website, and engaged more resources to be present in the provider community. We continue to find many of the same issues of non-compliance across different provider types, and we encourage all providers to take some time to incorporate compliance efforts into their day-to-day business activities. For more information about how to develop a compliance program and/or to conduct self audits, please review the Presentation titled: *Medicaid Provider Compliance Program & Provider Self Audits*, which is available in the [Florida Medicaid Provider Training e-Library](#) under the **Previous Training Materials** tab.

Record keeping issues continue to be a major point of provider non-compliance (from failing to document services altogether, to failing to document all of the necessary elements as required by policy). Other issues that providers should be mindful of include the following:

- Licenses required by state or local government for the goods or services being provided must be obtained, readily available, and properly displayed.
- Record keeping and services must be rendered in accordance with Medicaid policy. Records should be maintained in a systematic and orderly manner, readily available for inspection. Please familiarize yourself with the Medicaid provider handbook applicable for your practice. Policy may be different between Medicare and Medicaid.
- Any mandatory insurance or surety bonds must be current (not expired).
- If there has been a change in the provider’s taxpayer identification number, or a change in the ownership, shares, membership, or controlling interest, as well as any changes of ownership as defined in the provider’s licensure statute, the appropriate notice and documentation must be furnished to Medicaid.
- If a change of ownership has occurred, the records that relate to the sale or transfer of the business interest must be maintained and readily available for inspection. The seller must notify Medicaid of the intended change of ownership and the new owner shall submit a Medicaid [provider enrollment application](#) at least 60 days before a change of ownership occurs.
- Changes of address or telephone numbers must be reported to Medicaid as soon as they occur. Change of Address forms are available on the secure provider web portal under Demographic Maintenance/Location Name Address. Select the “Change Address” button at the bottom of the page to access the form.
- When an active Medicaid provider opens a new location, it is not necessary to fill out a new application. A [new location code request](#) form is the appropriate document.
- Member affiliations within a group practice should be current and accurate. Providers are required to notify Medicaid in writing when they leave or join a group.
- Changes to information supplied on the application must be reported in writing as described in the Florida Medicaid Provider General Handbook, Chapter 2. Please visit the [Public Provider Web Portal](#) for valuable enrollment information including handbooks, bulletins, training, and enrollment forms. You can also call Medicaid Provider Enrollment at 1 (800) 289-7799, Option 4, to speak with an enrollment specialist about your changes.

We appreciate your continued efforts to assist us by reporting suspected fraud and abuse. Please call the Agency’s Bureau of Medicaid Program Integrity for referrals of suspected fraud, abuse, or overpayments in the Medicaid program: 1 (888) 419-3456, or submit electronically by clicking on the button below. Suspected Fraud can also be reported to the Office of the Attorney General by calling the number below.



Providers are also welcome to email Kelly Bennett, the Medicaid Director’s liaison, regarding compliance matters: Kelly.Bennett@ahca.myflorida.com.

Coming to Your County in 2012-2013—The Statewide Medicaid Managed Care Program

In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes, directing the Agency for Health Care Administration (Agency) to create the Statewide Medicaid Managed Care (SMMC) program.

Specific timelines for implementation of the SMMC were delineated. The Agency must complete implementation of the Long-term Care Managed Care component in all regions by October 1, 2013.

The Agency must complete implementation of the Managed Medical Assistance component of the SMMC program statewide by October 1, 2014.

Details regarding the timeline for procurements, plan selection and contracting, plan network requirements, and future public meetings will be posted on the Agency's [Statewide Medicaid Managed Care website](#) as they become available. In order to keep current with the status of this program implementation, please visit the website often.

As a reminder, the following chart lists which counties are in each of the Medicaid regions:

Region 1:	Escambia, Okaloosa, Santa Rosa and Walton
Region 2:	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
Region 3:	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union
Region 4:	Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
Region 5	Pasco and Pinellas
Region 6	Hardee, Highlands, Hillsborough, Manatee and Polk
Region 7	Brevard, Orange, Osceola and Seminole
Region 8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
Region 9	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
Region 10	Broward
Region 11	Miami-Dade and Monroe

Managed Care Plan Provider Networks

The Agency will establish, and the plans will be required to maintain, provider networks that meet specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a region wide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan.

Do I have to contract with managed care plans?

If you want to provide Medicaid reimbursed services to Medicaid recipients enrolled in a health plan, you must be part of that plan's provider network.

Do managed care plans have to contract with me?

Managed care plans must have sufficient providers in their network to meet standards set by the Agency, but in general are not required to contract with "any willing provider." There are some exceptions to this rule for provider types that are determined to be "essential" providers by the Agency. For more information about essential providers, please see [Section 409.975, Florida Statutes](#).

Do I have to join a plan network now to participate in the SMMC program?

No. It is anticipated that plans who wish to participate in the Long-term Care component of the SMMC program will begin establishing provider networks sometime in early 2012. Plans who wish to participate in the Managed Medical Assistance component will begin establishing provider networks towards the end of 2012. However, you may want to contact existing health plans in your area now so that you are fully informed about their network provider requirements and any steps you need to take to ensure yourself the opportunity to participate.



Coming to Your County in 2012-2013—The Statewide Medicaid Managed Care Program

(continued)

Managed Care Plan Recipients/ Enrollees

Under the SMMC program, a majority of Medicaid eligibles will be required to enroll in a managed care plan, with limited excluded populations. Excluded populations include those eligible for either a limited set of services or for a limited time period, most notably the developmental disabilities population.

Will everybody have to be enrolled in a managed care plan?

No. A majority of Medicaid recipients will be enrolled in a managed care plan. Once fully implemented, it is anticipated that 80-85% of the Florida Medicaid population will be enrolled in health plans. Those not enrolled in health plans will receive their services through the fee-for-service system.

How will I know what plan a recipient participates with?

Medicaid providers have access to both the Florida Medicaid Management Information System (FMMIS) and the Department of Children and Families FLORIDA system. Providers can verify if a recipient is Medicaid eligible in both systems. Providers can determine whether a recipient is enrolled in a managed care plan, MediPass, or fee-for-service in the FMMIS system.

Am I responsible for knowing whether a recipient is enrolled in managed care or in fee-for-service?

Yes. A provider must verify if the recipient is enrolled in a managed care program prior to delivering services. If a recipient is enrolled in a health plan, the provider cannot be reimbursed on a fee-for-service basis.

SMMC Program Managed Care Plan Services and Provider Payment

The SMMC program provides for fully integrated health care through a statewide program which will ensure all Florida recipients have access to an equivalent level of services and a standard high level quality of care, regardless of whether they live in a metropolitan area or a rural area. Plans will receive per member per month payments negotiated pursuant to the procurements.



How are network providers paid under the Statewide Medicaid Managed Care program?

Under managed care, the Medicaid program makes a capitated (per member per month) payment to the managed care plan. The health plan is then responsible for making payments to its enrolled network providers for authorized services provided to health plan enrollees.

What services can I provide under the Statewide Medicaid Managed Care program?

Under the program, plans are required to provide all state plan services and, for the Long-term Care program, long term care and home and community based services. For additional information regarding minimum covered services under the SMMC programs, please see [Section 409.973, Florida Statutes](#), relating to the Managed Medical Assistance program and [Section 409.98, Florida Statutes](#), relating to the Long-term Care Managed Care program.

How are services authorized under managed care?

Health plans are responsible for prior authorization and utilization management of services for their plan enrollees. Each plan will have its own rules regarding authorization. Network providers will need to be informed about the policies and procedures for their plans.

Do health plans have to pay me a certain rate?

In most cases, health plans and their network providers negotiate rates through contract, and no specific rate is set by the Medicaid program. Under the SMMC program, there are some exceptions to this rule for specific provider types. Please see [Section 409.975 \(6\)](#), [Section 409.976](#), [Section 409.982\(5\)](#), [Section 409.983 \(6\) and \(7\)](#), Florida Statutes, for additional information regarding these exceptions.

Can I get paid for services if I am not in a managed care plan?

In most cases, no, a provider cannot be reimbursed for services provided to enrollees in a managed care plan unless the provider is part of the plan's provider network and has been through appropriate prior authorization procedures.

I have other questions that are not answered here --- Is there any way for me to submit my questions and to receive additional information about the SMMC program?

Yes! Please submit any questions that you have regarding the implementation of the SMMC program to FLMedicaidManagedCare@ahca.myflorida.com.

You can also sign up to receive alert notices about the program through the [Statewide Medicaid Managed Care website](#).

Regular updates will also be provided through future issues of the Provider Bulletin.

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. The Agency for Health Care Administration (Agency), as the single state agency responsible for administering the Medicaid program in Florida, 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, The Lewin Group, will provide statistical support to the program by selecting a sample of claims to be reviewed and then calculate Florida's error rate. The second contractor, A+ Government Solutions, will provide documentation/database support by collecting medical policies from the state and collecting medical records from the providers. This contractor will also conduct medical and data processing reviews of the sample claims.

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

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. Therefore, it is important that providers submit requested medical records in a timely manner.

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.

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."

In addition, Medicaid providers are required to comply with any medical records request from the CMS contractor. Follow-up contact regarding these medical record requests may be made by Florida Medicaid staff if any request is nearing the 75 calendar day time limit.

Look for additional details in upcoming Provider Bulletins regarding the [2011 PERM cycle](#), which is still underway for federal fiscal year 2010-2011. Medical reviews by A+ Government Solutions began in September 2011. We will continue to send out specific information that pertains to medical record requests by A+ Government Solutions as the information becomes available. If your claim has been selected as a sample, the billing and treating provider offices on the claim will be notified by a letter from the Agency. You will then need to provide medical records as requested by A+ 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, as you are required to report any changes per the Provider General Handbook (page 2-44): "To report a change of address, the provider must obtain and complete the Medicaid Provider Change of Address Request, AHCA Form 2200-0004, July 2008. The form is available by calling the Provider Contact Center at 1 (800) 289-7799 and selecting Option 4. It is also available from the Medicaid fiscal agent's [Web Portal](#). Select **Secure Information for Providers** and sign in. Select **Demographic Maintenance** and then **Location Name Address**. Click on **Change Address** and then click on the link to "Print the Change of Address form."

If you would like more information related to PERM and your role in this process, please visit the [CMS PERM website](#). 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 the Florida Medicaid program. If you have any questions, please contact Jason Ottinger, Office of Medicaid Program Oversight, by telephone at (850) 412-4695 or via email at Jason.Ottinger@ahca.myflorida.com.

ICD-10 Transition Plans

Health care entities are required by federal regulations to use a standard code set to indicate diagnoses and procedures on transactions. For diagnoses, the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code set is currently used. For inpatient hospital procedures, the ICD-9 procedure code set (PCS) is currently used. Effective **October 1, 2013**, the standard code set that is required for diagnosis codes is changing to the ICD-10-CM and the standard code set that is required for inpatient hospital procedures is changing to the ICD-10-PCS. The effective date of the ICD-10 conversion is not likely to be delayed. Other procedure code sets known as Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT), which are also used in claims transactions, are not changing.

Florida Medicaid policy and claims billing rules encompass a complex set of operations and standards. Compliance with the new standard set of diagnosis and inpatient hospital procedure codes requires the state conduct a comprehensive impact analysis. Subsequently, the state will review all codes used, Medicaid policies that govern application of the codes, and in some cases, the reimbursement amounts for services rendered to Medicaid recipients.

The Agency for Health Care Administration has begun to prepare Florida Medicaid for the changes in the diagnosis code set. The ICD-10 Transition Project contains five distinct areas of activities and tasks:

- A. Impact Analysis: Conduct an ICD-10 Impact Analysis.
- B. Medicaid Policy Changes: Develop changes in Medicaid policy that govern the use of diagnosis and inpatient hospital procedure codes.
- C. Medicaid Reimbursement Rates: Develop the most appropriate reimbursement rates for the new diagnosis/procedure code system in a budget neutral manner.
- D. Outreach and Training: Conduct provider training for the Medicaid changes needed for the ICD-10 transition. This training will not be “code set training,” but rather an opportunity to explain the impact of changes in Medicaid policies and reimbursement rates required because of the change in the code set.
- E. Update the Florida Medicaid Management Information System (FMMIS) to reflect the new policy and reimbursement rates.



A consultant will be hired to assist the Agency with this critical project. As the project progresses, more information will be shared with providers through our usual communication channels, including the impact that these changes will have on Florida Medicaid providers.

It is very important that providers begin to make their own preparations for the mandated diagnosis code set change, including obtaining training on the new code sets for their staff.

“Going Digital” to Achieve Meaningful Use

As Health Information Technology (Health IT) continues to expand and evolve, many providers are left wondering what Health IT can do for their practice, and how they can best use new technologies to improve the quality of health care they provide. The concept of Meaningful Use focuses on involving providers and hospitals in the utilization of new technologies that can improve health outcomes. The Agency for Health Care Administration is supporting Florida providers’ efforts in making the move from paper to “Going Digital” through programs designed to support and promote the meaningful use of Health IT.



The pivotal first step towards “Going Digital” is adopting an Electronic Health Record (EHR) system. The Florida Medicaid Electronic Health



Record Incentive Program recognizes providers’ efforts to adopt and use EHRs by offering incentive payments to eligible professionals and hospitals that purchase and integrate EHR technology into their practices. The ultimate goal of “Going Digital” is for providers to incorporate the use of their EHR system into the daily workflow, streamlining patient data, and improving communication with patients and other health care professionals.

data from one point to another augments the quality of care by streamlining business operations and allowing more time for patient-centered responsibilities.

One of the free services that providers have available to help achieve meaningful use of their EHR system is the Florida Health Information Exchange (Florida HIE) Direct Secure Messaging (DSM). DSM is a secure, encrypted email service that allows providers to send and receive emails and attachments containing patient clinical data (up to 10MB). This electronic transmission of

Achieving Meaningful Use is about utilizing the tools available to make the smooth transition to an electronic health care environment. Transmitting data electronically means fewer trips to the fax and copier, less time spent tracking down paper records, and more time spent focused on patient care. With your participation, we can help make the health care industry in Florida even more innovative, effective, and meaningful. Investigate which options are best for you, participate in opportunities to collaborate, and integrate Florida’s “Going Digital” efforts into your practice.

For more information, and to sign up for regular alert notices via email, visit the [Florida HIE](#) and [Medicaid EHR](#) websites.



Unborn Activation Tips

Having trouble getting unborn Medicaid identification numbers (IDs) activated for newborns using the Unborn Activation form?

Follow these steps to success:

- Complete the entire form, including the provider ID# and information.
- Write clearly or type the information on the form.
- Make sure you get the right Medicaid ID# for the baby. Check the Florida Medicaid Management Information System (FMMIS) using the card control number and verify name “babaof(mom’s name)”.
- Make sure the record you are trying to activate is an unborn record and not a regular Medicaid record on FMMIS.
- Check the mother’s ID on FMMIS to ensure she had full Medicaid coverage on the baby’s date of birth.
- The mother’s Social Security Number (SSN) is required. Make sure you enter it correctly.
- Don’t forget the sex code (male or female) for the baby.
- Do **not** give the activation form to the mother to complete and fax.



More information about the process can be found on the [Medicaid Newborn Eligibility Policy website](#).

Revised Wraparound-Supplemental Submission Worksheet

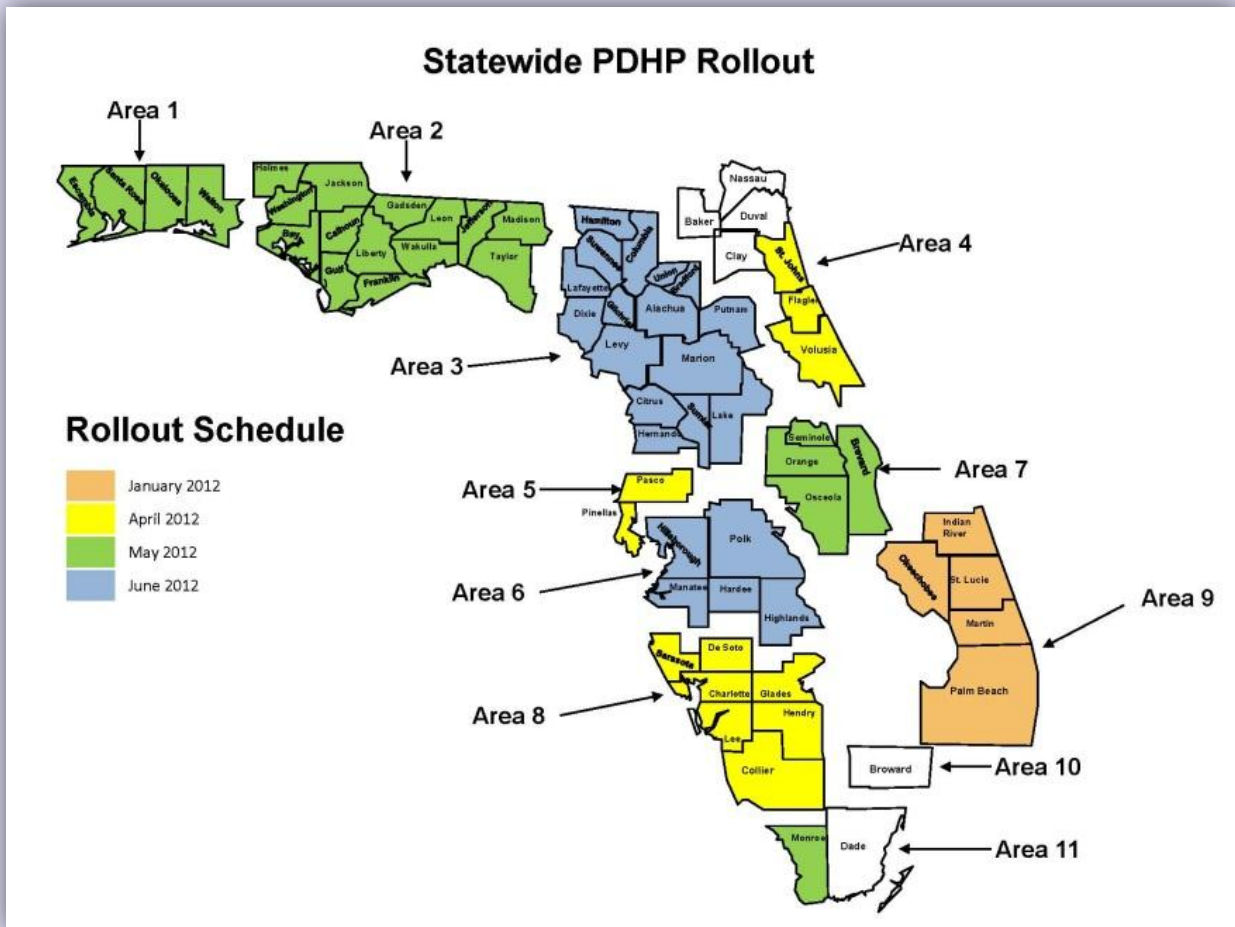
Please note the revised format for submission of Federally Qualified Health Clinic/Rural Health Clinic supplemental payment requests. This format is effective October 1, 2011 and supersedes any previous formats. This new workbook is located on the [Medicaid Reimbursement Plans](#) web page.

If you have any questions or need assistance completing the workbook, please contact Medicaid Cost Reimbursement at (850) 412-4103.

FLORIDA MEDICAID STATEWIDE PREPAID DENTAL HEALTH PLAN

Florida Medicaid has contracted with two prepaid dental health plans (PDHPs) to provide children’s dental services in all Florida counties with the exception of Medicaid Pilot Program counties, Baker, Broward, Clay, Nassau, and Duval. The two plans are DentaQuest and MCNA Dental Plans, which already operate as Medicaid PDHPs in Miami-Dade County.

The Statewide PDHP expansion will begin in January 2012 with Medicaid Area Nine counties (Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie) and expand to other Medicaid areas during the first half of the year according to the illustration below.



FLORIDA MEDICAID STATEWIDE PREPAID DENTAL HEALTH PLAN

(continued)

The PDHPs must provide all Medicaid State Plan dental services to children under 21 years of age, except children enrolled in Medicaid managed care plans that provide dental services and children in specifically excluded groups such as those receiving hospice services. The amount, duration, and scope of covered dental services will remain the same. Most Medicaid eligible children will be enrolled in one of the two PDHPs when the program is implemented in their counties.

Currently enrolled Medicaid fee-for-service dental providers will not be able to bill fee-for-service for children enrolled in either of the two PDHPs. If the provider is in the network for the PDHP in which the child is enrolled, services will be reimbursed through the PDHP. The PDHPs will be responsible for processing claims for their members. As always, it is important that providers and their staff check a recipient's eligibility and enrollment information carefully before furnishing services.

Providers interested in joining one or both of the PDHP networks should contact the provider service toll-free number for DentaQuest at 1 (877) 468-5581 or MCNA Dental Plans at 1 (855) 698-6262.

The Agency has created a [Medicaid PDHP website](#) to disseminate information about the upcoming Statewide PDHP expansion. Please visit the website for more information and updates as they become available. You may subscribe to PDHP and Dental Provider Alerts by clicking on the **Sign up for Alerts** tab. You can email specific questions to StatewidePDHP@AHCA.myflorida.com.



Child Health Check-Up (CHCUP) Early Periodic Screening, Diagnosis and Treatment AND.....

As licensed health care professionals, you understand the importance of preventive care. The Child Health Check-Up (CHCUP) program includes comprehensive physical exams, developmental assessments and anticipatory guidance. You can find more information about this program in the [Child Health Check-Up Coverage and Limitations Handbook](#).

Fluoride Varnish

Oral evaluation and fluoride varnish application are preventive services which should be provided within six months of eruption of the first primary tooth, especially to high risk patients. 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 SC.



Fluoride varnish may be applied to a child's teeth at the time of the CHCUP visit. Medicaid reimbursement for 99499 SC is \$27.00 for both the application of fluoride varnish and the oral evaluation for a child 6 months to 3 1/2 years of age.

The CHCUP visit should also include counseling the child's caregiver.



Dental Referrals

Dental referrals are required beginning at 3 years of age or earlier as medically indicated. CHCUP providers must refer Medicaid children who are 3 years of age and older for an assessment by a dentist and document the referral. 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.

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. 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, 2-14 and 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. You can find more information about this program in the [Child Health Check-Up Coverage and Limitations Handbook](#).