



FLORIDA MEDICAID PROVIDER BULLETIN

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UPDATE ON FLORIDA MEDICAID'S MANAGEMENT OF HURRICANE KATRINA EVACUEES



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

Florida Medicaid is using federal emergency policies adopted September 8 to help meet the needs of thousands of people who were displaced by Hurricane Katrina.

The covered programs include both Medicaid and SCHIP (KidCare). Evacuees deemed eligible will have the full range of services offered through Florida's Medicaid program and SCHIP. Medicaid eligibility will be based on Florida eligibility rules.

AHCA and the Department of Children and Families (DCF) are encouraging Katrina evacuees from impacted counties and parishes in the three affected states who are already on Medicaid in their home state or believe they qualify to log on to the DCF online enrollment website www.myflorida.com/accessflorida to apply. Evacuees also can contact Medicaid area offices for further information. Applications filed by evacuees will be processed quickly based on the person's self-declaration of their circumstances.

AHCA strongly urges Florida health services providers who serve evacuees to encourage them to enroll under this emergency services program. This allows providers to deliver health services immediately and be assured of reimbursement from Florida Medicaid. For follow-up services, providers can verify an evacuee's Florida Medicaid eligibility through the normal eligibility verification process, and also bill for services through the normal claims submission (billing) processes. Providers and evacuees can also access the following link that provides helpful tips on applying for benefits with DCF: <http://www.dcf.state.fl.us/katrina/>

As long as the Katrina evacuees enroll in the Florida Katrina Emergency Medicaid program, providers can be assured of reimbursement for Florida Medicaid covered services through the Florida Medicaid program.

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



All Providers

MEDICAID REFORM UPDATE



The 2005 Florida Legislature authorized the Agency for Health Care Administration to seek federal approval of a waiver that will permit a Medicaid reform demonstration project in Broward and Duval Counties.

The target for implementation in the two counties is between April and June 2006. Enrollment will be staggered, and not all eligibility groups will be included in the first phase.

The waiver was posted on the Agency's web site for 30 days prior to submission to the federal Centers for Medicare and Medicaid Services. Following federal approval, the waiver must again be reviewed and approved for implementation by the Legislature.

Reform will replace most fee-for-service Medicaid with a risk-adjusted, premium-based program offered through state contracted managed care organizations, including Provider Services Networks and other licensed insurers. There will be no change in eligibility criteria. People who are eligible for Medicaid will be able to choose among the available reform plans or have their premium paid to an employer-sponsored health plan, if it is available to them.

All plans will offer the Medicaid mandatory services under the State Plan along with the optional services historically utilized by their enrollees. Some latitude may be allowed by the state that will permit specialty plans to adjust their benefits to more closely meet the needs of their target populations.

Existing Medicaid HMOs and other managed care plans that want to participate in reform will need to submit their health plans for approval. Medicaid anticipates that new plans also will be formed. All will be reviewed for adequacy of their networks and benefit packages and for financial soundness.

Information about Medicaid reform is available on the Agency's web site at <http://ahca.myflorida.com>.



DID YOU KNOW...

- Florida EDI Service (800-829-0218) is available to assist electronic submitters with file transmission errors and technical support of the WINASAP 2003 software packages.
- For issues with claim reimbursement and Florida Medicaid coverage and limitations, please refer to the Provider Inquiry Unit (800-289-7799 for in state providers or 800-955-7799 for out of state providers) or your Medicaid area office
- Electronic claims transmission requires that your computer have an asynchronous dial up modem, also referred to as a fax modem. Currently DSL or cable modems cannot be used for transmission to Florida EDI.
- Only paid claims can be adjusted electronically; a new claim should be submitted if the previous claim was denied for payment.
- When reporting issues with electronic claims submitted via a Clearinghouse or Billing Agent, the ACS file number reported back to the Clearinghouse/Billing Agent is necessary for tracking the claim(s) in question.
- Real-time pharmacy transmission inquiries should be referred to our Pharmacy Helpdesk at 800-603-1714.



NPI: NATIONAL PROVIDER IDENTIFIER



In May 2005 the National Provider and Payer Enumeration System (NPPES) began accepting applications from health care providers for assignment of an NPI. Applicants must obtain and start to use an NPI by the May 23, 2007 deadline. Either a paper or electronic application may be submitted. Florida Medicaid requests that providers include their Florida Medicaid provider numbers on the application to assist in linking the current Medicaid number with the new NPI number. For more information, visit the NPPES web site at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.



MMIS/DSS AND FISCAL AGENT PROCUREMENT

Florida Medicaid uses a complex computer system to process Medicaid claims, manage Medicaid recipient and provider data and complete the complex tasks of managing the application of Medicaid policy to the processing of claims. Providers may hear this system referred to as the "FMMIS", which stands for Florida Medicaid Management Information System. We also maintain a decision support system (DSS) that houses the data produced in the claims processing system and provides many tools to analyze the data to help the Agency make decisions about the program and to oversee the proper disbursement of the Medicaid budget. The Agency has begun the long and involved process of procuring a new electronic claims processing and decision support system and of selecting a fiscal agent to operate the system for the next contract period (2007-2012). The next major phase in the project will be the Design and Development phase, scheduled to begin in October. You will receive more news as the system is developed and plans are made for testing and transition to the new system. The new system will include Web portals for Medicaid providers and recipients, efficient navigation of the Medicaid system, development of Electronic Health Records, and modern filing and reconciling of claims, and will allow the Agency to more effectively measure health outcomes.

MEDICAID PHARMACY IMPLEMENTS IMPORTANT CHANGES TO PRESCRIPTION DRUG PROGRAM



Florida Medicaid serves more than two million recipients, all of whom have equal access to pharmacy services. Over the past five years, expenditures for Medicaid pharmacy claims have increased an average of 14 percent annually, outpacing spending in all other Medicaid areas.

The 2005 Florida Legislature directed Medicaid to implement changes in the prescription drug program that provide continued access to a broad range of FDA-approved medications while ensuring cost savings to the state of \$292 million dollars.

On July 1 Medicaid began a “step-therapy” process requiring patients to try preferred drugs before they can be approved to receive medications not included on the Medicaid Preferred Drug List (PDL).

Step-therapy is based on current medical findings, FDA-approved manufacturer labeling information, cost, and manufacturer rebate agreements. If it is medically necessary, a physician can obtain authorization for a non-PDL drug by completing a “Miscellaneous Pharmacy Prior Authorization Request” form. The form is available on the Agency’s website and should be accompanied by supporting documentation that demonstrates the patient has tried the PDL medications in the past and that they were ineffective in treating the condition or were not tolerated due to other drug interactions or side effects.

The legislation also removed the exemption from the prior authorization process for mental health drugs and drugs for nursing home residents and other institutional residents.

The changes in the PDL were based on recommendations from the Pharmacy and Therapeutics (P&T) Committee, an independent group of pharmacists and doctors, which reviewed the clinical efficacy and cost effectiveness of drugs in the 27 therapeutic categories. The latest version of the PDL is available on the Internet at <http://ahca.myflorida.com>.

The Legislature also removed the four-brand limit on prescriptions. The only requirement now is that the drugs be on the approved PDL. This change allows physicians greater latitude in prescribing a broader range of medications for patients.

Any changes resulting from the P&T Committee’s September 21 meeting are being implemented effective October 1.



REMINDER TO CHILD HEALTH CHECK-UP (CHCUP) PROVIDERS:



Articles carrying this graphic contain important Medicaid Provider Handbook Information.



- Federal regulation requires that all Medicaid children receive a screening blood lead test at 12 months and 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. The procedure code for blood lead testing is 83655. This is explained in the Medicaid CHCUP Coverage and Limitations Handbook, October 2003, pages 2-13 and 2-14; and page 3-6. There is the potential for recoupment if medical record audits indicate that a screening blood lead test has not been done.
- CHCUP providers may only bill for one visit, a CHCUP or a sick visit per day, per Medicaid child, per provider. Provider discretion in evaluating the degree of illness should determine if a Child Health Check-Up should be performed. This is explained in the Medicaid CHCUP Coverage and Limitations Handbook, October 2003, page 2-3. There is the potential for recoupment if medical record audits indicate that a provider has been reimbursed for a CHCUP and a sick visit on the same day, for the same child.
- A CHCUP referral code is required on the claim form in order to be reimbursed for a CHCUP. This is explained on page 7 of this Bulletin per claim format.
- It is critical that the federally required Referral Code be appropriate for the Diagnosis Code on Child Health Check-Ups. For example, a diagnosis code of V20.2 (routine infant or child health check) would be appropriate with a referral code "U" or "NU" (complete normal/no referral). A diagnosis code of V20.2 (routine infant or child health check) is not appropriate with a referral code of "T" or "ST" (abnormal, patient referred). For the required referral codes see page 7 of this Bulletin per claim format.
- CHCUP providers are responsible for referrals and follow-up on a Medicaid child as a result of a CHCUP. This is explained in the Medicaid CHCUP Coverage and Limitations Handbook, October 2003, page 2-2.



CHILD HEALTH CHECK-UP (CHCUP)

The Child Health Check-Up (CHCUP) claim is now billed as a physician claim. CHCUP is referred to as EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) in national publications. The CHCUP procedure code is entered on one line and any other services provided can be entered on subsequent lines. CHCUP claims can only be billed in the following formats: CMS-1500, NSF, X12N 837P, or WINASAP 2003, Professional.



CHCUP Providers

	CHCUP Indicator	CHCUP Referral Code	Special Program Indicator
CMS-1500 Claim Form	Box 24H (EPSDT/Family Planning) – Enter “E” if service is a result of a CHCUP referral. (Used when service is not a CHCUP procedure code)	Box 24H (EPSDT/Family Planning) – Enter “V”, “U”, “2” or “T” (see table) for the referral code most applicable. (Use only when service is a CHCUP procedure code)	Not applicable
NSF Format	FB0-22.0 (EPSDT Indicator) – Enter “Y” if service is a result of a CHCUP referral, “N” or space if not. (Used when service is not a CHCUP procedure code) To bill a CHCUP screening claim as a physician claim also complete these fields: BA0-03.0 Batch Type = 100 EA0-32.0 Diagnosis Code 1 = required (at least one diagnosis is required) FA0-14.0 Diagnosis Code Pointer 1 = required (at least one is required)	FB0-22.0 (EPSDT Indicator) – Enter “V”, “U”, “2” or “T” (see table) for the referral code most applicable. (Use only when service is a CHCUP procedure code)	Not applicable
X12N 837P	Loop 2400, Segment SV1, Element 11 (EPSDT Indicator) – Enter “Y” if service is a result of a CHCUP referral. (Used when service is not a CHCUP procedure code)	Loop 2300, Segment CRC , (EPSDT Referral), Element 03 (Condition Code) – Enter “AV”, “NU”, “S2” or “ST” (see table) for the referral code most applicable. If CRC02 is “N”, this value must be “NU”. (Use only when service is a CHCUP procedure code)	Loop 2300, Segment CLM, Element 12 (Special Program Code) – Enter “01” if any line item in the transaction contains a service that is a CHCUP procedure code.
WINASAP 2003, Professional Claim	Claim Line Items Tab , Miscellaneous Indicators button, Other Indicators. Was the service a result of a screening referral? – Check “Yes” if service is a result of a CHCUP referral. (Used when service is not a CHCUP procedure code)	Claim Information Tab , EPSDT Info button – Check “Yes” for Certification Condition Indicator. Select from the list of conditions which appear in the drop down list: “Available-Not Used” “Under Treatment” “New Service Requested” Do not check the Certification Condition Indicator when selecting “Not Used” from the conditions drop down list. (Use only when service is a CHCUP procedure code)	Claim Codes Tab , Special Program Indicator Code – Select “Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Child Health Assessment Program” from the drop-down list if any line item in the transaction contains a service that is a CHCUP procedure code.

CHCUP Procedure Codes (as of 10/16/03)				Referral Codes	
HCPC	Modifier	HCPC	Modifier	Referral Code	Description
99381		99391		AV	Patient Refused Referral (Available, Not Used)
99382		99392		NU	Not Used (Patient Not Referred)
99383		99393		S2	Under Treatment (For referred diagnostic or corrective health problem)
99384		99394		ST	New Services Requested (Abnormal, Patient Referred to another provider for diagnostic or corrective treatments or scheduled for another appointment with check-up provider for diagnostic or corrective treatment for at least one health problem identified during a Child Health Check-Up, not including dental referrals)
99385	EP	99395	EP		

JULY 2005 LIST OF PROCEDURES APPROVED FOR AMBULATORY SURGICAL CENTERS



The list of procedures approved for the ambulatory surgical center (ASC) setting has been revised effective July 5, 2005. These changes reflect recent additions and deletions made by the federal Centers for Medicare and Medicaid Services.

DELETIONS: 21440, 23600, 23620, 53850, 69725

ADDITIONS: 15001, 19296, 19298, 21125, 28108, 29873, 30220, 31545, 31546, 31603, 31636, 31637, 31638, 33212, 33213, 33233, 36834, 37500, 42665, 43237, 43238, 44397, 45327, 45341, 45342, 45345, 45387, 45391, 45392, 46230, 46706, 46947, 49419, 51992, 52301, 52402, 57155, 57288, 58346, 58565, 55873, 62264, 64517, 64561, 64581, 64681, 65780, 65781, 65782, 65820, 67343, 67445, 67570, 67912

The revised list is available on the fiscal agent's website at floridamedicaid.acs-inc.com, in the fee schedules section. An official update to the ASC Services Coverage & Limitations Handbook will soon be published.

If you have any questions, please call your local area office or Melissa Vergeson at (850) 922-7724.

