

The Medicaid Bulletin

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CROSSOVERS

Medicare and Medicaid are frequently confused as the same program; yet, there are distinct differences.

Medicare is a federal program that is 100 percent federally funded. Medicaid is a state program that is jointly funded by the federal and state governments, with the actual percentage paid by the state or the federal government varying for each state. State Medicaid agencies administer their own programs; determine their own eligibility requirements; determine the amount, scope and duration of services for each group of eligibles and rate of reimbursement. Medicare eligibility is determined through the Social Security Act and the benefits and limitations are the same in every state.

Within broad federal guidelines, state Medicaid programs can have a wide variety of services. Medicare has two types of coverage, Part A, which is hospital insurance that pays for inpatient hospital, skilled nursing facilities, home health agencies, and hospice programs; and Part B, which is a medical insurance that helps pay for medically necessary services such as doctor's visits and durable medical equipment.

Unlike Medicaid, Medicare claims are not processed by a single fiscal agent or by federal employees. The Health Care Financing Administration (HCFA) contracts with health insurance organizations around the country for the processing of claims. The contractors are referred to as "intermediaries" (processes part A claims) or "carriers" (processes part B claims). When Medicare receives a claim (part A or B coverage) and the beneficiary is eligible for both Medicare and Medicaid (dually eligible), the claim is automatically sent to Medicaid for payment of any deductibles or coinsurance. These claims are referred to as "crossovers."

A claim will not be automatically submitted to Medicaid by a Medicare contractor unless specific conditions are met, one of which is that the Medicare contractor must be one with which the state Medicaid program has made automated arrangements.

Florida Medicaid has made arrangements with the following Medicare carriers and intermediaries to receive automated crossover claims:

Blue Cross & Blue Shield of Florida	Part A and B
Blue Cross & Blue Shield of Tennessee	Part A
Palmetto Government Benefits Administrator (DMERC) of South Carolina	Part B
AdminaStar Federal	Part A
Blue Cross & Blue Shield of Texas	Part A
Blue Cross & Blue Shield of Georgia	Part A
Blue Cross & Blue Shield of Connecticut	Part A
Blue Cross & Blue Shield of S.Carolina	Part A
Mutual of Omaha	Part A

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Medicaid is also testing automated claims with United Government Systems and Veritus. If you bill a Medicare contractor other than one of those listed on the previous page and you would like for Medicaid to pursue automated arrangements with them, please contact your area Medicaid office for assistance.

If you are using one of the contractors listed as a Florida authorized Medicare carrier/intermediary, your claims should cross over automatically from the contractor to Medicaid. This process requires no paper claims and thus saves your office additional time and expense.

Provider Cross-Reference Files

When a Medicare carrier/intermediary sends Medicaid a tape for crossover processing, they do not send a provider Medicaid identification number; however, they do send a provider Medicare number. Therefore, it is imperative that Medicaid have a record all of your current Medicare numbers so that it can be entered in the Medicaid provider cross-reference file. The cross-reference file must be updated every time you add an additional suffix to an existing Medicare provider number or change Medicare provider numbers. In order for your claims to crossover properly, you must notify Unisys Provider Enrollment of any changes to your Medicare provider number. You do this by sending Unisys a letter on your letterhead to P. O.Box 7070, Tallahassee, Florida 32314. Be sure to include both your Medicare and Medicaid provider numbers for your facility or group and their effective dates. Don't forget to include all treating providers as their cross-reference files must be updated as well.

Drop Report Letters

A recent modification to the Florida Medicaid Management Information System (FMMIS) allows providers to see which claims are being transmitted to Medicaid by Medicare but are subsequently going to be dropped from FMMIS because of processing problems. This process is called a "drop report letter," which is a letter generated from the Medicaid claims processing system whenever a contractor sends a claim that cannot be processed. Accompanying the drop report letter is a list of claims that are affected. "Drop" reasons are:

- ⇒ a valid Medicaid number is not located for the Medicare provider number;
- ⇒ the deductible and/or coinsurance amount paid by Medicare is negative (indicating an adjustment);
- ⇒ the total deductible and coinsurance is zero; or
- ⇒ there is no Medicare assignment.

Crossover claims that cannot be processed are held in a recycle status for four weeks, during which time a drop report letter is sent each week reminding providers that these claims are in recycle. If there is an error that can be and is corrected (provider cross-reference records) within the four-week recycle period, then the claims will be released from recycle and put into the normal claims processing cycle. If no corrective action can be taken or if corrective action is not taken within the four-week period, the claims will be dropped from the system and no further processing will take place.

Filing Limit

The filing limit for crossover claims is 12 months from the date of service or 6 months from the Medicare paid date.

Physician Reimbursement Methodology By Date of Service

For dates of service prior to March 3, 1997, reimbursement was calculated at 100 percent of the deductible and 75 percent of the coinsurance up to the Medicaid allowable for the procedure code. Applicable recipient copayments applied.

For dates of service from March 3, 1997 to September 30, 1997, reimbursement was 100 percent of the deductible and 100 percent of the coinsurance. Applicable recipient copayments applied.

For dates of service from October 1, 1997 and thereafter, reimbursement is calculated at 100 percent of the deductible and coinsurance up to the Medicaid allowable for the procedure code. Applicable recipient copayments applied.

Physician Crossover Claims Reprocessing

Some crossover claims were incorrectly paid at 100 percent of the deductible and 100 percent of the coinsurance when the date of service was prior to March 3, 1997. Medicaid will be reprocessing these claims and adjusting them to the correct methodology for the date of service.

Blood Deductible

Inpatient and outpatient blood deductibles are reimbursable at a maximum of three pints for no more than \$25.00 per pint. To ensure accurate reimbursement, you must enter on both the claim form and the EOMB, the correct value code and number of pints not replaced. Paper claims should be sent to your area Medicaid office unless they have been automatically forwarded from the Medicare contractor or are for previous payment that needs to be adjusted.

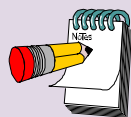
Area Medicaid Offices Offer Provider Training

Don't forget, all area Medicaid offices offer ongoing Medicaid provider training! If you want information concerning the details of provider training offered in your area, refer to Appendix C of your *Medicaid Provider Reimbursement Handbook* to find the telephone number and address of your area Medicaid office.

Featured below is the provider training schedule for areas 2A and 2B:



Area 2A serves Bay, Franklin, Gulf, Holmes, Jackson, and Washington counties. Provider training is conducted on the second Tuesday of each month beginning at 9:00 A.M. (C.S.T.) MediPass training is held the second Thursday of each month beginning at 10:00 AM. Both training sessions are held at the Area 2A office at 651-K West 14th Street in Panama City. Space is limited and reservations are required. Call (850) 872-7690 to sign up.



Area 2B serves Leon, Gadsden, Calhoun, Liberty, Wakulla, Madison, Jefferson and Taylor counties. HCFA-1500 training is conducted on the second Thursday of each month at 9:00 A.M.(E.S.T.) MediPass provider training is held on the second Tuesday of each month at 9:00 A.M. Both training sessions are held at the Area 2B office at Cedars Executive Center, 2639 North Monroe Street, Suite 104-B, Tallahassee. Space is limited and reservations are required. Call (850) 921-8474 to sign up.

Medicaid provider training tip:

- ⇒ Primary care providers must remember to give your *correct* MediPass authorization number when referring a MediPass recipient for other Medicaid services.
- ⇒ MediPass authorization numbers are unique to each office/clinic location. Incorrect numbers are frequently the reason for denied claims.
- ⇒ Consult your area office for assistance before a claim filing deadline date is exceeded.

Project AIDS Care Waiver and HMO Eligibility

Medicaid recipients who are enrolled in Medicaid health maintenance organizations (HMOs) are not eligible for enrollment in the Medicaid Project AIDS Care (PAC) Waiver. Conversely, persons enrolled in PAC cannot enroll in Medicaid HMOs.

- ✓ If you are a PAC waiver provider and receive an authorization to provide a PAC service to a PAC recipient, you should first check to see if the recipient is enrolled in an HMO before you provide the service.
- ✓ If the person is enrolled in an HMO, do not provide the service.
- ✓ Call the PAC case manager who authorized the service and report the recipient's HMO status and that you could not provide the service.

By doing so, you will eliminate the possibility of having to refund Medicaid for a service that you should not have rendered or billed.

Dental providers

Prior Authorizations for Dental Services

Requests for prior authorization for all dental services must be submitted on a "Form 1041: Dental Prior Authorization." This includes any dental or oral and maxillofacial surgery procedure code that requires prior authorization. Refer to Chapter 3 in your *Dental Coverage and Limitations Handbook* for procedure codes that require prior authorization. Dental requests submitted on the "Medical Prior Authorization Request" form will be returned.

RHCs, FQHCs

Excluded Codes Listing

Bulletin Correction

In the September 1997 Medicaid Bulletin, procedure code W1992 ("antepartum visit" plus "Healthy Start Prenatal Risk Screening" completed in the first trimester) was inadvertently omitted from the excluded code list (codes that rural health centers and federally qualified health centers should not bill to Medicaid because they are included in their "all inclusive" rates).

all providers/DME/home health/pharmacies

All providers

New Utilization Review Contract Awarded

FMQAI

For several years Florida Medicaid has contracted with KePro South, Inc., to perform utilization review functions relating to services provided to Medicaid recipients statewide. On August 1, 1997, the Agency for Health Care Administration issued a "Request for Proposals" for the Medicaid Utilization Review Program, and on October 28, 1997, awarded the contract to Florida Medical Quality Assurance, Inc., (FMQAI), located in Tampa.

FMQAI begins its contract with Medicaid on January 1, 1998, and continues the contract through June 30, 2000. The Medicaid utilization review activities performed by FMQAI refers to the review of all Medicaid services except behavioral health care. All reviews will be done off-site from the Tampa office.

FMQAI has been the federally designated peer review organization for Medicare in the State of Florida since 1993.

DME, Home Health

Hospital Bed PA Requirements

A large number of prior authorization requests for hospital beds (E0250 and E0255) are being denied or returned to the provider. Durable medical equipment (DME) requests must include:

- ◆ a prescription,
- ◆ a certificate of medical necessity,
- ◆ an established plan of care, or
- ◆ a hospital discharge plan signed by a qualified medical practitioner.

The equipment code must match the equipment description. Page 2-17 of the *DME/Medical Supply Services Coverage and Limitations Handbook* outlines additional documentation requirements for hospital beds. If all requirements are not met, the request will either be denied or returned to the provider. It is also important to note that if procedure code E0255 is requested by a provider, additional documentation for a "multi-height bed" must accompany the authorization request.

Pharmacies

New Pharmacy Provider Handbooks



A completely revised handbook for Medicaid prescribed drug services providers is being mailed to all active pharmacy providers. The revision combines the *Pharmacy Coverage and Limitations Handbook* and *Pharmacy Reimbursement Handbook* into one handbook. The new handbook is called the *Pharmacy Coverage, Limitations and Reimbursement Handbook*. If you do not receive the new handbook by February 1998, please check with your corporate office or your billing office to see if it was sent to that address. You may request a duplicate handbook by calling Unisys Provider Services 1-800-289-7799; however, there is a charge for mailing and handling of duplicate handbooks.

Important changes in the new handbook include the coverage for adults of OTC nicotine patches and gum when used in a short-term program to help recipients quit smoking (see related article on page 5 of this Bulletin), and coverage for adults of all forms of guaifenesin as a single-entity expectorant. Excluded from coverage now are drugs used to induce ovulation such as clomiphene, menotropins, and urofollitropin, and OTC pancreatic enzymes. Also, information about out-of-state provider enrollment is clarified in the new handbook in order to be consistent with general Medicaid policy.

All providers are strongly encouraged to keep your new pharmacy handbook in a large loose-leaf notebook for ready reference and to become familiar with the location of various subjects within the handbook.

Pharmacies, Physicians

Smoking Cessation Therapy Now Available to Medicaid Recipients



Effective January 1998, adult Medicaid recipients will be able to receive one course of nicotine replacement therapy, either nicotine transdermal patches or nicotine gum, in order to help them quit smoking. The products that are now covered by Medicaid include Nicorette®, Nicotrol®, NicoDerm CQ®, and Zyban®, an oral antidepressant indicated for use in a smoking cessation program.

Recipients will be limited to one course of therapy, either 8, 10 or 12 weeks, as specified by the manufacturers in the product labeling, and will be allowed to select only one of the nicotine replacement products. Each of the manufacturers has created a behavioral management program for recipients using its product and will provide useful aids such as audiovisual tapes, calendars, stickers, counselor-staffed hot lines, etc., for anyone who enrolls. Pharmacists should become familiar with these programs and recommend them to any recipient who is currently smoking and desires to quit.



Additional information about each product and its behavioral management program can be obtained by calling the telephone number listed in the following company-specific information.

NicoDerm CQ® and Nicorette® SmithKline Beecham Consumer Healthcare, L.P., “Commit to Quit” Committed Quitters™ plan 1-800 # available in Nicorette® Starter Kit and NicoDerm CQ® Step 1 and Step 2 packs.

Nicotrol® McNeil Consumer Products Co., Pathways to Change™ Program 1-800-699-5765, kit available in starter pack, continued in refill packs.

Zyban® Glaxo Wellcome, Inc. ZYBAN Advantage Plan™ 1-800-UCAN-QUIT (800-8226-7848) enrollment questionnaire also available in Zyban Advantage Packs.

In addition, the **Clinical Practice Guideline on Smoking Cessation** (CPG no. 18), a Quick Reference Guide for Smoking Cessation Specialists, and a Consumer Version (available in English and Spanish) are available by calling 1-800-358-9295 or through the Internet at the following address <<http://www.ahcpr.gov/guide/>>.

To help ensure that all recipients have an opportunity to take advantage of the benefits of these programs, companies will report to Medicaid on the enrollment and progress of recipients who participate in any of the above programs.

Note: Medicaid will not reimburse for any of nicotine replacement products or Zyban® after the initial 8 to 12 weeks of therapy.

Physicians, Therapists

Medicaid To Reimburse Augmentative Communication Devices



Beginning January 1, 1998, Medicaid therapy services began reimbursing for “Augmentative and Alternative Communication (AAC) Services and AAC Systems” for eligible recipients under 21 years of age.

Provider handbook material related to AAC evaluations and recipient “fitting/adjustment/training” sessions is being prepared for the *Medicaid Therapy Services Coverage and Limitations Handbook* and will be distributed to all Medicaid physicians as well as speech, occupational and physical therapists.

Physicians, Pharmacies

H. pylori Therapy Covered by Medicaid



Medicaid currently reimburses for all FDA-approved combinations for the eradication of H. pylori infection, which has been found to be a significant causal factor in peptic ulcer disease (PUD). Use of the RDA-approved combinations has been shown to reduce or eliminate a recipient’s need for chronic antiulcer therapy. Medicaid continues to spend more than \$60 million each year on antiulcer therapy so providers are encouraged to test for the presence of H. pylori in their PUD patients and where indicated, treat the H. pylori infection and discontinue chronic long-term use of antiulcer drugs.

Note: Most H. pylori treatments are 28 days, so a 30-day supply or “prn” refills are not medically indicated.



Diagnosis Code Requirements for Independent Lab Claim Submissions

Medicaid requires all laboratory tests to be medically necessary for the diagnosis or treatment of an illness, injury or disorder. Florida Medicaid does not currently require that an independent laboratory include a diagnosis code to attest to the medical necessity of each test billed; however, there are situations requiring that a diagnosis code be included on an independent laboratory claim form in order for the system to appropriately process the claim.

A diagnosis code is required on the claim line under the following circumstances:

The procedure is limited to specific conditions/diagnoses.

Procedure codes W1958 - W1965 for genetic diagnostics are covered only for the diagnosis of Huntington's Chorea (333.4), Spinal Muscular Atrophy (335.0, 335.10, 335.11, 335.19), Muscular Dystrophy (359.1), Myotonic Dystrophy (359.2), or Fragile X Mental Retardation (758.81).

The standard frequency limit varies with the diagnosis.

Effective January 1, 1998, the following procedures will have variable frequency limits depending on the diagnosis and are limited as indicated except for a recipient with end-stage renal disease (ESRD), diagnosis code 585. Only recipients with a diagnosis of ESRD will be routinely entitled to exceed the standard limits for the tests listed below:

Procedure Code	Brief Description	Standard Limit
82108	Aluminum	1/year
82728	Ferritin	2/year
82746	Folic Acid; Serum	2/year
83540	Iron	4/year
83550	Iron binding capacity (TIBC)	4/year
83970	Parathyroid hormone	2/year
84466	Transferrin	4/year
86287	Hepatitis B Surface Antigen (HBsAg)	4/year
86291	Hepatitis B surface antibody (HBsAb)	3/year

The procedure is exempt from MediPass prior authorization requirements.

A laboratory service related to family planning requires a family planning diagnosis code or the MediPass authorization number.

A laboratory service related to vision services requires a vision-related diagnosis code or the MediPass authorization number.

A laboratory service related to psychiatric services requires a psychiatric diagnosis code or the MediPass authorization number.

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Independent Labs

Diagnosis Code Requirements . . . (continued)



Claims processing requirements must be accommodated.

All claims submitted using electronic claims submission (ECS) require a diagnosis code in order to be accepted for processing. An example of an acceptable diagnosis code for ECS is V72.6.

Initially, when alpha numeric procedure codes are covered, a diagnosis code must be provided. Currently, this applies to procedure codes W1958 - W1965.

Medicaid does not accept Medicare's "Advance Beneficiary Notice" by which a physician or laboratory can notify a recipient of potential liability for lab charges not paid by Medicaid. However, prior to rendering a service, a provider must inform the recipient of his or her responsibility for the payment of any services received that are not covered by Medicaid and must document this in writing in the recipient's medical record.

(Refer to page 1-4 of the *Medicaid Provider Reimbursement Handbook, HCFA-1500 and EPSDT 221* for additional information concerning the limited circumstances under which a recipient may be billed for services not covered by Medicaid.)

Questions from in-state providers about independent laboratory services or the information found in this article should be directed to area Medicaid offices. Addresses and telephone numbers for area Medicaid offices are found in Appendix C of the *Medicaid Provider Reimbursement Handbook, HCFA-1500 and EPSDT 221*.

Out-of-state providers should direct their questions about independent laboratory services or the information found in this article to Medicaid Program Development at (850) 487-2641.



Independent Labs

Watch Out And Don't Lose Those Copayment Dollars

If you are a new independent laboratory provider, you may not be aware that Medicaid deducts a copayment from claims for laboratory services unless the service or recipient is exempt from a co-payment.



To show that a family planning or pregnancy-related laboratory service is exempt from a copayment, you must put an "F" in field 24H of the HCFA-1500 claim form.

If you do not enter an "F" in item 24H, the system will deduct a recipient copayment amount from your claim.

For additional information about recipient copayments, please refer to page 6-27 of the *Medicaid Provider Reimbursement Handbook, HCFA-1500 and EPSDT 221*. Copayment exemptions are found on pages 1-5 through 1-7 of the same handbook.

Independent Labs, Physicians, CMS, CPHUs, FQHCs, Hospitals, RHCs



Policy Change Regarding Frequency of Pap Smears

Effective August 13, 1997, the policy regarding allowable frequency of normal pap smears was changed from "one in 365 days" to "one in 200 days." This change was made to allow for more flexibility in the scheduling of annual pap smears and to accommodate the needs of postpartum women.

Exceptions to the frequency limitation may be made for recipients with abnormal cytology reports.

Medically indicated repeat services must be billed with modifier -22 and must include a report.

If you have questions regarding this policy change, please call your area Medicaid office for assistance.

RHCs/ independent labs/all providers

RHCs, Independent Labs

Rural Health Clinics and Independent Labs

Medicaid rural health clinic (RHC) providers that own separate laboratories must, in accordance with Section 1877 of the Social Security Act, enroll any separate laboratory as a Medicaid independent laboratory provider. All independent laboratory providers must comply with the rules and regulations as specified in the *Medicaid Independent Laboratory Coverage and Limitations Handbook*. Independent laboratory provider enrollment packets may be obtained from Unisys by calling 1-800-289-7799.

Rural health clinics owning independent laboratories must also comply with the rural health clinic laboratory specifications, Code of Federal Regulations (C.F.R.) 491.9(2) for their on-site laboratory. The basic laboratory tests specified in C.F.R. 491.9(2) are regarded as integral to providing primary care and are considered reimbursed in the all-inclusive RHC encounter rate.

In addition to separately maintaining the two laboratories in different physical locations and with separate staff, both the RHC laboratory and the RHC's independent laboratory must have separate CLIA certifications and Florida laboratory licenses.

All providers

Plastic Card Eligibility Verification Alert

There are still some older versions of the plastic Medicaid Card in circulation that do not have the correct telephone numbers for eligibility verification listed on the back.

The correct numbers on the current cards are:

1-800-925-1955 (in-state) - or - **1-800-955-7799** (out of state).

For recipient eligibility call:

1-800-925-1955 (in-state)

1-800-955-7799 (out-of-state)

All providers

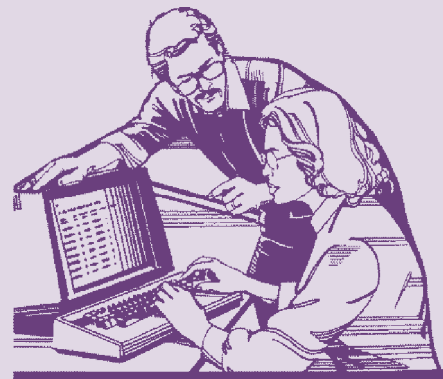
Up-to-date Medicaid Provider Publications Available On the World Wide Web



Medicaid Program Development has just updated the Medicaid publication section of the Agency for Health Care Administration's (AHCAs) Internet homepage. If you want on-line, up-to-date provider coverage and limitations handbooks and other Medicaid publications, then all you have to do is access the AHCA homepage using the following address:

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

Once you access AHCAs homepage, find "Services," choose and click on Medicaid. When the Medicaid screen comes up, locate the list of Medicaid links below the text about Medicaid Services, choose and click on Medicaid Publications and Forms. You can then access the Medicaid provider coverage and limitations handbooks if you choose and click on Handbook Library. Also available under Medicaid Publications and Forms are Bulletins, Forms, and the Medicaid Summary of Services.



Physicians

Incompatible Procedure Code Combinations Edit 110 Claim Denials

Recently, Medicaid has received a large number of resubmitted claims previously denied for edit 110. Edit 110 is a fatal edit and resubmissions will not result in payment of the procedure in a later claim submission. Reprocessing these previously denied claims creates unnecessary administrative costs to both the provider and Medicaid. The claims review logic has already determined that the procedures previously denied are incompatible with each other and they won't pay.

There are three types of incompatible procedure code combinations within edit 110:

- ⇒ **Procedure unbundling** occurs when two or more CPT procedures are used to describe a procedure performed when a single, more comprehensive CPT procedure exists that accurately describes the entire procedure performed (e.g., procedure codes 47425 and 47610 should not be billed as separate codes, but rather, code 47620 should be billed as the more comprehensive code). **Unbundled procedure codes will not be reimbursed.**
- ⇒ **Incidental procedures** are carried out at the same time as a more complex primary procedure. However, the incidental procedure requires little additional physician resources or is clinically integral to the performance of the primary procedure (e.g., when a patient undergoes a transurethral incision of prostate [52450] and a cystourethroscopy, separate procedure [52000], the cystourethroscopy is considered incidental). **An incidental procedure will not be reimbursed.**

If your claim is manually reviewed for multiple surgery reasons, you may see it denied with edit 907 (incidental procedures).

- ⇒ **Mutually exclusive** refers to two or more procedures that are usually not performed during the same patient encounter on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures in which the physician should be submitting only one of the procedure codes (e.g., procedure 58260 and 58150 are considered to be mutually exclusive because it is medically contraindicated to perform a hysterectomy using two totally different approaches; in this example, the default is the procedure code with proper documentation supporting the surgery). **Mutually exclusive procedures will not be reimbursed.**

Physicians, ASCs

Place of Service Code 24

Physicians who provide Medicaid reimbursable services in an ambulatory surgical center (ASC) and bill Medicaid for those services *must* use place of service (POS) code 24, ambulatory surgical center, in field 24b of the HCFA-1500 claim form.

- ⇒ Reimbursement for physician-provided ASC services does not include payment to the ASC for use of the facility.
- ⇒ The ASC must bill Medicaid separately to be reimbursed for use of the facility. An ASC's claim for facility charges will be denied as a duplicate when a physician submits an ASC claim with the POS code for an office (11) or hospital (21, 22).

For more information on Place of Service codes, please refer to Chapter 6 of your *Medicaid Provider Reimbursement Handbook, HCFA-1500 and EPSDT 221*.

Physicians, Hospitals, Independent Labs

DNA Diagnostic Testing



Effective September 18, 1997, Medicaid began providing coverage for DNA diagnostic testing using procedure codes W1958-W1965 when performed in an independent laboratory or the outpatient hospital department.

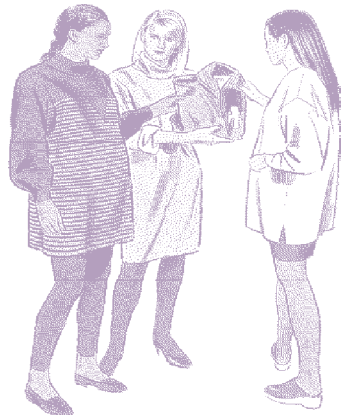
DNA diagnostics are limited to two complete studies per recipient per lifetime.

These procedure codes will be reimbursed only when used with the following diagnoses:

Diagnosis	Procedure Code
Huntington's Chorea	333.4
Spinal Muscular Atrophy	335.0, 335.10 335.11, 335.19
Muscular Dystrophy	359.1
Myotonic Dystrophy	359.2
Fragile X Mental Retardation ...	758.81

ARNPs/licensed midwives

ARNPs, Licensed Midwives



Procedure Code Change for Licensed Midwife - Supplies/Materials



For dates of service from July 1, 1997 to October 31, 1997, providers should use procedure code 99070 for supplies/materials associated with a home birth. The claims should have been filed on a paper claim and had the words "Birth Kit" attached to the claim. Those claims will be or were reimbursed at \$30.00.

For dates of service on or after November 1, 1997, providers should use procedure code W1856 for the same service. No report or paper claim is required and this code will be reimbursed at \$30.00.

Licensed Midwives - Labor Management



Procedure code X5907, labor management fee, may be billed by licensed midwives assisting recipients who labor at home and are then transferred for delivery. Reimbursement for this code is \$200.00.

For dates of service on or after November 1, 1997, licensed midwives performing home deliveries can be reimbursed by Medicaid for a home delivery and any of the following services:

Procedure Code	Brief Description	Reimbursement
W1856	Supplies/Materials associated with home births	\$ 30.00
J0290*	Ampicillin, 500 mg IV (Max 14 units)	\$ 1.30/500mg
J1642*	Heparin Lock Flush	\$ 10.00
J3430	Vitamin K Injection	\$ 2.32
J7050*	Normal Saline, 250cc	\$ 2.50
X5906	Post Delivery Recovery	\$160.00
X5907**	Labor Management Fee	\$200.00



* For recipients who are positive for beta strep

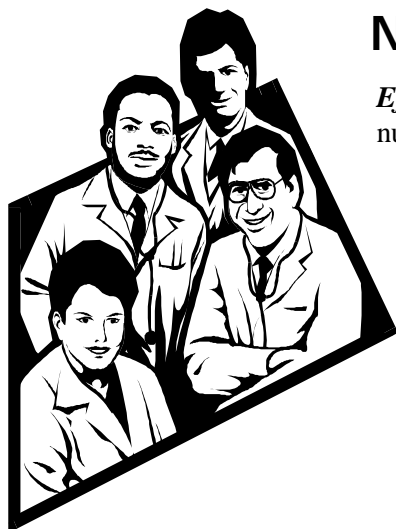
** For recipients who labor at home and are then transferred for delivery

ARNPs

New Reimbursable Services for ARNPs



Effective for dates of service on or after September 1, 1997, advanced registered nurse practitioners have been added as valid providers for the following procedure codes:



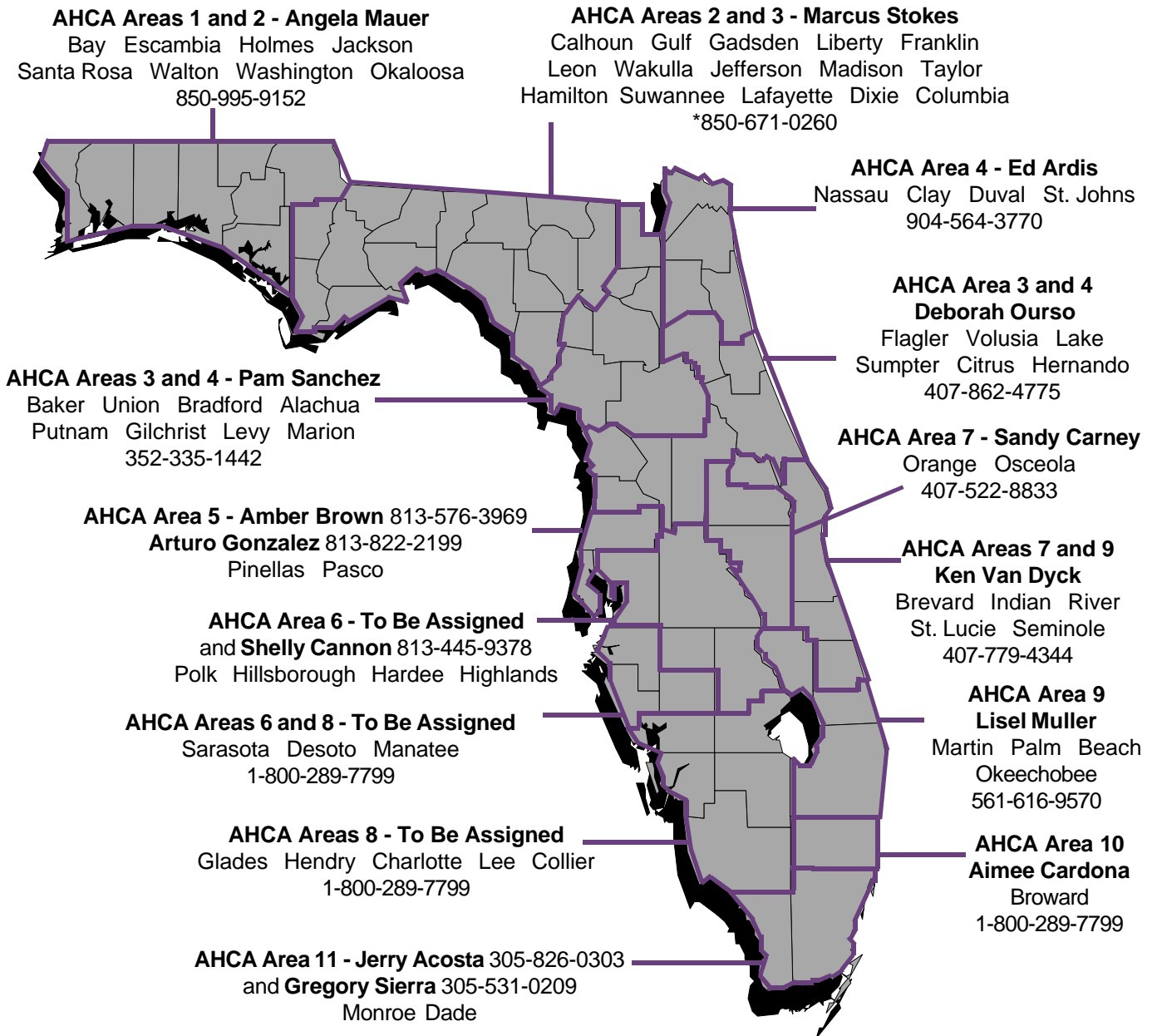
Procedure Code	Brief Description	Reimbursement
99332	Domiciliary or rest home visit, established patient (moderate complexity)	\$22.96
99333	Domiciliary or rest home visit, established patient (high complexity)	\$22.96
87072	Culture by commercial Kit	\$ 5.60
99312	Subsequent nursing facility visit (moderate complexity) ...	\$23.59
99313	Subsequent nursing facility visit (high complexity).....	\$31.21



UNISYS field representative map

* Effective March 1, 1998, area code 904 will not be in service for portions of Areas 2 and 3. Please use area code 850 .

** Please note new area code or telephone number.



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.



Articles carrying this graphic contain information about utilization review. =



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