

The Medicaid Bulletin

Volume 9, Issue 2

July 1996

*A Publication of the Agency for Health Care Administration
and UNISYS, the fiscal agent*

1996 LEGISLATIVE UPDATE from the Medicaid Director

The 1996 Florida legislative session ended in early May, and we now begin the task of implementing enacted legislation. Key areas related to Medicaid services include the implementation of cost containment measures to achieve nearly \$200 million in reductions and reforms in the areas of managed care and fraud and abuse.

General Appropriations Act

Fiscal year 1996-1997 funding for Medicaid services will be approximately \$6.7 billion — with only about one percent allocated for administrative costs within the Agency for Health Care Administration (AHCA). To achieve the overall \$194.8 million in reductions called for in the 1996 General Appropriations Act, several major cost containment reforms were mandated by the Legislature.

Transportation Reforms — Reforms will include: increased use of mass transit, an enhanced prior authorization process, elimination of incentives for individual trips, a transportation eligibility process, development of alternative means of transportation for high users, and greater control of rates to major purchasers. The transportation reductions apply only to non-emergency services.

Home Health Reforms — Medicare beneficiaries will be required to receive home health services from Medicare-certified home health agencies, ensuring that the beneficiaries exhaust their Medicare benefits prior to using Medicaid coverages. Other reforms include prior authorization of home health care and additional utilization review of durable medical equipment and supplies.

Prescribed Medicine/Pharmacy Reforms — Physicians will be encouraged to prescribe more cost-effective drugs. Pharmacists will be paid a higher dispensing fee when maintenance drugs are dispensed in 60 or 90-day supplies, which will achieve savings through volume discounts and fewer dispensing fees.

Community Mental Health/Inpatient Psychiatric Reforms — Reforms include the development of mental health managed care for community mental health services and the application of managed care strategies to therapeutic services for children. Reforms also include the implementation of a gatekeeper program to require prior authorization of plans of care for Medicaid community mental health recipients, prior authorization of inpatient

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care, concurrent stay reviews of inpatient stays, and reviews of patient treatment and billings. AHCA may also include community mental health services in HMO contracts.

ICF/DD Reforms — The legislation calls for the transition of services for individuals living in privately owned or operated facilities that are reimbursed through the optional ICF/MR-DD program to a home and community-based waiver services program. These facilities will no longer be licensed as ICF/MR-DDs.

Competitive Bidding/Mandatory Assignment to HMOs — Upon receipt of approval from the Health Care Financing Administration (HCFA), managed care-eligible individuals in Medicaid not voluntarily selecting a managed care option will be assigned to either MediPass or an HMO. AHCA will also begin competitively bidding HMO contracts at an estimated savings of 3 percent over current HMO capitation rates.

Other Measures — The 1996 Appropriations Act also calls for expansion of the state's estate recovery contract, modifications to the nursing home reimbursement plan, provider enrollment reforms to include site visits and bonding requirements, a reduction in hospital outpatient rate increases, and changes to the county billing methodology for hospital inpatient days under HMOs/PHPs.

Managed Care Legislation

Quality in managed care is one of AHCA's highest priorities, and the managed care reforms adopted during the '96 session will strengthen the quality of care among Medicaid HMOs. The reforms include: marketing restrictions, quality assurance reviews, expanded use of the statewide grievance panel, expansion of the Medicaid hotline, a new health quality improvement system, choice counseling for recipients, and a new Medicaid recipients' care standards committee.

Fraud and Abuse

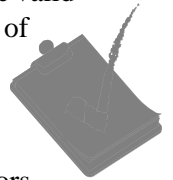
Enacted fraud and abuse legislation grants AHCA more authority to better ensure the enrollment of only qualified providers through site visits and bonding requirements. The legislation also strengthens Medicaid's ability to terminate fraudulent providers.

As we move forward with these and other Medicaid reforms, AHCA and the Medicaid program remain committed to ensuring access to quality health care for our state's most needy population. Thank you for your services to these citizens of Florida.

Updating Provider Enrollment

Medicaid has implemented changes to the provider enrollment process. In December 1995, a new provider enrollment application and agreement were issued. The major changes to the enrollment process are:

- For new applicants, eligibility will be established on the date the application is received by AHCA or by Unisys.
- For all providers, the agreement will be valid for a period of five years. At the end of five years, providers will be asked to sign a new agreement to continue participation in Medicaid.
- For every business, all officers, directors and principle owners (5% or more) must be identified, their names and social security numbers listed on a separate sheet of company letterhead and the letter signed and dated by the CEO of the business. (*Note: HCFA 1513 enrollees are exempt from this request.*)



Over the next several months, all currently enrolled providers will be asked to sign the new provider agreement, provide a \$50,000 surety bond if applicable, and verify information regarding their Medicaid provider status through a re-enrollment process.

Any questions regarding re-enrollment should be directed to the Unisys Provider Enrollment team at their new telephone number: 1-800-377-8216.

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).

Error in March 1996 Medicaid Bulletin


The address for mail sent to the Florida State Employees' Insurance Program (FSEIP) was incorrectly printed in the March 1996 Medicaid Bulletin. The correct address for FSEIP paper claim submissions is:

**UNISYS
P.O. Box 13500
Tallahassee, Florida 32317-3500**

Provider Re-enrollment Request

The Agency for Health Care Administration is requiring all providers currently enrolled in the Florida Medicaid program be re-enrolled. This process has already started for DME, Home Health, and Transportation providers. To ensure that you receive your re-enrollment package, Unisys must have your current and correct business address on file. If the file address is an incorrect and thus “undeliverable” address, **your Medicaid provider ID number will be terminated until you mail in your change of address information.** A request for a change in address or phone number will not be accepted based on a telephone call or a fax; however, you can inquire about the street and/or pay-to address currently in your Medicaid provider file by calling 1-800-377-8216. In order for Unisys to update your file, **you must mail your address and/or phone change request** (see sample below) on

- (1) *COMPANY LETTERHEAD* which must include:
- (2) *your OLD ADDRESS;*
- (3) *the NEW STREET ADDRESS* (the physical location address where you are rendering services or products);
- (4) *any NEW PAY-TO ADDRESS* (where payments will be mailed to, if different from #3);
- (5) *your NEW TELEPHONE NUMBER* (including area code);
- (6) *the EFFECTIVE DATE* for new address(es);
- (7) *a SIGNATURE* of individual provider, for group providers a company president or other authorized agent signature is required;
- (8) *the PROVIDER NAME;*
- (9) *and the matching PROVIDER NUMBER.*

①  ***** Dr. John Doe *****

PO Box 99999 City, FL 32301 (904)999-9999 (904)999-9999 FAX

Attn.: Provider Enrollment
 Unisys Corporation
 PO Box 7070
 Tallahassee, FL 32314-7070

Dear Sirs:

My **old address** was:

② OLD ADDRESS, CITY, STATE ZIP.

My **new street address** is:

③ NEW STREET ADDRESS, CITY, STATE ZIP.

My **new pay-to address** is:

④ NEW PAY-TO ADDRESS, CITY, STATE ZIP.

⑤ My **new phone** number is: (999) 999-9999.

⑥ My new address will be **in effect** starting _____ (date) _____.

Sincerely,

⑦ John Doe MD

⑧ Dr. John Doe

⑨ PN#9999999-00

Address/Phone
 Change Requests
**MUST BE
 MAILED TO:**

**Unisys -
 Provider Enrollment
 P. O. Box 7070
 Tallahassee, FL 32314-7070**

Bill Claims and Receive Medicaid Payment Within Seven Days

Electronic Claims Submission (within ONE DAY)

If you want a more cost-effective operation, submit your claims electronically by 11:59 p.m. every **Wednesday**.

Electronic billing is free and will:

- eliminate data entry errors;
- reduce claim form order fees and postage costs;
- enable you to check the status of your claims within five working days of submission; and
- allow you to receive your Medicaid reimbursement check within 7-14 days of submission.

Call the Unisys Electronic Claim Submission (ECS) Team at 1-800-377-8221 to sign up and receive software to help you bill electronically.

Note: If you currently use a software company to bill for other types of insurance, ask them if they are approved vendors for Florida Medicaid. If your vendor is not approved, then have them call Unisys at 1-800-377-8221 to obtain the requirements and specifications.

Electronic Funds Transfer (by DAY SEVEN)

As a Medicaid provider, you could potentially have your reimbursement payment in your bank account on the **Wednesday** following your electronic claim submission. *For holiday weeks, payments are made no later than Friday of the next normal weekly processing cycle.*

Follow these easy steps:

1. Submit a completed Electronic Funds Transfer (EFT) agreement with a letter on office stationery confirming the bank information, and a voided check or deposit slip to Unisys Provider Enrollment. In cases where the account is either a savings or checking account, submit a confirmation letter from your bank.
2. Wait for the two-week, pre-notification process to be completed.
3. Verify with your bank that the payment has been direct deposited into your account each week.

If you are interested in ECS, ERV or EFT call the Unisys ECS Team at 1-800-377-8221.

Electronic Remittance Vouchers (by DAY SIX)

You can receive an Electronic Remittance Voucher (ERV) after 12 noon on **Tuesday** following your claim submission (if submitted electronically by 11:59 p.m. on Wednesday). Receiving ERVs speeds up the claim process because Unisys can receive and post your claims

faster. ERVs can also eliminate weekly calls to Unisys to verify claim status or reimbursement payments. If you would like to have electronic RVs instead of paper, please contact the ECS team at 1-800-377-8221.

Unisys Field Representative Survey

There are 17 Unisys field representatives who cover the entire state of Florida. For quality control and accuracy, providers are called and surveyed at random on a specific field representative's performance. The feedback from these surveys allows Unisys to evaluate and improve their customer service and performance.

Upon request, field representatives will visit and train providers on how to bill Medicaid claims. Help is available for all types of providers with electronic or paper billing questions. Field representatives also assist the AHCA offices with local training and are available to attend any provider-related activities.

If you need assistance, call the field representative in your county. To find your field representative, refer to page 19 in this bulletin.

Please note: Area codes in Florida have recently changed; if your call does not go through you may need to check the area code).

Are You Missing any Checks?

Tear Out and Keep This!

The Unisys Banking Team can help locate a missing check or help you get a stop payment request. The most commonly asked questions are listed below with the appropriate action that must be taken to correct the problem. The Unisys Banking Team must have written authorization from you, in the form of a stop payment request to take action.

Provider: “The check I expected to get this week didn’t arrive. What should I do?”

Unisys: Wait seven days to allow for postal delays. If you still have not received your check, then fax or mail a stop payment request to the Banking Team. (See instructions below.)

Provider: “I think my check has been returned to you because we moved to a new location.”

Unisys: To expedite getting your check, fax a stop payment request using the instructions below. The Banking Team will research its undeliverable address check log. If your check is found, it will be mailed to you as soon as Unisys receives your address update. (See page 3 for update instructions.) If your check is not found, the Banking Team will place the stop payment and reissue your check promptly. **Please wait 10 working days before making an inquiry.**

Note: For your street and pay-to address to be updated on your provider file, you must mail an address change request to Unisys Provider Enrollment. See instructions on page 3.

Provider: “I don’t want to make a stop payment. I just want to find out if the check has been cashed.”

Unisys: A stop payment request authorizes the Banking Team to take action on your behalf. Once your stop payment request is received, the Banking Team will confirm your check’s status with the bank. If the check has been cashed, then the Banking Team will mail a copy of the cancelled check to you. If it is proven that someone else has cashed the check, then at your request, the Banking Team will send you an affidavit to complete and return.

Instructions: To initiate a stop payment, fax or mail the information below on COMPANY LETTERHEAD to the Unisys Banking Team at the address in the box below.

- < Attention: Banking Team
- < Provider NAME
- < PROVIDER ID number
- < CHECK AMOUNT (if available)
- < CHECK NUMBER*
- < CHECK DATE*
- < All other pertinent information
- < The statement “PLACE STOP PAYMENT AND REISSUE CHECK”
- < SIGNATURE of individual provider or for group providers, a company president or other authorized agent signature

Note: Items marked with an asterisk () can be obtained from the Provider Services Group by calling 1-800-289-7799.*

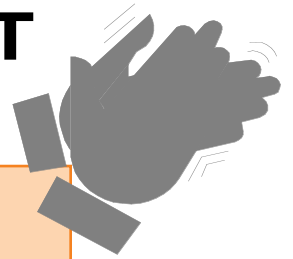
Fax your
STOP PAYMENT
request to
904-671-4527
or mail it to:

Unisys - Banking Team
2525 So. Monroe St.
Tallahassee, FL 32301

If the address on your company letterhead does not match the address Unisys has for the matching provider number on file, the stop payment request will not be completed.

MEDICAID PROVIDER SPOTLIGHT

COURAGE, INNOVATION, AND COMMITMENT

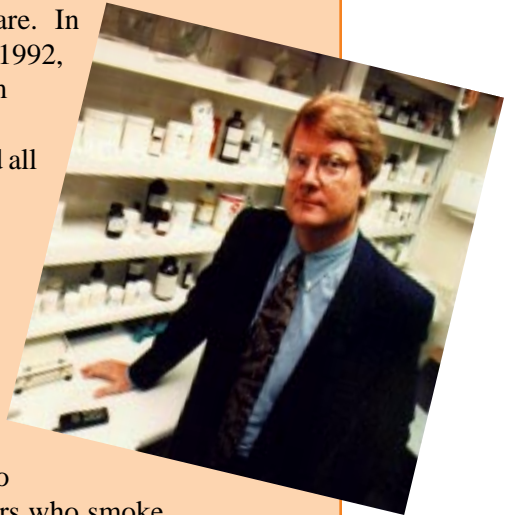


MEDICAID PHARMACY PROVIDER PUTS THE HEALTH CARE OF CUSTOMERS FIRST

In 1953 W. Marvin Gresham started a pharmacy business in Gainesville with a single downtown store which included a soda fountain that seated one hundred people. Over the next forty years, Mr. Gresham built up that beginning to six drug stores in Gainesville and Alachua and one home health care business. In 1992, Marvin's son Steve Gresham bought the business from his father and has since carried on the Gresham success by adding other holdings. These include another drug store in Melrose, several satellite locations, a long term care pharmacy, a home infusion pharmacy, and a home health care business located in Ocala. But the real success is an inspiring story of Gresham courage and their commitment to people, their community and health care.

Ahead of the times!

Steve Gresham, Gresham Drugs company president, has always seen a conflict between smoking and health care. In January 1992, Gresham Drugs removed all tobacco products from its shelves and offered nicotine patches at cost to customers who smoke.



Steve Gresham worked with his dad all his life prior to buying the business. He started out cleaning shelves and dusting merchandise.

... the real success is an inspiring story of Gresham courage and commitment to people, their community and health care.

Although he had aspirations of becoming a dentist, after he graduated from the University of Florida in the pharmacy program, he went to work again in his dad's store in 1977, this time as a pharmacist and store manager.

Over the years his responsibilities gradually expanded to cover the entire operation.

Steve must have always known that his dad's shoes would be hard to fill because Gresham's soda fountain was one of the first integrated eating establishments in Gainesville. Despite warnings that he was making a mistake, it came as no surprise to most people when Steve decided in 1992 to remove all tobacco products from the Gresham stores. Just like his father before him, he felt then as he does now, that he was doing the right thing!

"I had been bothered by the obvious conflict between being a health provider and selling cigarettes for a long time. I talked to drug store owners in other areas of the country and could not find anyone that thought it was a good idea to discontinue the sales of tobacco. My banker and lawyer questioned whether we could afford to lose those sales. Nonetheless, I felt that most customers would still buy their prescriptions and other needs from me even if we did not have cigarettes. I hoped



MEDICAID PROVIDER SPOTLIGHT

(continued)

that the missing profits would be made up by new customers that appreciated my decision. As it turns out, our sales have increased at a record rate since we removed tobacco from our stores and three years later I still am getting comments about it.”

In a 1992 article by Gary Kirkman in the *Gainesville Sun*, when discussing tobacco Gresham is quoted, “It's obviously a conflict of interest on what our purpose is supposed to be.” The *Sun* pointed out that the change carried a cost that would be spread out over the Gresham stores that had been selling tobacco products, and although Gresham said that it wasn't a big part of the business, the loss represented net profits of about \$20,000 a year. We must agree with the American Cancer Society, “it was a courageous thing to do!”

As far as advising others about the use of tobacco, Gresham says that he feels that it is a personal choice and he goes out of his way not to judge others. What Gresham does offer is help for better health choices by providing customers with alternatives through education, products that can help a person kick the tobacco habit, and a commitment to his customers and the people of his community.

(Information for this article was provided by Steve Gresham and a 1992 article in the Gainesville Sun. The photo is reprinted with permission from the Gainesville Sun, 1996.)

I don't know when we first became a Medicaid provider, how old is the program? . . . I have always felt that the Medicaid program served a very important purpose . . . and has always been important to my business. Medicaid customers may not have the disposable income of some of my customers, but they make up for it in their consistent and loyal support of my business. I value our Medicaid customers as much as any potential customer in the market place. We recognize that pharmacies fill a bigger role than merely dispensing medication. It is vital to our customers and our own future that we play a major role in helping make sure that the right medicine is being used, that it is being used properly, and that other related care is not being neglected.

-- Steve Gresham

Steve Gresham

- ▶ **Native Floridian, born and reared in Gainesville**
- ▶ **Graduate of the University of Florida (School of Pharmacy)**
- ▶ **President of Gresham Drugs**
- ▶ **Married to Elise Gresham**
- ▶ **Proud father of two sons Austin (15) and Parker (13)**
- ▶ **President of the Florida Museum of Natural History Associates**
- ▶ **Vice-Chairman of Chain Drug Marketing Associates**
- ▶ **Board member for the American Cancer Society, the McKesson Advisory Board and the Southern Drug Store Association**
- ▶ **Has previously served on the board for the North Florida Kidney Foundation and the American Heart Association;**
- ▶ **Past Chairman of the Southern Drug Store Association**
- ▶ **Medicaid provider**
- ▶ **Health care provider extraordinaire!**



Medicare Part A and Part B Crossover Submitters

Are you mailing your Medicare crossover claims to Unisys for reimbursement? If you are, then you may be double billing.

The following carriers and intermediaries automatically send claims to the Florida Medicaid system electronically:

- | Blue Cross and Blue Shield of Florida - Part A
- | Blue Cross and Blue Shield of Florida - Part B
- | Blue Cross and Blue Shield of Tennessee - Part A
- | Blue Cross and Blue Shield of South Carolina (DMERC) - Part B
- | Mutual of Omaha - Part A

If you send your claims to one of these Medicare carriers or intermediaries and your claims are not crossed over automatically, contact the Unisys Provider Enrollment Unit at 1-800-377-8216 and ask them to verify your provider cross reference file. Medicaid must have a record of your Medicare number before your claims will cross over automatically.

1996 Legislature Revises Copayment Laws



Although Medicaid recipient copayments are still required by law to be deducted from provider reimbursements, the 1996 Legislature repealed the section of the law that made it a felony if a provider did not attempt to collect or bill for these copayments. Therefore, providers are no longer required to bill or collect a copayment from Medicaid recipients. However, Medi-aid will continue to deduct the amount of the copayment from reimbursements to providers.

Physicians

Audiometric Evaluations



Effective May 1, 1996, physicians may be reimbursed for the following audiometric evaluations:

92552	pure tone audiometry, air only	\$ 9.77
92553	pure tone audiometry, air and bone	\$14.97
92555	speech audiometry threshold	\$ 8.55
92556	speech audiometry threshold with speech recognition	\$12.83
92557	comprehensive audiometry threshold evaluation and speech recognition	\$26.99

Physicians



Procedure Limits/Office Setting

Effective May 13, 1996, the following procedures are limited when performed in an office setting:

One of each per month

72010 72069 72220 74240 74241
93230 93235 94642

Two of each per month

70250 72040 72070 72100 72110
73550 73560 94664 95819

Three each per month

71020 93000 93010

Ten per month

94665

One each every 6 months

93307 93308 93320
93875 93880 93882

One each per year

76830 76856 76857 86003 86005
93922 93923 93924 93925 93926
93930 93931 93965 93970 93971
94010 94060 94070 94150 94160
94200 94240 94375 94667 95004
95010 95024 95028 95869 95900
95904 95925 95935 95937

Two of each per year

76700 76705 76770 76775

One per pregnancy

76825

Two per pregnancy (except high risk)

76818

Note: Some of these procedures have multiple units of service. Refer to your provider handbook for specific procedure code information. If a limit must be exceeded due to medical necessity, then bill the procedure with a 22 modifier and send a report. The claim will be reviewed by medical consultants for approval and pricing.

Physicians



Billing Procedure Code 99070

Medicaid is processing a significant number of denials for medical supply/drug claims (99070) billed on the HCFA-1500 form. When billing claims for medications that have no J code:

- ◆ Each claim must have an invoice attached that clearly indicates the exact item(s) used. The item should be correctly circled, checked off or written on the invoice.
- ◆ Medication invoices must indicate the dose used, its concentration and cost. Also, medical documentation of the supply/drug necessity must be attached, e.g., doctor or nurses notes.
- ◆ Medicaid will only pay the cost that is clearly indicated on the invoice. If the invoice is not complete or the additional supply/drug necessity documentation is not attached, the claim will deny.

Note: See *Physician Services Coverage and Limitations Handbook*, Chapter 2, “Injectable Medication Services,” for additional information.

When billing for subsequent casting and strapping procedures for an open reduction: use the appropriate CPT code, not the miscellaneous 99070 code.

When using procedure code 99070 for closed fx treatment, you must:

- ◆ attach the invoice showing the cost of the casting and strapping supplies (if the invoice lists more than one item be sure to circle the item or items that correspond to the claim being submitted);
- ◆ indicate the quantity utilized;
- ◆ indicate the unit price; and
- ◆ multiply the unit price by the quantity utilized and clearly indicate a total cost for that recipient.

Note: See *Physician Services Coverage and Limitations Handbook*, Chapter 2, “Orthopedic Services,” for additional information.

Accuracy and complete documentation will promote faster processing of these claims and fewer denials.

Provider Handbook Questionnaire

Over the past year, Medicaid has been publishing provider handbooks in a new format. Our goal is to continually improve all handbooks so that they are an effective tool for providers and their staff in determining what services can be furnished, what groups of eligible Medicaid recipients can be served, and how reimbursement can be successfully obtained.

If your provider handbook has been rewritten in the new format style, you should have received two Medicaid provider handbooks: a Services Coverage and Limitations Handbook and a Medicaid Reimbursement Handbook. We hope you’ve used the handbooks enough to be able to complete an evaluation of their effectiveness, because we need your feedback.

- ❖ Please have the individual in your office who uses the handbooks most frequently, **complete the evaluation on pages 10-11 and return it to us by September 15, 1996.** The evaluation is stamped and just needs to be folded, stapled and dropped in the mail.
- ❖ Your feedback will give us the valuable information we need to improve the clarity and usefulness of the Medicaid provider handbooks.
- ❖ The questionnaire can be completed and returned anonymously, but we do need to know your provider type.
- ❖ You can write in your name and mailing address if you would like to be included in other Medicaid provider questionnaires.

We appreciate your assistance!
Your views, comments and feedback make a difference.

Question 4 continued

How would you rate the following in the *Reimbursement Handbook*?

	Agree	Somewhat Agree	Disagree
● Information is clear and concise	_____	_____	_____
● Format style and appearance is easy to read and understand	_____	_____	_____
● Information is easy to find	_____	_____	_____
● Instructions are easy to follow	_____	_____	_____
● Difficult policies are clear	_____	_____	_____

5. Is there any section or topic in either handbook that you find difficult to understand? What and why?

6. What do you find particularly helpful in either handbook?

7. Is there additional information that you think should be added or any changes that you would like to see made to either handbook? (specify):

8. We have tried to write the new handbooks for staff of all experience levels. Please place a check beside the level of staff that most frequently reference the handbooks:

_____ New, with minimum experience	_____ With 1-2 years of experience
_____ 3-4 years of experience	_____ 5 or more years of experience

9. What is the job position of the person who uses the handbooks most frequently as a reference or a guide?

If your office is interested in answering other questionnaires that will help improve Medicaid provider publications, please write in your office name and address:

Name: _____

Address: _____

**Thank YOU for helping us
serve you better!**

State of Florida
Agency for Health Care Administration
Medicaid Program Development
P. O. Box 12600
Tallahassee, Florida 32317-2600

FIRSTCLASS
U.S. Postage
PAID
Tallahassee, FL
Permit #672

Agency for Health Care Administration
Medicaid Program Development
P. O. Box 12600
Tallahassee, Florida 32317-2600



Physicians (Ophthalmologists, Neurologists)

Ganciclovir Ophthalmic Implant Now A Covered Service

The ganciclovir ophthalmic implant marketed under the trade name of Vitrasert is now a covered service. Physicians needing to implant this device for cytomegalovirus infection of the eye may do so by:

1. Obtaining the device from the manufacturer and billing for reimbursement by attaching the invoice and using procedure code 99070. Prompt billing should ensure timely reimbursement. The manufacturer (Chiron) has assured Medicaid that the device will be supplied on a 60-day net basis.
2. Use procedure code 67299 for the transplant procedure. This code requires the submission of the operative report with the billing.

It is expected that the Health Care Financing Administration (HCFA) will be issuing procedure codes for the above two procedures in the near future. At that time, electronic claims will be feasible.

To expedite processing of paper claims for the **above procedures only**, mail your claim to:

ATTENTION: Lee Dufresne, RN
Agency for Health Care Administration
Medicaid Program Development
P. O. Box 12600
Tallahassee, Florida 32317-2600

.....

Vertebral Segments Procedure Code Changes

Effective June 1, 1996, procedure codes 63035, 63048, 63057, 63066, 63078, 63082, 63086, 63088 and 63091 will be removed from the multi-surgery pricing rule. All incidences of these procedures should be billed on one line. The maximum number of units for each procedure has been increased from one to a number appropriate for the procedure. Since these procedures are identified as "each additional" in the *Physicians Current Procedural Terminology (CPT)*, they are to follow the primary procedure code on each claim.

Physicians

Revised Prior Authorization Requirements for Physicians

Medicaid has further revised its prior authorization requirement for several procedures. Effective immediately, regardless of claim date of service, prior authorization is **no longer required** for the procedures and programs indicated below:

19350	19357	19361	19364	19366
19367	19368	19369	21210	21215
42820	42825	42830	42835	43848
65760	65765	65770		

Beginning with dates of service on and after July 1, 1996, prior authorization **is required** for the following codes that formerly did not require prior authorization:

21235	54407	54409
-------	-------	-------

Effective immediately **the following codes**, formerly requiring prior authorization, **are no longer covered** by Florida Medicaid:

15780	15781	15782	15786
15787	19325	21209	54400
54401	54405		

Note: MediPass authorization requirements still apply.

Hospitals

Revised Prior Authorization Requirements for Hospitals

Medicaid has further revised its prior authorization requirement for several procedures. Effective immediately, regardless of claim date of service, prior authorization is **no longer required** for the procedures and programs indicated below.

44.64	44.65	76.91	85.7
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Beginning with dates of service on and after July 1, 1996, prior authorization **is required** for procedure code 76.69, which did not formerly require prior authorization. .

Effective immediately, **the following codes**, formerly requiring prior authorization, **are no longer covered** by Florida Medicaid.

64.94	64.95	64.97	85.50
85.53	85.54	86.25	

Note: MediPass authorization requirements still apply.



Physicians, PAs, ARNPs

MediPass Changes

Prior to May 1996, Advanced Registered Nurse Practitioners (ARNPs) and Physician Assistants (PAs) were enrolled in MediPass as physician extenders. This meant physicians who enrolled in MediPass as primary care providers and who had a PA or ARNP working in their office was allowed to increase their maximum patient caseload by 300 patients for each PA or ARNP that worked 40 hours per week. The ARNP or PA was then allowed to provide services to the physicians' MediPass recipients and any services rendered were billed to Medicaid using the physician's Medicaid provider number.

Two modifications have now been made to MediPass. The first modification increases the maximum patient caseload for full-time equivalent (40 hrs per week) physician extenders from 300 to 750. The second modification allows ARNPs and PAs to participate independently in MediPass as primary care providers.

If an ARNP or PA wishes to enroll independently as a MediPass primary care provider, he or she must sign an Agreement for Participation in MediPass and must adhere to the same requirements as physician primary care providers. However, independent ARNPs and PAs must bill under their ARNP or PA Medicaid provider number and will be subject to the provisions of the ARNP or PA Coverage and Limitations Handbooks. In addition, only MediPass recipients who voluntarily request an independent ARNP or PA practice will be enrolled with an independent ARNP or PA; no mandatory enrollments will be made to these practices. Regardless of whether an ARNP or PA is enrolling with MediPass as a physician extender or enrolling independently, and regardless of the number of locations they practice, each full time equivalent ARNP or PA may not receive more than 750 MediPass patients.

If you are currently a MediPass physician and wish to increase the maximum patient caseload for your physician extenders, or if you are an independent ARNP or PA and wish to become a MediPass provider, please contact your local Medicaid office.

Physicians, PAs, ARNPs

Newborn Examination

The appropriate billing code for newborn assessment performed on recipients born in a birth center is either 99432 or W9881 (Early Periodic Screening, Diagnosis and Treatment, EPSDT). Requirements for EPSDT must be met in terms of comprehensive assessment and documentation when either of these codes is used.

Reimbursement for 99432 is \$55.40 for physicians. PAs and ARNPs are reimbursed at 80% of this fee.

EPSDT reimbursement is \$64.82 for physicians. PAs and ARNPs are reimbursed at 80% of this fee. EPSDT procedures must be billed on the EPSDT 221 claim form.

Physicians, PAs, ARNPs, Rural Health, CPHU, FQHCs

Varicella Vaccine (Chickenpox)

On April 4, 1996, CPT-4 code 90716, varicella vaccination, became a covered service. At the present time, this vaccination is not covered by the Vaccine For Children (VFC) program. Reimbursement for physicians, rural health clinics, county public health units, and federally qualified health centers is \$52.20, which includes the cost of the vaccine and an administration fee. ARNPs and PAs are reimbursed \$50.20.

When available through the VFC program, Medicaid will only pay for the administration of the vaccine. Further information concerning varicella vaccine and the VFC will be forthcoming.

Licensed Midwives

Procedure Code 99435 Valid for Licensed Midwives

Licensed midwives have been added as valid provider types for procedure code 99435, history and examination of normal newborn, including preparation of medical records (used for newborn assessed and discharged from hospital or birthing room on the same day). Reimbursement is \$52.70.



Birth Centers

Birth Center Policy

Effective April 22, 1996, birth centers are valid providers for the following services: family planning, ultrasounds, non-stress tests, and evaluation and management (E/M) services for gynecological care. The E/M services are not exempt from MediPass. See Chapter 1 of the *Medicaid Provider Reimbursement Handbook, HCFA-1500*, for managed care and copay information. The 4/96 update of the *Birth Center and Licensed Midwife Services Coverage and Limitations Handbook* reflects these policy changes.

Procedure code 99435, history and examination of normal newborn, including preparation of medical records (used for newborn assessed and discharged from hospital or birthing room on the same day) is a new code for 1996. Birth centers have been added as valid providers. Reimbursement is \$65.87.

Home Health

Private Duty and Personal Care Services

There may be times when a home health agency provides private duty/ personal care services to two or more recipients at a single location.

If the needs of two or more children at a single location can be met by one nurse/home health aide for the specified time, Medicaid reimburses the services as follows:

1. Services for the first recipient shall be reimbursed at the established Medicaid rate;
2. The second recipient shall be reimbursed at 50 percent of the established rate; and
3. Any additional recipients at 25 percent of the established rate.

Please contact your area Medicaid office for billing instructions.

Radiologists

Radiology Policy

When the professional service component of a radiology procedure is performed for an emergency room recipient, use place of service 22 (outpatient hospital) on the claim.

LT and RT modifiers are now valid for the following:

- 73720 - MRI, lower extremity, other than joint
- 73721 - MRI, any joint of lower extremity
- 73220 - MRI, upper extremity, other than joint
- 73221 - MRI, any joint of upper extremity

When a radiological study is performed in an office setting, the physician billing the maximum fee must have performed (or supervised the performance) and interpreted the study.

Pharmacy

Electronic and POS Billing of Prescriptions over \$1000 Now Possible



Medicaid has implemented a system change that replaces the \$1,000 limit on electronic media pharmacy claims with a variable limit designed to allow the electronic billing of expensive drugs and also to prevent billing errors in general. There are now nine different “thresholds” or limits for electronic media pharmacy claims, ranging from as low as \$100 per prescription to \$15,000. Each drug has its own threshold, so that any prescription under the threshold can be processed electronically. Claims over the established threshold will deny for EOB 321, manual claim required, but will generally indicate that an error in billing quantity has been made.

For example, claims for Acetaminophen with Codeine #3 will be denied if the amount to be paid exceeds \$100 (approximately the price for 1,500 tablets), but claims for Taxol will be processed electronically up to \$15,000.

If your pharmacy routinely bills for high-cost drugs on paper claim forms, you should start using the pharmacy point-of-service (POS) system for all your claims. If you still get POS claims denied for EOB 321, check the billing quantity on the submitted claim for accuracy, or ask your local Medicaid office for assistance.

Pharmacy POS “Dispense As Written” Codes

In an effort to standardize the Medicaid point-of-sale (POS) claim transaction with other third party processors, Medicaid will be adopting the “Dispense as Written” (DAW) codes as defined by the National Council for Prescription Drug Programs (NCPDP). The DAW field will be accepted from the POS claim transmission and added to the Medicaid claim record to facilitate pharmacy billing for multisource drug products. Proper use of the DAW field by POS users will allow pharmacy providers to override generic upper limit prices on drugs that are on the Florida Negative Formulary, as provided for in Chapter 465, F.S., and for products on the Medicaid preferred drug list (see article in this bulletin describing this list).

Only the numbers “0” through “9” are defined by NCPDP and will be considered valid values in the DAW field. Blanks, alphabet letters, or other characters will be considered invalid values and may result in a claim denial (NCPDP reject 22), since these values are not supported by NCPDP standard.

The following is a list of the DAW code definitions from the NCPDP Data Element Dictionary:

0 = No Product Selection Indicated

This is the default value to use for prescriptions where product selection is not an issue, such as prescriptions written for single source products or prescriptions written using the generic name when a generic is dispensed.

1 = Substitution Not Allowed By Provider

Use only when the prescription is for a multisource product and prescriber has indicated, by handwriting “medically necessary” on the prescription, that the product is to be dispensed as written. The product’s generic upper limit price will be overridden for

brand drugs on the Florida Negative Formulary, the preferred drug list, and for Ritalin and Tegretol.

2 = Substitution Allowed - Patient Requested Product Dispensed

Use when the prescription is for a multisource product and generic substitution is permitted by the prescriber, but the patient requests a brand product. The product’s generic upper limit price will not be overridden in this case and the pharmacy may not collect the difference in price from the recipient.

3 = Substitution Allowed - Pharmacist Selected Product Dispensed

Use when the prescription is for a multisource product and generic substitution is permitted by the prescriber, but the pharmacist determines that the brand product should be dispensed. The product’s generic upper limit price will not be overridden in this case and the pharmacy may not collect the difference in price from the recipient.

4 = Substitution Allowed - Generic Drug Not In Stock

Use when the prescription is for a multisource product and generic substitution is permitted by the prescriber, but the brand product is dispensed because the generic is not immediately in stock. The out-of-stock occurred due to the buying habits of the pharmacy, not because of the unavailability of the generic in the marketplace. The product’s generic upper limit price will not be overridden in this case and the pharmacy may not collect the difference in price from the recipient.

5 = Substitution Allowed - Brand Drug Dispensed As Generic

Use when the prescription is for a multisource product and generic substitution is permitted by the prescriber,

but the pharmacist is using the brand product as the generic entity. The product’s generic upper limit price will be overridden for brand drugs on the preferred drug list.

6 = Override

This value is not currently being used in Medicaid.

7 = Substitution Not Allowed - Brand Drug Mandated By Law

Use when the prescription is for a multisource product on the Florida Negative Formulary and, although generic substitution is permitted by the prescriber, the pharmacist is dispensing the brand product since Florida law prohibits the substitution of such products. The product’s generic upper limit price will be overridden.

8 = Substitution Allowed - Generic Drug Not Available in Marketplace

Use when the prescription is for a multisource product and generic substitution is permitted by the prescriber, but the pharmacist is dispensing the brand product since the generic is not currently manufactured, distributed, or is temporarily unavailable. The product’s generic upper limit price may be overridden in limited circumstances.

9 = Other

This value is reserved and currently not in use. In compliance with NCPDP standards, Florida Medicaid will not use this value.

Please contact your software vendor immediately to make sure that your software supports this NCPDP standard, and uses the default “0” rather than a blank in the field.

Note: Once these DAW codes become operational, the use of “cert code 1” and “cert code 9” will not be necessary, as DAW “1,” “5,” and “7” will be used when indicated.

Processing Pharmacy Claims For Recipients With Other Third Party Resources

(This is a reprint of a Bulletin article published in March 1995. It is being repeated to inform new providers and those providers who continue to have problems correctly filing claims for Medicaid recipients with other insurance. The procedures have not changed. These steps are also described in the new Medicaid Provider Reimbursement Handbook, Pharmacy, Chapter 6, "Submitting Claims" and Appendix A, "Troubleshooting.")

Since July 1993, Medicaid has been denying payment for pharmacy claims when the recipient has other insurance coverage from a commercial HMO or a medical plan with a prescription drug card benefit. The denial code for these claims is 265. Providers may still bill Medicaid for any applicable copayments or deductibles, or for services not covered by the other insurance, by following the simple steps outlined below.

Billing via POS: Submitting claims via the point-of-sale (POS) system is the easiest and quickest method for most claims with third party liability (TPL). Submit the claim first to the primary third party. Then when the paid response is received, complete the Medicaid claim in the usual manner, with the quantity dispensed and the usual and customary charge for the original prescription (not the amount remaining). In the field called "Other Payer Amount," enter the amount paid by the primary third party, using the paid amount from the response received from the other payer. The Medicaid claims processing system will automatically calculate the amount due from Medicaid and process the claim. The amount paid by Medicaid may be slightly different than the copayment of the other plan, because it is calculated to total the amount that would have been paid in full by Medicaid. (Note: If your POS software does not have a field known as "Other Payer Amount," please contact your vendor immediately. This is a required POS field, and is a part of the NCPDP 3.2 transmission standard.)

Billing via Tape or ASAP: Pharmacy claims with TPL cannot be processed via tape or ASAP. You must submit paper claims, or convert to POS, using version 3.2.

Billing via Paper: Paper claim submission is required in two instances. If your system cannot process TPL claims or cannot enter data in the "Other Payer Amount" field, you must use paper for **all** TPL claims. Complete the claim form as usual. In addition, enter the third party payment in the "Remarks" section to the left of each claim line entry. Remember to bill for your usual and customary charges in the billed amount field (not the difference, the copay, or the remaining amount due). Attach the Explanation of Benefits (EOB) or evidence of payment from the other third party, and underline the charges and payments for claims you are submitting to Medicaid.

You must also submit on paper if you normally use POS, but have a claim denied by the other third party. If the claim was not paid because the member copay exceeded the drug cost, or if the drug was not covered by the third party, complete the paper claim as above, but enter a "TPL paid \$0.00" in the "Remarks" section, and attach the EOB.

If the claim was denied by the third party for member eligibility or any other reason, complete the claim as usual but do not enter anything in the "Remarks" section, and attach the EOB from the third party with the reason for denial. These claims require review of the attached documents by Medicaid TPL staff, who will update the recipient file if necessary, thereby allowing future claims to be easily paid by Medicaid.

Further information about Third Party Liability can be found in Chapter 1 of the *Medicaid Provider Reimbursement Handbook, Pharmacy*.

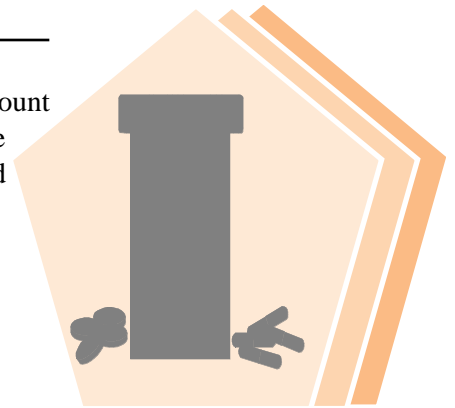


Preferred Drug Listing

Florida Medicaid receives rebates from drug manufacturers. Because the amount of rebate varies with the manufacturer's best price to other customers, some drugs are significantly less costly than competing products. In some cases, brand name products are more cost effective for Medicaid than generic equivalent products.

The above circumstances led the Florida Legislature to direct Medicaid to furnish prescribers and pharmacists with a list of the most cost effective Medicaid drug products. These will be referred to as "preferred." Also, Medicaid must request voluntary preferential utilization of these products where there are no medical or therapeutic reasons to use other more expensive drugs.

In July 1996, Medicaid will publish and distribute to all physicians, ARNPs and pharmacies a "Preferred Drug" listing. This listing will not be an all inclusive formulary, but will target those therapeutic classes where significant differences in cost to Medicaid offer the most potential to reduce costs. Your cooperation in prescribing and dispensing products from the list can help achieve significant cost savings for Medicaid and avoid future program restrictions. Drugs not included on the "Preferred Drug" list will still be available.



Also, in May 1996, Medicaid initiated policy changes that permit "medically necessary" specification for two products, Tegretol and Ritalin. These changes were made because rebates for these brands reduce their costs to levels comparable to or below their respective generic equivalent products.

90-100 Days Supply Encouraged for Maintenance Drug Prescriptions

As stated in Chapter 2, Service Requirements, of the *Prescribed Drug Services Coverage and Limitations Handbook*, "Medicaid does not limit prescriptions to a 30-day supply. Providers need not split a prescription into multiple orders in order to facilitate Medicaid billing. Maintenance drugs must be dispensed in at least a 30-day supply or more if so prescribed, up to a 100-day supply." This has been Medicaid policy for many years.

In order to encourage dispensing routine maintenance drugs in larger quantities, the Florida Legislature has authorized Medicaid, starting in July, to begin paying pharmacy providers an additional \$1.00 for each prescription for a 60-day or more supply, and \$2.00 for each prescription in a 90 to 100-day supply.

There will not be a published list of "maintenance drugs" as is done by other insurance companies. Instead, prescribers and pharmacists may exercise their professional judgment in assessing which recipients would benefit from receiving larger quantities of medicine. Patients who have changed doses frequently, or who have changed eligibility status recently, or who are acutely ill would not be candidates for such large doses. In addition, in accordance with state law, pharmacists may not dispense quantities that exceed the total authorized by the prescriber. Some drugs that are not considered maintenance drugs will still have quantity and supply limits in order to discourage abuse/misuse. Early refill edits will still apply to all prescriptions.

Although the claims processing system will add the additional amount to the dispensing fee, pharmacy providers may wish to increase their "Amount Billed" when appropriate, in order to capture this increased fee.

UNISYS field representative map



Please note new area codes marked with an asterisk (*). Dialing the number "1" before the area code may be necessary to complete your telephone call.

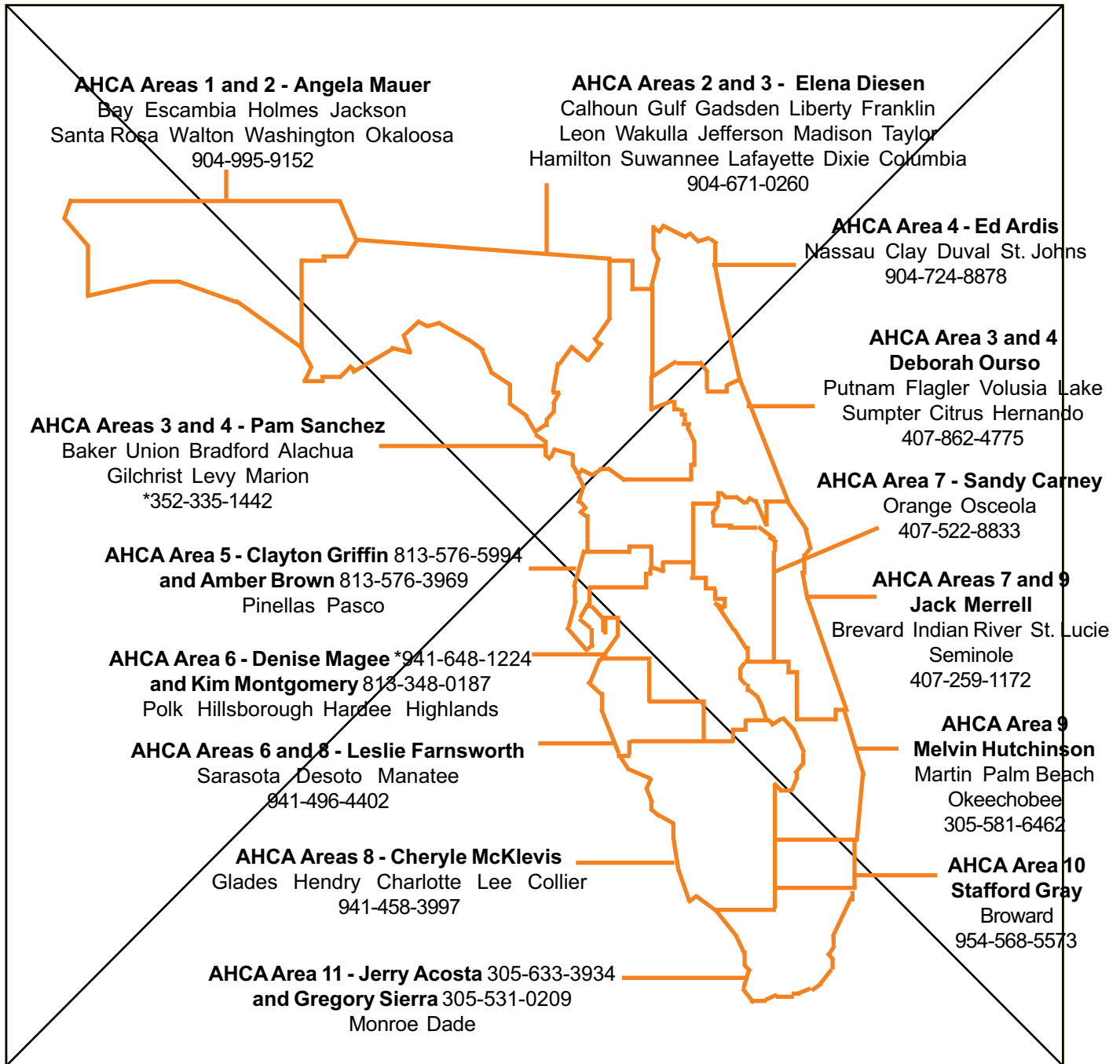


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