



The Medicaid Bulletin

Volume 10, Issue 3

November 1996

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

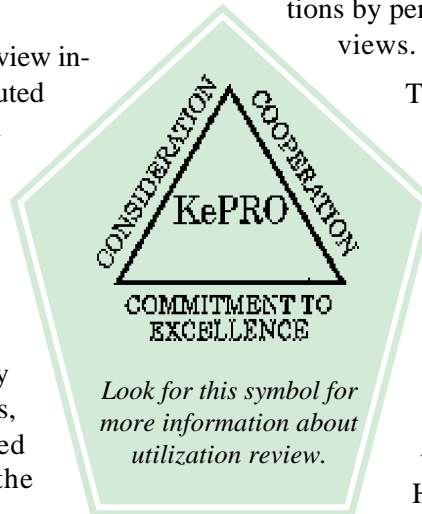
Medicaid Bulletin To Include Utilization Review

Medicaid providers whose provision of services are reviewed by the state contracted peer review organization (PRO), will now find utilization review information incorporated into the Medicaid Bulletin.

Formerly utilization review information was just distributed to hospitals and health maintenance organizations (HMOs); however, recent changes have added more provider groups to the PRO review list. As different provider groups become affected by utilization review policies, they will now be informed about those policies in the Medicaid Bulletin.

The purpose of utilization review is to ensure that Medicaid recipients are receiving medically necessary and appropriate services, and that the quality of those services meet professionally rec-

ognized standards of care. The Agency for Health Care Administration (AHCA) contracts out the function of utilization review to a professional peer review organization, which makes the determinations by performing medical record reviews.



The peer review organization currently performing the Medicaid reviews is **KePRO South, Inc., of Tampa**. KePRO has had the AHCA/PRO contract since April of 1992. KePRO performs medical record reviews of health care services provided by hospitals, HMOs, MediPass providers, county public health units, and home health agencies. This year, KePRO will also be reviewing services provided by Hospice, Project AIDS Care waiver providers, rural health clinics and federally qualified health clinics.

INSIDE THIS ISSUE

<i>Utilization Review articles.....</i>	<i>3, 7, 8, 9, 11</i>	<i>Nursing Facility Bed Hold Days</i>	<i>11</i>
<i>New Medications Available</i>	<i>5</i>	<i>MediPass and Public Health Providers</i>	<i>11</i>
<i>Newly Approved Diagnosis Codes.....</i>	<i>6, 7, 9</i>	<i>Home Health Aide Visits.....</i>	<i>12</i>
<i>Emergency Services and MediPass.....</i>	<i>8</i>	<i>New Dental Codes.....</i>	<i>13</i>
<i>Medicaid Provider Spotlight</i>	<i>10</i>	<i>PAC New Services and Fees</i>	<i>14</i>
<i>CMH Treating Physicians</i>	<i>10</i>	<i>Unisys Field Representative Map</i>	<i>15</i>

Change In Ownership

The notification responsibilities for change in ownership as stated in Florida Statute 409.907(6) is as follows: "a provider shall give the Agency 60 days notice before making any change in ownership of the entity named in the provider agreement as the provider."

Please assist us by giving proper and timely notice. For more information or to make notification, call 1-800-377-8216 or write to:

Unisys - Provider Enrollment
Post Office Box 7070
Tallahassee, Florida 32314-7070

Don't Mail Those Tapes!

Although technology is fast-moving and constantly changing, it offers great benefits and rewards. *Technology can:*

- Save staff time and effort;
- Save on the cost of resources needed in a nonelectronic world;
- Process smoother, quicker communications; and
- Be obtained at affordable prices.

Start saving now. Don't mail tapes; transmit your claims instead! The advantages are that you will:

- Be able to process more claims (with tapes if one claim rejects, the entire tape rejects; however, by transmitting asynchronously only the claim in error would reject);
- Save on costly shipping fees or expensive tape media; and
- Receive on-line confirmation for all claims transmitted (this eliminates time-consuming phone calls to verify receipt or status of tape claims).

To transmit your Florida Medicaid claims directly to Unisys, or to obtain electronic billing requirements and asynchronous specifications, **call: 1-800-377-8221.**

Bill Electronically

If you are not billing your claims electronically, then you may be losing out on some great advantages. The following are just four of the many reasons to bill electronically. You will have:

1. ***Cleaner claims with fewer errors:*** on-line edits combined with reduced handling and re-keying of claim information eliminates the source of most common billing errors.
2. ***Increased cashflow and productivity:*** fewer errors means fewer denials, and fewer denials increases payments to your office.
3. ***Reduced clerical handling and labor requirements:*** administration costs are greatly reduced by curtailing detailed claim preparation and processing resources in your office.
4. ***Increased useful management information:*** the layout of your recipient information can be used for other business functions in your office.

Unisys will supply software to Medicaid providers who currently submit claims on paper forms (handwritten, typed, or computer generated). There is no charge for the software, and a Unisys field representative will provide technical assistance if needed. See page 15 of this bulletin for a list of the Unisys field representatives.

To bill electronically, you need:

- An IBM compatible PC with 4 megs of memory;
- A modem with at least 9600 baud rate; and
- Unisys software or asynchronous specifications.

Call the Unisys Electronic Claims Submission (ECS) Team at 1-800-377-8221 to sign up and receive software to help you bill electronically. Or, if you prefer, Unisys will supply you with a list of vendors that bill Medicaid claims electronically.

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

All providers

Medical Necessity



During the last legislative session, a bill amending Sec. 409.913, Florida Statutes was passed that may impact administrative hearings on peer review organization (PRO) denials.

According to the new legislation, medical necessity is defined as “any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice.” For purposes of determining Medicaid reimbursement, the amended statute states that the Agency for Health Care Administration is the final arbiter of medical necessity. The law further provides that the written findings of the applicable PRO are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

All providers

Did You Know?

In one month’s time, Unisys field representatives are in contact with over 2,000 providers and personally visit over 500 providers. To enable the field team to provide the most current Medicaid changes affecting the Medicaid provider community, the Unisys Tallahassee office is in constant contact with their field representatives by telephone, electronic messages and teleconference calls. Also, to further ensure correct information is furnished to providers, printed copies of all information is sent through the mail to each member of the field team.

See page 15 for a map showing the field representative supporting providers in your county.

Physicians



Radiology Update for LT/RT Modifiers

Radiology procedure codes with LT/RT modifiers have recently been updated to allow duplicate billing on the same claim, when the same service is performed on the same date of service on both the left and right sides.

Physicians

Procedure Code W1700



Effective July 1, 1996, non-hospital employed physicians may bill procedure code W1700 (screening, evaluation and examination in emergency room).

For MediPass recipients, if a recipient comes into an emergency room with a medical condition defined as an emergency, reimbursement for services rendered to that recipient will be made through the existing evaluation and management codes, 99281-99285. The emergency physician will indicate whether the recipient came in with an emergency medical condition by marking the appropriate box on the HCFA-1500 claim form.

If the MediPass recipient came into the emergency room with a condition that the emergency physician determined did not meet the criteria for an emergency, the only code that should be billed is W1700. Reimbursement for W1700 will be paid at the same level as code 99281.

Physicians



Breast Biopsies

Breast biopsies include:

- ♦ Needle, procedure code 19100; and
- ♦ Incisional, procedure code 19101.

Breast biopsies are limited to one per day per recipient. If additional biopsies must be performed, you must bill with a -22 modifier and attach a report that documents medical necessity.

Physicians, ARNPs, Birth Centers, PAs, CPHUs

Family Planning



Medicaid does not reimburse for family planning services to a recipient age 17 years or younger unless the minor:

- ❖ Has his or her parent/legal guardian’s written consent;
- ❖ Is married;
- ❖ Is a parent;
- ❖ Is pregnant; or
- ❖ In the provider’s opinion, will suffer from probable health hazards if services are not provided.

physicians/DOs/ARNPs/PAs

Physicians

Modifiers Removed



Modifiers 76 and 99 have been removed from the following procedure codes:

70200 70320 70350 70370
70310 70328 70355

Modifier 99 has been removed from the following procedure codes:

70336 70480 70487 70492 70552
70450 70481 70488 70540
70460 70482 70490 70541
70470 70486 70491 70551

Modifier 22 has been removed from the following procedure codes:

70010 70140 70260 70350 70460
70015 70150 70300 70355 70470
70030 70160 70310 70360 70480
70100 70200 70320 70370 70481
70110 70201 70328 70373 70482
70120 70220 70330 70380 70486
70130 70240 70332 70390 70487
70134 70250 70336 70450

Physicians, ARNPs, PAs



Reimbursement Revised for High Risk Newborn Acute Care

Effective January 1, 1996, a locally assigned code, W1993 - Acute Care of the High Risk Newborn, was established for acute services provided to high risk newborns who do not require positive pressure ventilation and/or chest compressions. CPT-4 code 99440 was revised to limit its use to include the provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate cardiac output.

Physicians, DOs, ARNPs, PAs

Use of Modifier -22 Requires Attachment of a Report

The use of modifier -22 is only for services that are beyond the usual service. This modifier requires a report to be attached documenting the circumstances that are beyond the usual service. These claims are pended for medical review, and thus are slower in processing.

Increasingly, Medicaid is seeing the use of modifier -22 for situations that are not unusual or services that are not beyond the usual service. Not only is no additional payment made in the majority of claims, but this trend is causing delays throughout the reimbursement system.

Providers who continue to use modifier -22 inappropriately may be subject to review and audit.

Billing for Transesophageal Echocardiograms



A transesophageal echocardiogram performed in the physician's office (place of service code 11) should be billed using procedure code 93312 as described in the CPT manual. The provider will be reimbursed for the use of equipment owned by the practice, the staff performing the test, placement of the probe, and interpretation and report.

If a transesophageal echocardiogram is performed in an inpatient or outpatient hospital setting (place of service code 21 or 22), it should be billed using procedure codes 93313 and 93314. The provider will be reimbursed for placement of the probe with image acquisition, interpretation and report. The technical component of the diagnostic test is reimbursed to the facility through the per diem rate.

Both 93313 and 93314 pay the full fee on file. The fee schedule is found in Appendix D of the *Physician Services Coverage and Limitations Handbook*.

ARNPs, PAs

New Service Added for ARNPs and PAs



Effective July 1, 1996, Advanced Registered Nurse Practitioners (ARNPs) and Physician Assistants (PAs) can perform "wedge excision of skin of nail fold," procedure code 11765. Medicaid reimburses \$20.41 for this service.



Physicians

New Medications Available Through Physician Offices

New pharmaceutical products are being approved at an increased rate by the Food and Drug Administration. As each new drug becomes available, there is usually a quick response by physicians and drug companies requesting a code to bill for its provision.

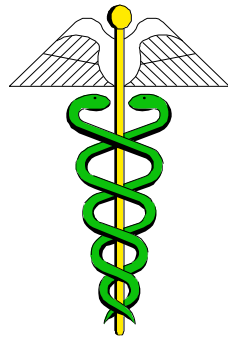
Pharmaceutical representatives are frequently telling physicians that a drug is covered by Medicaid. While this may be accurate, the provider should be aware that Medicaid has two methods for coverage of pharmaceuticals: (1) through the use of "J" codes for injectable medications in the physician's office, and (2) through the pharmacy program.

Reimbursement to physicians for injectable medications requires the use of a "J" code on HCFA-1500 claims. The "J" codes are issued by the Health Care Financing Administration (HCFA), not by a state agency and are updated annually.

Often there may several months before a "J" code is issued for a newly approved injectable medication. For Medicaid to cover the medication during the interim, a HCFA-approved locally assigned procedure code ("W") must be used. Medicaid may ask for a locally assigned code if medical necessity is shown for its use through written requests from physicians.

Once the code has been approved and added to the Medicaid fee schedule, the physician can be reimbursed for its provision. This code should be used until a designated "J" code is established for the product. Procedure code 99070, supplies and materials, should NOT be used for these medications.

Reimbursement of new drugs in the Medicaid pharmacy program requires the recipient to submit a prescription to his or her pharmacy. The pharmacist would then submit a claim to Medicaid on behalf of the recipient using the NDC code.



Physicians

Radiology Update for MRI Diagnoses

Florida Medicaid has added the following diagnoses for Magnetic Resonance Imaging (MRIs):

MRI, Orbit, Face & Neck	524.60
MRI, Upper Extremities	719.41 - 719.44
MRI, Lower Extremities	719.41 - 719.44
MRI, Cervical Spine	782.0 and 847.0
MRI, Thoracic Spine	847.1
MRI, Lumbar Spine	847.2
MRI, Pelvis & Abdomen	789.0

See Appendix D of the *Physician Services Coverage and Limitations Handbook* for a listing of diagnoses and fees.

Replaced or Deleted Diagnosis Codes for Physicians and Hospitals

The following diagnosis codes are invalid beginning on October 1, 1996. They have been either replaced or deleted.

Diagnosis Code	Description
291.8	Other specified alcoholic psychosis
466.1	Acute bronchiolitis
575.1	Other cholecystitis
752.5	Undescended testicle
752.6	Hypospadias and epispadias
753.2	Obstructive defects of renal pelvis and ureter
758.8	Other conditions due to sex chromosome anomalies
922.3	Contusion of back
995.5	Child maltreatment syndrome
998.1	Hemorrhage or hematoma complicating a procedure
998.5	Postoperative infection
V15.4	Psychological trauma
V61.1	Marital problems



Newly Approved Diagnosis Codes for Physicians and Hospitals

Effective October 1, 1996, new diagnosis codes have been approved by the Health Care Financing Administration (HCFA) for 1997. The list below represents all the new 1997 diagnosis codes that Medicaid covers. Any new diagnosis code that is not found on the list below is not covered by Medicaid.

Diagnosis

Code	Description
079.6	Respiratory syncytial virus (RSV)
291.81	Alcohol withdrawal
293.84	Organic anxiety syndrome
300.82	Undifferentiated somatoform disorder
315.32	Receptive language disorder (mixed)
414.04	Coronary atherosclerosis of artery bypass graft
414.15	Coronary atherosclerosis of unspecified type of bypass
466.11	Acute bronchiolitis due to respiratory syncytial virus (RSV)
483.1	Pneumonia due to chlamydia
574.60	Calculus of gallbladder and bile duct with acute cholecystitis without mention of obstruction
574.61	Calculus of gallbladder and bile duct with acute cholecystitis with obstruction
574.70	Calculus of gallbladder and bile duct with other cholecystitis without obstruction
574.71	Calculus of gallbladder and bile duct with other cholecystitis with obstruction
574.80	Calculus of gallbladder and bile duct with acute and chronic cholecystitis without mention of obstruction
574.81	Calculus of gallbladder and bile duct with acute and chronic cholecystitis with obstruction
574.90	Calculus of gallbladder and bile duct without cholecystitis without mention of obstruction
574.91	Calculus of gallbladder and bile duct without cholecystitis with obstruction
575.10	Cholecystitis, unspecified
575.11	Chronic cholecystitis
575.12	Acute and chronic cholecystitis
752.51	Undescended testis
752.52	Retractile testis
752.61	Hypospadias
752.62	Epispadias
752.63	Congenital chordee
752.64	Micropenis
752.65	Hidden penis

(continued on next page)



Newly Approved Diagnosis Codes (continued) for Physician and Hospitals

Diagnosis Code	Description
753.20	Unspecified obstructive defect of renal pelvis and ureter
753.21	Congenital obstruction of ureteropelvic junction
753.22	Congenital obstruction of ureterovesical junction
753.23	Congenital ureterocele
753.29	Obstructive defects of renal pelvis and ureter, NEC
922.31	Back contusion
922.32	Buttock contusion
922.33	Interscapular region contusion
995.51	Child emotional/psychological abuse
995.52	Child neglect (nutritional)
995.53	Child sexual abuse
995.54	Child physical abuse
995.55	Shaken infant syndrome
995.82	Adult emotional/psychological abuse
995.83	Adult sexual abuse
995.84	Adult neglect (nutritional)
995.85	Other adult abuse and neglect
998.11	Hemorrhage complicating a procedure
998.12	Hematoma complicating a procedure
998.13	Seroma complicating a procedure
998.51	Infected postoperative seroma
998.59	Other postoperative infection
998.83	Nonhealing surgical wound

Inpatient Stay or Outpatient Visit: The 23-Hour Question

Question: If a recipient is in the hospital for less than 24 hours, should the stay be billed as an inpatient stay or an outpatient visit? And what utilization review (UR) policy should be applied?

Answer: According to Medicaid UR policy, if a Medicaid recipient is admitted to a hospital bed, and is expected to stay at least 24 hours, but it is later determined that the recipient can be discharged or transferred in less than 24 hours, the services can be billed as an inpatient stay as long as the severity of illness (SI) criteria are met.

If on admission the recipient does not meet SI screens, and the utilization review committee determines that the stay is not medically necessary, the services must be billed as an outpatient visit.

- The key in determining whether a less than 24-hour stay can be billed as an inpatient stay versus an outpatient visit is the determination by the hospital utilization review committee of the presence or absence of medical necessity.
- Medicaid policy allows for up to 48 hours in outpatient observation status.
- Hospitals are not expected to substitute outpatient observation services for medically appropriate inpatient services.
- Admission to any bed in the hospital can be billed as outpatient. Each outpatient day must be billed separately, however.
- Finally, if the Peer Review Organization denies an inpatient stay, the hospital can void the inpatient hospital bill and rebill appropriate outpatient revenue center codes. ***If adjustments exceed the 12-month filing deadline, they should be sent to:*** Medicaid Program Development, Long Term Care/PRO, 2728 Mahan Drive, Tallahassee, Florida 32317-2600.



Emergency Services and MediPass

Recent legislation mandated that the Agency for Health Care Administration reimburse providers for emergency services and care regardless of whether the provider obtained authorization from the MediPass primary care provider. Effective for dates of service on or after September 1, 1996, providers are no longer required to obtain post-authorization for emergency services and care rendered to a MediPass recipient experiencing an emergency medical condition.



The Florida Medicaid claim processing system is being modified to allow emergency service claims to pay without the MediPass authorization number on the claim form. Outpatient hospital claims will be exempt from MediPass based on emergency diagnosis codes, and physician claims will be exempt from MediPass based on the HCFA-1500 emergency indicator field. Notification will appear in weekly remittance vouchers when the system is ready to accept this new billing procedure.

Please be aware that if a MediPass recipient arrives at the emergency room without symptoms of a potentially emergent nature, and a basic screening determines that an emergency medical condition does not exist, the provider must still obtain prior authorization from the MediPass primary care provider before rendering service.

Emergency services and care mean "medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital." An emergency medical condition, as defined by Sec. 409.901, Florida Statutes, means "a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient, including a pregnant woman or a fetus; serious impairment to bodily function; or serious dysfunction of any bodily organ or part."

In these instances, non-hospital employed physicians may bill procedure code W1700 (screening, evaluation and examination in the emergency room) for the screening if the MediPass provider refuses authorization and the recipient elects to be treated by his or her primary care provider. Procedure code W1700 is effective for dates of service on or after July 1, 1996, and reimburses \$12; the procedure code may not be billed in conjunction with an emergency room evaluation and management code. For these same situations, Medicaid reimburses hospitals through the hospitals' cost reports and established outpatient rates.

Replaced or Deleted



Procedure Codes for Hospitals

Beginning October 1, 1996, the following ICD-9-CM procedure codes have been replaced by expanded codes, other codes, or have been deleted:

- 47.0 Appendectomy
- 47.1 Incidental appendectomy
- 54.5 Lysis of peritoneal adhesions
- 59.01 Ureterolysis with freeing or repositioning of ureter for retroperitoneal fibrosis
- 65.0 Oophorectomy
- 65.3 Unilateral oophorectomy
- 65.4 Unilateral salpingo-oophorectomy
- 65.8 Lysis of adhesions of ovary and fallopian tube
- 68.5 Vaginal hysterectomy

Tubal Ligations Following Deliveries



A tubal ligation is medically necessary on an inpatient basis if it is performed within 48 hours following a normal delivery and performed during the same hospital stay. Otherwise tubal ligations are not usually reimbursable as an inpatient procedure.



Early Discharge of OB Recipients

Effective October 1, 1996, Florida State Senate Bill No. 1860 provides coverage for a medically necessary length of hospital stay for maternity and newborn services.

Medicaid has always reimbursed hospitals for medically necessary maternity and newborn services. The PRO evaluates each day of hospitalization for documented evidence of medical necessity. Normal vaginal deliveries of three days length of stay (from the time of admission) and less are excluded from the review sample as are cesarean sections of five days or less. Any delivery in the review sample is reviewed for the presence of medical necessity for each day of the stay.

Hospital PRO Review Statistics



KePRO recently issued their second quarter 1996 provider utilization review statistics. The review period was from April 1 through June 30, 1996. Listed below is a breakdown of hospital utilization reviews by type and denial rates:

Total cases reviewed:	9,678
Overall statewide denial rate:	11%
1-2 day (3,651 cases)	11%
Outlier (2,445 cases)	13%
Adolescent Psychiatric (240 cases)	5%
Adult Psychiatric (1,697 cases)	10%
Random Sample (1,645 cases)	10%

Top occurring diagnosis:

Pneumonia (293 cases)

Top occurring procedure:

Spinal Tap (189 cases)

Newly Approved Procedure Codes for Hospitals



Effective October 1, 1996, the ICD-9-CM procedure codes listed below have been approved by the Health Care Financing Administration (HCFA) for 1997. Medicaid covers all the new codes below. New procedure codes that are not found on the list below are not covered by Medicaid.

Procedure

Code	Description
36.17	Abdominal-coronary artery bypass
39.90	Insertion of noncoronary artery stent(s)
47.01	Laparoscopic appendectomy
51.21	Other partial cholecystectomy
51.24	Laparoscopic partial
65.01	Laparoscopic oophorectomy
65.09	Other oophorectomy
65.13	Laparoscopic biopsy of ovary
65.14	Other laparoscopic diagnostic procedures on ovaries
65.23	Laparoscopic marsupialization of ovarian cyst
65.24	Laparoscopic wedge resection of ovary
65.25	Other laparoscopic local excision or destruction of ovary
65.31	Laparoscopic unilateral oophorectomy
65.39	Other unilateral oophorectomy
65.41	Laparoscopic unilateral oophorectomy
65.49	Other unilateral salpingo-oophorectomy
65.53	Laparoscopic removal of both ovaries at same operative episode
65.54	Laparoscopic removal of remaining ovary
65.63	Laparoscopic removal of both ovaries and tubes at same operative episode
65.64	Laparoscopic removal of remaining ovary and tube
65.74	Laparoscopic simple suture of ovary
65.75	Laparoscopic reimplantation of ovary
65.76	Laparoscopic salpingo-oophoroplasty
68.23	Endometrial ablation
68.51	Laparoscopically assisted vaginal hysterectomy (LAVH)
68.59	Other vaginal hysterectomy

Medicaid Provider Spotlight

Medicaid would like to applaud and give special recognition to the following hospitals for their exceptionally low utilization review denial rates:

<i>Bay Medical Center</i>	2% denial rate (201 reviews)
<i>Deering Hospital</i>	1% denial rate (70 reviews)
<i>South Seminole Community Hospital</i>	1% denial rate (70 reviews)
<i>Imperial Point Medical Center</i>	2% denial rate (60 reviews)
<i>Indian River Memorial Hospital</i>	2% denial rate (60 reviews)
<i>Holmes Regional Medical Center</i>	2% denial rate (63 reviews)

Medicaid would also like to recognize the following CPHUs who had no appropriate billings for the 1995/1996 fiscal year and commend them for their outstanding work in providing Medicaid services to our recipients:

<i>Clay CPHU</i> , in Green Cove Springs	<i>Marion CPHU</i> , in Ocala
<i>Dixie CPHU</i> , in Cross City	<i>Martin CPHU</i> , in Stuart
<i>Flagler CPHU</i> , in Bunnell	<i>Okeechobee CPHU</i> , in Okeechobee
<i>Gilchrist CPHU</i> , in Trenton	<i>Palm Beach CPHU</i> , in West Palm Beach
<i>Jefferson CPHU</i> , in Monticello	<i>St. John's CPHU</i> , in St. Augustine

Medicaid would like to offer special thanks to the following providers for their accurate and timely medical documentation to KePRO:

Able Care/Naples, Englewood, Ft. Myers, Lehigh Acres

Care Point/Ft. Lauderdale

Olsten/Gainesville

Staff Builders/West Palm Beach

Superior In Home Care/Pensacola

Community Mental Health Services Treating Physicians

The responsibilities of the community mental health services treating physician are clarified below:

State law governing the community mental health services program requires the treating physician to personally render, or authorize on behalf of the group provider, all Medicaid reimbursable services.

The treating physician must sign and date the recipient's treatment plan, indicating his or her concurrence with all components of the treatment plan.

The treating physician must also sign and date a statement certifying that all services are medically necessary and appropriate to the recipient's treatment needs.

The treating physician, by virtue of his or her signature, not only authorizes specific treatment, but concurs with the results of the evaluation that led to the diagnosis and plan of treatment.

By signing, the physician is stating that in his or her professional opinion the diagnosis is correct, the treatment is medically necessary, and the course of treatment is appropriate to meet the recipient's needs.

Nursing Facilities/Hospitals

Nursing Facility Bed Hold Days



Effective July 1, 1996, the Medicaid policy for nursing facility reserved bed payments was revised. Medicaid now pays up to 8 days for each medically necessary hospitalization, and up to 16 days annually (July 1-June 30) for therapeutic leave (home visits). The new policy applies to hospital admissions and home visits that began on or after July 1, 1996.

If paid bed hold days run out, federal regulations allow a nursing facility resident or their responsible party to voluntarily pay to hold a bed. If a recipient is unwilling or unable to make private payments to continue to hold the bed, the facility may either continue to hold the bed without compensation or discharge the recipient. If the facility chooses to discharge the recipient when the bed hold days run out, they must readmit the recipient to the first available Medicaid bed, as specified in 42 Code of Federal Regulations (C.F.R.) 483.12(b)(3).

Federal regulations in 42 C.F.R. 483.12(b) and state regulations in 59G-4.200(5)(d)5, Florida Administrative Code, require nursing facilities to establish and follow a written bed hold policy that must include the duration of the bed hold days and the federal requirement to readmit discharged recipients to the first available bed.

Nursing facilities should review their written bed hold policy to ensure it contains the required information, and advise Medicaid recipients and their families of this change. For additional information, contact your area Medicaid office.

CPHUs

County Public Health Unit Medicaid Audits



Beginning July 1, 1996, all Medicaid CPHU utilization review audits will occur offsite in the KePRO South Inc., office in Tampa. KePRO will notify each CPHU of the requirements for review.

MediPass providers

MediPass and Public Health Providers



Effective September 1, 1996, county public health units (CPHUs) and federally qualified health centers (FQHCs) are no longer required to obtain prior authorization from the MediPass primary care provider for certain services. Services covered by this policy change include:

- ◆ The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and HIV;
- ◆ The provision of immunizations; and
- ◆ Services rendered on an urgent basis.

CPHUs and FQHCs are still required to obtain post authorization for these services in order to bill Medicaid.

Urgent services are defined as “those services needed to immediately relieve pain or distress for medical problems such as injuries, nausea, and fever; and services needed to treat infectious diseases and other similar conditions.”

MediPass is revising its Agreement for Participation to include this stipulation. MediPass providers should familiarize themselves with this new policy and begin supplying post authorization to CPHUs for these particular services. Services not meeting the above criteria will still require prior authorization from the MediPass primary care provider.

MediPass providers

MediPass: New Agreement and Expanded Services



Effective December 1, 1996, MediPass primary care providers will begin managing maternity services. This newly managed service is included in the revised “Agreement for Participation in MediPass,” which incorporates additional changes in the program resulting from passage of Chapter 96-99, Laws of Florida.

In order to continue participating in the MediPass program, current MediPass providers must sign a new MediPass agreement and submit it to their area MediPass office by December 6, 1996.



Home Health providers

Home Health Services for Dually-Eligible Recipients

Effective September 15, 1996, the home health services listed below must be billed to Medicare when provided to a Medicare/Medicaid dually-eligible recipient. This is in response to the 1996-97 General Appropriations Act directing the Agency for Health Care Administration to ensure that Medicare is the primary payer of home health services for dually eligible recipients. The services are:

- Home health visits** (procedure codes W9611, W9612, W9613);
- Therapy services** (procedure codes Q0103, Q0104, Q0086, Q0109, Q0110, H5300, W1887 and W1888); and
- Durable medical equipment (DME) services**, (procedure codes A4100 - A9999, B4030 - B9999, L0100 - L9999, V2623 - V2629 and E0100 - E1830 **except** E0608).

If the above home health services for dually-eligible recipients are initially billed to Medicaid, the claims will be denied for Edit 237, "Medicare coverage is present." The services must first be billed to Medicare.

If Medicare pays the claim, Medicaid will pay the deductible and/or coinsurance, if applicable. If Medicare denies the claim, you must attach the denial to a straight Medicaid claim form and submit the claim to your area Medicaid office. (See the *Medicaid Provider Reimbursement Handbook, HCFA 1500*, Chapter 4, for information on Medicare crossover claims.) Medicaid cannot reimburse a non-Medicare home health agency for Medicare-reimbursable home health services rendered to a dually-eligible recipient.

Any service denied by Medicare will be subject to Medicaid home health policy, including the over 60-visit prior authorization requirement. However, visits reimbursed by Medicare will not be applied to the Medicaid 60-visit service limitation.

Medicaid reimbursement policy requires submission of a clean claim to Medicaid within twelve months of the date of service or six months from the date of Medicare's payment or denial. (See the *Medicaid Provider Reimbursement Handbook, HCFA-1500*, Chapter 6, for information on timely claim submission.)

Home Health providers

Home Health Aide Visits

Beginning September 15, 1996, Medicaid reimburses for two types of home health aide visits. Those visits that are:

- Associated with a skilled nursing service, **OR**
- Unassociated with a skilled nursing service.

Both types of visits must meet all requirements for reimbursement including being provided under the supervision of a registered nurse.

The current procedure code, **W9613**, will continue to identify the home health aide visit **associated** with a skilled nursing service. The doctor's order and plan of care must identify the recipient's need for both home health aide services and skilled nursing services at home. This type of home health aide service may be reimbursable by Medicare. For the dually-eligible recipient this service must be billed first to Medicare.

A new procedure code, **W9620**, will identify a home health aide visit that is **unassociated** with a skilled nursing service. The doctor's order and plan of care must identify the recipient's need for home health aide services **only**. This type of home health aide service is not reimbursable by Medicare. For the dually-eligible recipient, this service is billed to Medicaid, and not billed first to Medicare.

On September 15, 1996, Medicaid Program Integrity began conducting random reviews on home health providers' use of procedure codes W9613 and W9620.

Replacement pages in Update 96-1 to the *Home Health Services Coverage and Limitations Handbook* incorporating this procedure code information were sent to Home Health Providers in August 1996. If you did not receive these replacement pages, they may be obtained from Unisys by calling 1-800-289-7799.

Birth Centers

Labor Management

Effective July 1, 1996, labor management may be billed for recipients who go into labor at the birth center and are then transferred for delivery. The procedure code used for this service is X5907 and Medicaid reimbursement is \$200.

Home Health providers

Home Health Prior Authorizations



For faster KePRO responses please be sure the following information is included with requests for home health prior authorizations for *adult Medicaid recipients*:

1. Send only physician signed and dated plans of treatment for consideration.
2. For fax submissions of prior authorization requests, identify on each piece of paper submitted to KePRO the type of request that is being made, for example:
 - Initial request,
 - Additional visit request,
 - Recertification request,
 - Request to change approved RN visits to LPN visits,
 - Additional information submitted in response to a pending denial, or
 - Other types of special requests.
3. The actual onset date needs to be reflected on the plan of treatment and not changed with each recertification period.

Birth Centers



“Invalid Place of Service” Edit Correction

If you have recently billed for family planning, ultrasound, fetal non-stress test, or visit and labor management and received a claim denial due to “invalid place of service” (edit 365), please resubmit those claims. The system error that caused the above claims to deny with edit 365 has been corrected.

Community Mental Health providers



Medicaid Coverage for Children

The following policy concerns Medicaid coverage for children under age 21 receiving services from psychiatric speciality hospitals:

Psychiatric specialty hospitals under contract with local Department of Health and Rehabilitative Services (HRS) Alcohol, Drug Abuse, and Mental Health (ADM) program office may request enrollment as a Medicaid Community Mental Health Services (CMHS) provider.

If approved for enrollment, Medicaid will reimburse for services for children residing in the facility only if it has 16 beds or less.

For those CMHS enrolled psychiatric specialty hospitals with 17 or more beds, Medicaid will reimburse only for those services provided to children who have been unconditionally discharged from the facility and who are being served on an outpatient basis.

Dental providers



New Dental Codes

Effective August 1, 1996, Medicaid began coverage of procedure codes D2380 and D7970.

- Procedure code D2380, used for a one surface primary posterior resin, is limited to a maximum age of 20 years and has a reimbursement rate of \$22.00.
- Procedure code D7970, used for excision of hyperplastic tissue, per arch, may be used with both children and adults and has a reimbursement rate of \$75.00. D7970 must not be billed in conjunction with an alveoloplasty on the same date of service.

TMJ Dysfunction Treatment

Procedure code D7880, Occlusal Orthotic Appliance, is the correct code to use when billing for an occlusal splint, nightguard or biteguard when provided for the treatment of temporomandibular joint dysfunction. D7880 requires submission of a report with the claim and is limited to recipients age 20 years or younger. A request for prior authorization of this code is not required.



Project AIDS Care New Services and Fees

Effective October 1, 1996, four new services have been added to the Project AIDS Care (PAC) Waiver. The new services are: Health Assessment, Companion Services, Physical Therapy and Massage Therapy.

To be eligible for reimbursement by Medicaid for furnishing PAC waiver services, a provider must be enrolled as a Medicaid Project AIDS Care Waiver provider and meet the qualifications listed under each service explained below.

Health Assessment

Procedure Code: W9956
Maximum Fee: \$11 per quarter hour.
Service Limitations: Health assessments are limited to two per year, and no more than three hours per assessment.

Provider Qualifications: Health assessments can be provided by an Advanced Registered Nurse Practitioner (ARNP) who is licensed under Chapter 464, Florida Statutes (F.S.), or by a Physician Assistant (PA) who is licensed under Chapter 458 or 459, F.S. ARNPs or PAs who provide health assessments cannot be affiliated with the home health agency furnishing the waiver recipient's care.

Companion Services

Procedure Code: W9957
Maximum Fee: \$1.75 per quarter hour.
Service Limitations: Companion services must be authorized by PAC case manager.
Provider Qualifications: Companion services can be provided by the following:

- ☞ Home Health Agency currently licensed under Chapter 400, F.S.;
- ☞ Hospice currently licensed under Chapter 468, F.S.;
- ☞ Registered Nurse (RN), Licensed Practical Nurse (LPN), or Certified Nursing Assistant (CNA) who is currently licensed under Chapter 464, F.S.; or
- ☞ Registered Companion who is certified under Chapter 400, F.S. and registered with Medicaid Health Quality Assurance in the Homemaker, Companion, Sitter Registry. A copy of the registration card and proof of AIDS 101 certification must be submitted with the provider enrollment package.

Home and Community-Based Services (HCBS) Physical Therapy

Procedure Code: W9958
Maximum Fee: \$12.50 per quarter hour.
Service Limitations: Eight units (two hours) of service are permitted for the initial physical therapy evaluation. Subsequent to the initial evaluation, physical therapy sessions must be limited to no more than one hour per day (maximum 4 units per day). This service must be prescribed by a licensed physician, ARNP, or PA. The therapist must maintain records noting the treatment rendered, progress and the change in the client's status due to treatment.
Provider Requirements: Physical Therapists who are licensed under Ch. 486, F.S.

Massage Therapy

Procedure Code: W9959
Maximum Fee: \$8.75 per quarter hour.
Service Limitations: Massage therapy sessions are limited to a maximum of one hour per week (4 units per week) and must be prescribed by a Physician, ARNP, or a PA.
Provider Qualifications: Massage therapy can be provided by a Massage Therapist who is licensed under Chapter 480, F.S., and who is certified in neuromuscular massage techniques.

If you have any questions or need additional information concerning these new services, please contact your area Medicaid PAC Waiver Liaison or your PAC Case Management Agency.

Increased Maximum Fees for PAC Waiver Services

Effective September 1, 1996, the following maximum fees for PAC waiver services were increased:

Procedure Service	Procedure Code	Unit of Service	New Fee
Case Management	W9999	15 min.	\$11.00
Education and Support	W9988	15 min.	\$10.00
Homemaker	W9997	15 min.	\$2.50
Personal Care	W9992	15 min.	\$2.75
Respite	W9996	15 min.	\$4.50
Specialized Personal Care Services to Foster Children	W9993	DAY	\$37.00

UNISYS field representative map



Upon request, Unisys furnishes on-site training for any Florida Medicaid provider billing Medicaid. If you are interested in receiving training, call the field representative for your county. A list of Unisys field representatives can also be found in Chapter 8 of your *Medicaid Provider Reimbursement Handbook*. You can call your field representative directly to schedule an

appointment or you can call the Unisys Provider Services Group at 1-800-289-7799 who will call your field representative for you.

Unisys is very proud of the quality and professionalism of the field representative team and we hope you will take advantage of the assistance they have to offer every Medicaid provider.

AHCA Areas 1 and 2 - Angela Mauer
Bay Escambia Holmes Jackson
Santa Rosa Walton Washington Okaloosa
904-995-9152

AHCA Areas 2 and 3 - Elena Diesen
Calhoun Gulf Gadsden Liberty Franklin
Leon Wakulla Jefferson Madison Taylor
Hamilton Suwannee Lafayette Dixie Columbia
904-671-0260

AHCA Area 4 - Ed Ardis
Nassau Clay Duval St. Johns
904-724-8878

**AHCA Area 3 and 4
Deborah Ourso**
Putnam Flagler Volusia Lake
Sumpter Citrus Hernando
407-862-4775

AHCA Areas 3 and 4 - Pam Sanchez
Baker Union Bradford Alachua
Gilchrist Levy Marion
*352-335-1442

AHCA Area 7 - Sandy Carney
Orange Osceola
407-522-8833

**AHCA Area 5 - Clayton Griffin 813-576-5994
and Amber Brown 813-576-3969**
Pinellas Pasco

**AHCA Areas 7 and 9
Jack Merrell**
Brevard Indian River St. Lucie
Seminole
407-259-1172

**AHCA Area 6 - Denise Magee *941-648-1224
and Kim Montgomery 813-348-0187**
Polk Hillsborough Hardee Highlands

AHCA Areas 6 and 8 - Leslie Farnsworth
Sarasota Desoto Manatee
941-496-4402

**AHCA Area 9
Melvin Hutchinson**
Martin Palm Beach
Okeechobee
305-581-6462

AHCA Areas 8 - Cheryle McKlevis
Glades Hendry Charlotte Lee Collier
941-540-7885

**AHCA Area 11 - Jerry Acosta 305-633-3934
and Gregory Sierra 305-531-0209**
Monroe Dade

**AHCA Area 10
Stafford Gray**
Broward
954-568-5573

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.

table of contents

All Providers

- Utilization Review News1
- Change In Ownership2
- Don't Mail Those Tapes!.....2
- Bill Electronically.....2
- Medicaid Necessity.....3
- Did You Know?.....3
- Unisys Field Representative Area Map.....15

Physicians/Family Planning

- Radiology Updated for LT/RT Modifiers3
- Procedure Code W1700.....3
- Breast Biopsies3
- Family Planning3

Physicians/DOs/ARNPs/PAs

- Modifiers Removed.....4
- Reimbursement Revised for the High Risk Newborn ...4
- Use of Modifier -22 Requires Attachment of a Report ...4
- Billing for Transesophageal Echocardiograms.....4
- New Service Added for ARNPs and PAs.....4

Physicians/Hospitals

- New Medications Available thru Physician Offices5
- Radiology Update for MRI Diagnoses5
- Replaced or Deleted Diagnosis Codes5
- Newly Approved Diagnosis Codes..... 6-7
- Inpatient Stay or Outpatient Visit: The 23-hour ??.....7
- Emergency Services and MediPass.....8

- Hospital Diagnosis Codes Replaced or Deleted8
- Tubal Ligations Following Deliveries8

Hospitals

- Early Discharge of OB Patients.....9
- Hospital Review Statistics.....9
- Newly Approved Procedure Codes.....9

Spotlight and Community Mental Health (CMH)

- Medicaid Provider Spotlight10
- CMH Services Treating Physicians.....10

Nursing Facilities/Hospitals/CPHUs/MediPass

- Nursing Facility Bed Hold Days 11
- County Public Health Unit Medicaid Audits 11
- MediPass and Public Health Providers 11
- MediPass: New Agreement and Expanded Services .. 11

Home Health/Birth Centers

- Home Health Services for Dually-Elig. Recipients12
- Home Health Aide Visits12
- Labor Management.....12

Home Health/Dental/Community Mental Health

- Home Health Prior Authorizations13
- New Dental Codes13
- TMJ Dysfunction Treatment13
- Medicaid Coverage for Children13
- Invalid Place of Service Edit Correction13

Project AIDS Care New Services and Fees 14



= Articles carrying this graphic contain important Medicaid Provider Handbook information.



UNISYS

Florida's Medicaid Fiscal Agent
 2525 South Monroe Street
 Tallahassee, FL 32301

FIRST CLASS
 U.S. Postage
 PAID
 Tallahassee, FL
 Permit #672