

Medicaid Bulletin

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

CONSULTEC

The New Medicaid Fiscal Agent

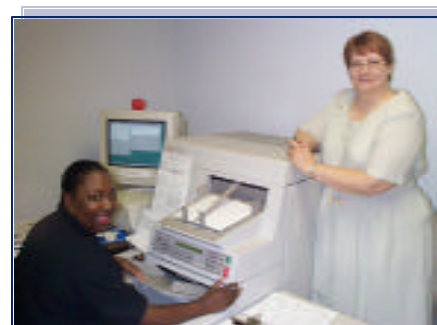
Consultec has become Florida's Medicaid fiscal agent as of July 1, 1999. The five year, \$123.6 million contract serves 1.5 million state Medicaid recipients by paying the claims for their medical services. Since its founding in 1970, Consultec has been dedicated to providing federal and state health care agencies with automated solutions. The company is involved nationally in everything from design, development, operation of decision support, and claims administration to managed care support and prescription drug benefits management systems. Consultec is no stranger to Florida Medicaid, having been the fiscal agent from 1989-1994.



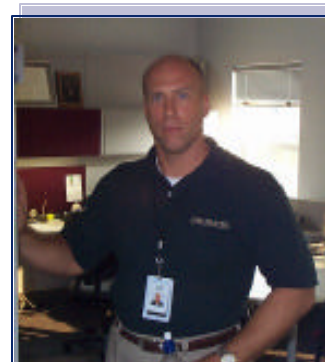
Jay Ter Louw, AHCA Bureau Chief of Contract Management (left) welcomes Consultec to Florida Medicaid, as Don Bruns, Consultec Executive Director (right) welcomes AHCA Contract Management to the new facility.

Under the new contract Medicaid will enjoy many technical enhancements such as "COLD," which stands for "Computer Output to Laser Discs," the new system used to image claims and provider documents and store them on CD-ROM. Agency employees with access to the Florida Medicaid Managed Information System (FMMIS) can log on to "Unite," an Intranet based system that allows users to view imaged documents related to claims or provider files. If a provider has a dispute with a claim, staff can point and click their way to an accurate review of any discrepancies.

Consultec's new Prescription Drug Card System (PDCS) will process Medicaid pharmacy claims at the rate of hundreds per minute, in real time, without the downtime and time-outs experienced in the past. PDCS also provides a pharmacy-only help desk to answer provider questions as well as on-line "drug prior authorization approvals." PDCS's drug database contains up-to-date drug utilization review (DUR) criteria to prevent drug misuse. (continued on page 2)



Sandra Randolph (left) scans claims as Pat Thomas, Imaging Administrator (right) supervises the process. Approximately 25,000 claims are scanned per day.



Steve Smith, Deputy Director oversees the operations of over 200 employees.

all providers

Consultec has been and will continue to communicate with providers about the necessity of becoming Year 2000 compliant with computers and electronic billing software.

Changes in health care and welfare reform coupled with ever-advancing computer technologies create continuous challenges for both the public and private sectors. All the new enhancements will work together to give Florida a stronger and more user-friendly FMMIS. All the system and corresponding process changes allow Medicaid to better assist providers and recipients.



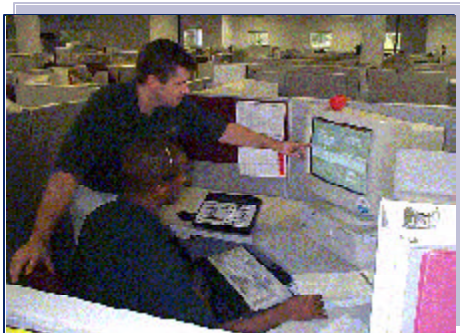
Mannix Hawkins provides AHCA with "technical services" for the new millennium and beyond.



Consultec receives over 25,000 paper claims each day.



Provider Enrollment maintains over 75,000 provider files and receives about 50 applications per day.



Jason Buckner, Provider Inquiry Supervisor, assists Seba Pambu, with a provider call. Provider Inquiry handles over 2,800 callers per day.

Y2K Checklist

Use this checklist as a supplement to your Y2K readiness preparations. This list is not all-inclusive, it is intended to help in your planning.

- Appointment scheduling system
- Answering machines
- Bank debit/credit card expiration dates
- Banking interface
- Billing system
- Building access cards
- Clocks
- Computer hardware (list)
- Computer software (list)
- Custom applications (list)
- Diagnostic equipment (list)
- Elevators
- Fire/smoke alarm
- Indoor lighting
- Insurance/pharmacy coverage dates
- Medical devices (list)
- Membership cards
- Monitoring equipment (list)
- Office forms (claims, order, referral)
- Outdoor lighting
- Paging system
- Payroll system
- Security system
- Telephone system
- Television/VCR
- Sprinkler system
- Treatment equipment (list)
- Safety vaults

The Medicaid Bulletin is published quarterly for Medicaid providers and staff of the Agency for Health Care Administration and Consultec, the fiscal agent.

Year 2000 - Are You Ready?

The Florida Medicaid Program and its new fiscal agent, Consultec, are aggressively managing Year 2000 (Y2K) compliance issues and the impact those issues may have on the Medicaid and Medicaid-related computer systems and applications. A comprehensive strategy is in place and implementation is under way.

Consultec has established a Year 2000 Enterprise Program Office (EPO) with the sponsorship of executive management. The purpose of the office is to establish compliance standards and guidelines and to coordinate and monitor the Year 2000 effort.

The Florida Medicaid Management Information System (FMMIS) has been modified and tested for Year 2000 readiness. Now, it is up to each Medicaid provider interfacing with the FMMIS to make sure that any software being used to submit claims is ready for the year 2000.

If you currently use ASAP, you should already know that it is not Year 2000 compliant. A replacement Windows-based field software will be available in the fall on CD-ROM, or through the Internet. In order to support the new Windows-based software, your computer must have Windows 95/98 or NT. Consultec will be furnishing further information about transition to this new field software in the near future.

CATTS, CATTS-LTC, and UMAP are electronic claims software developed by UNISYS are accepted by Consultec. CATTS is Year 2000 compliant. However, technical support is not available for these products.

Consultec's Year 2000 Compliance Program

"Consultec's Year 2000 compliance program includes all facets of its business to ensure that it can continue to provide reliable products and services to its clients," said Don Bruns, Consultec Project Director for Florida. Strategies have been developed to resolve Year 2000 issues for mainframe applications, distributed applications, vendor packages, client data communications, facilities, equipment, and system software and hardware.

As a result of the Year 2000 effort, some of Consultec's existing systems are being replaced with new Year 2000 compliant systems and technology while others are being modified to correctly process all dates from this century and beyond. Third party suppliers and vendors are also being contacted to verify that the products and services

they provide to Consultec are Year 2000 compliant. Consultec will also perform a validation of each vendor's software to confirm its compliance in the FMMIS environment.

A Promise and a Motto

"Consultec strives to furnish innovative products and services. We value the confidence the state, its health care providers and its recipients have placed in Consultec. We intend to fulfill the promise of our motto, Products to value, people to trust," said Bruns.

Year 2000 Readiness Disclosure under Year 2000 Information and Readiness Disclosure Act (P.L. 105-271)

Websites Offering Y2K Assistance

The General Services Administration (GSA) website at www.itpolicy.gsa.gov/mks/yr2000/y2khome.htm offers valuable information to assess your building and infrastructure.

The Health Care Financing Administration (HCFA) website at www.hcfa.gov/y2k contains the checklist provided on the preceding page and lists continuing medical education programs that HCFA sponsors throughout the year.

The Food and Drug Administration (FDA) website at www.fda.gov/cdrh/yr2000/year2000.html offers an extensive listing of the status of medical equipment readiness by manufacturer.

The Small Business Administration (SBA) website at www.sba.gov/financing/fry2k.html offers information on obtaining SBA-guaranteed bank loans that can be used by small, for-profit providers to pay for a variety of Y2K-related repairs, adjustments, consultations and the purchase of needed hardware/software.

The state of Florida has established a Year 2000 Project Management Office whose responsibilities include monitoring all state agencies' progress in preparation for the Year 2000. The state's Y2K web site contains a great deal of Y2K related information (including links to other Y2K websites); it is located at: <http://y2k.state.fl.us/>.

Medicaid's Year 2000 Contingency Plan

Year 2000 Preparation

Medicaid began addressing the "Year 2000" issue in 1997. In March 1999, AHCA certified to the Governor's Year 2000 project office that the Medicaid system has made all changes necessary for the Year 2000.

All revisions have been completed, fully tested and installed into the FMMIS. Modules revised by Consultec were tested to assure accurate processing with current dates and with dates beyond January 1, 2000. Testing was done by both Consultec and Unisys. The state reviewed and approved the test results. Providers (hospitals, doctors, etc.) were given the opportunity to test the system end-to-end in May, and will be given similar opportunities this fall. Additional testing was performed between Medicaid and the Department of Children and Families that included the transfer of eligibility information, the payment of claims, and the production of management reports based on the transferred, eligible recipients.

The federal Health Care Financing Administration (HCFA) met with state representatives for a detailed review of Medicaid's Year 2000 compliance on March 22-24, 1999. Both the eligibility system (FLORIDA) and FMMIS were assessed at "Low Risk" of failure for Year 2000. HCFA plans a further review this fall, because Florida is one of the ten largest states. The focus of that review will be testing and contingency planning.

AHCA and Consultec reviewed the system again for Year 2000 compliance in September 1999 and will review it again in December 1999 with the assistance of an independent validation and verification (IV&V) contractor, Alydaar, Inc. AHCA will not allow any changes to be made to FMMIS from December 1 through January 15. Consultec has a staff of 40 programmers ready to make any emergency system changes that may be necessary.

Contingency Strategy

AHCA will continue its diligent efforts to make sure all Medicaid business functions continue without interruption on and after January 1, 2000. The contingency plan identifies events that may result in the inability to continue normal business operation. If normal business procedures do not restore service, Medicaid will implement emergency strate-

gies. The contingency plan identifies the failure scenarios, the actions taken to prevent or prepare for such a scenario, the triggers to the contingency plans, and the plan actions to assure the continuation of business without interruption.

Actions are presented at two levels. The first level identifies likely failure points and the immediate actions that will be taken to resolve the problems. The solutions are practical and based upon restoring service as quickly as possible. Level two represents the two major failure scenarios and the absolute fall-back position of Florida Medicaid. These are formulated to provide for business continuation with very limited support from automated systems. For a complete copy of Medicaid's Year 2000 Contingency Plan, visit AHCA's website at www.fdhc.state.fl.us/medicaid.

Electronic Remittance Vouchers (ERVs)

Consultec has a new way of delivering Electronic Remittance Vouchers (ERV) for Florida Medicaid. The new vehicle for delivering these files is over a secure Internet site. Many providers, billing agents and clearinghouses have taken advantage of this service already. For those who wish to receive an ERV registration form, contact the EDI Support Unit at 1-800-829-0218. Once you receive the form, complete the information on the form for each billing provider number you wish to register. Each form must be notarized and mailed back to Consultec for processing.

Consultec offers two different formats of the ERV files via the Internet. The first option is called a "report" file. This file looks exactly like what you would receive in the mail. You have the option of receiving this file and receiving a copy in the mail. The second option is called a "dataset" file. This file is very different from the report file as it follows a specific set of data parameters in the layout of the file. The dataset file is in the exact same format as the previous fiscal agent (Unisys) file and is a popular way to automatically post payments.

If you wish to receive the "dataset" ERV file from Consultec, you will no longer receive a hardcopy of your RV in the mail nor will you be able to retrieve the "report" file from the Internet site. On the other hand, if you wish to only retrieve the "report" file from the Internet, you will continue to receive a hardcopy in the mail.

New Windows-Based Claims Submission Software!!



Since 1989 Medicaid providers have been using the electronic billing software, ASAP, to submit claims to Florida Medicaid. ASAP has been a dependable and well liked product, but it is not Year 2000 (Y2K) compliant.

Consultec has designed a new Windows-based software product called Windows Accelerated Submission and Processing 2000 (WINASAP2000). Just like ASAP, this new Windows-based software allows the user to submit claim data electronically from a personal computer to Consultec. And just like ASAP, this software is FREE to all active Florida Medicaid providers.

WINASAP2000 has many new features including electronic voids, adjustments and Part A and Part B crossover claims submissions. To use WINASAP2000, your personal computer must meet the following MINIMUM configuration:

- ✍ Windows 95 or higher operating system
- ✍ Pentium 90 processor
- ✍ CD-ROM drive
- ✍ 50 megabytes of free disk space
- ✍ 16 megabytes of RAM
- ✍ Hayes compatible 9600 baud asynchronous modem
- ✍ Telephone connectivity

In October, Consultec will begin distributing WINASAP2000 to all providers who are currently transmitting claims via ASAP, CATTs, or UMAP. Providers will receive a CD-ROM that will include the WINASAP2000 program, a user manual, a logon, password, and submitter ID information.

Consultec will discontinue accepting ASAP December 31, 1999. By January 1, 2000, all ASAP users must be converted to WINASAP2000. The Consultec EDI Support

Unit at 1-800-829-0218 will be available to assist users during the conversion process.

If you are not currently using ASAP, CATTs, or UMAP and would like to use WINASAP2000, please call the Consultec EDI Support Unit in October to receive a copy of the software. Also, beginning in October WINASAP2000 and the user manual can be downloaded from the Internet at <http://floridamedicaid.consultec-inc.com>.

A screen shot from WINASAP2000, shows how easy it is to submit claims. Just fill in the blanks. It is user friendly, dependable, and free to all active Florida Medicaid providers.

When Submitting A Claim

Please do not request payment on a claim form that has been photocopied from your provider reimbursement handbook. The claim form samples in the handbook are not standardized and cannot be read by Medicaid's claims processing system. The claim will be returned without processing.

All claim forms used for Medicaid billing, with the exception of the HCFA-1500, should be ordered using the Medicaid Claims Order Form. To get a copy of the Claims Order Form call Provider Inquiry at 1-800-289-7799 or download the form from the Medicaid fiscal agent web site at <http://floridamedicaid.consultec-inc.com>. HCFA-1500 claim forms are to be reproduced by your local printer or forms company.

New Enrollment Procedures for Managed Health Care



November 1999, Medicaid recipients will begin encountering a new concept for Florida Medicaid managed health care—an annual open enrollment period.

Most Florida Medicaid recipients are familiar with managed health care, either through a Medicaid HMO, the Children's Medical Services (CMS) Network, or the state's primary care case management program, MediPass. Currently, however, recipients are allowed to change managed care plans at any time. Towards the end of November, recipients will begin receiving revised choice counseling materials that will explain the new annual Open Enrollment process: once recipients enroll with a managed care plan, they will begin a 12-month enrollment period in which they have 90 days to try the plan. After the initial 90 days, they will remain with their plan for the next nine months as long as they do not lose Medicaid eligibility. Thereafter, each year recipients will receive notification of their Open Enrollment period when they can change plans if they want. Much like state employees' insurance, information on their plan choices will be sent to them at that time.

Why implement Open Enrollment?

By implementing an annual Open Enrollment process, the agency hopes to: stabilize Medicaid managed care membership levels and reduce monthly turnovers; reduce opportunities for inappropriate episodic care and promote more effective continuity of care; offer members a greater length of time in which to develop rapport with their chosen plan and primary care provider; reduce state administrative costs of monthly processing of enrollments and disenrollments; and align Medicaid enrollment to more closely resemble the model generally available to employees in the commercial health care market.

Who is Affected?

Recipients who are eligible for Medicaid managed care, such as TANF recipients and SSI recipients without Medicare, will be affected by this new policy. However, SSI recipients under age 19, foster care children, children in subsidized adoption arrangements, children eligible for and enrolled in the CMS Network, and American Indians will still be allowed to change managed care plans at any time.

When does it start?

Recipients who become eligible for Medicaid managed care or who request a plan change after November 18, 1999, will receive counseling regarding the Open

Enrollment process and could start their 12-month enrollment period as early as January 1, 2000.

How does it work?

When a recipient becomes eligible for Medicaid managed care, Medicaid Options, the agency's choice counseling program, will send the recipient materials explaining the managed care options available in the area. The materials explain that the recipient has 30 days in which to choose a plan or the state will assign one. Once the person voluntarily enrolls with a plan or the state makes a mandatory assignment, the recipient enters the 12-month enrollment period. The recipient will be given 90 days to try the plan and change plans. At the end of the 90 days, the selection is locked in for the next nine months as long as Medicaid eligibility continues. Only plan changes for "good cause" will be allowed during these nine months. Before the 12-month enrollment period ends, the recipient will be sent notification of the Open Enrollment period and be able to change plans for the following year. Information on available managed care options will be sent at that time.

How are current enrollees affected?

A recipient who is currently enrolled in Medicaid managed care and does not wish to change plans will not be affected. A recipient who changes plans after November 18, 1999, begins a 12-month enrollment period.

Will everyone have the same Open Enrollment period?

No, each recipient will have an individual Open Enrollment period. Each Open Enrollment period will be based upon the recipient's first effective enrollment date after the new policy is implemented.

What if a recipient loses and regains Medicaid eligibility?

A recipient who loses and regains Medicaid eligibility prior to the tenth month of the 12-month enrollment period will be re-enrolled with the previous managed care health plan. A recipient who loses and regains Medicaid eligibility after ten months will be treated as a newly eligible Medicaid managed care recipient and will begin the choice counseling/enrollment process again.

What are "Good Cause" change reasons?

Recipients may have special reasons that would allow them to change plans during their 12-month enrollment period. Recipients will be directed to contact Medicaid Options, the agency's choice counseling program, for review of these situations.

(continued)

Can recipients change Primary Care Providers (PCPs)?

Yes, a recipient who may not change managed care plans may still change primary care providers within the current plan.

Where can recipients receive more information on Open Enrollment?

After November 18, 1999, recipients can call the Medicaid Options helpline or attend a Medicaid Options outreach presentation in their area to receive more information regarding Open Enrollment.

MediPass Disease Management Initiative

In June, the Agency for Health Care Administration began a new Disease Management Initiative for MediPass recipients. This statewide effort is aimed at improving health outcomes and quality of life for MediPass members who have certain chronic illnesses. All MediPass recipients with an applicable diagnosis are eligible to participate in this initiative. Exceptions are children enrolled in Children’s Medical Services (CMS) or the Prescribed Pediatric Extended Care (PPEC) program as well as those residing in an institutional care setting.

MediPass recipients can be enrolled in only one Disease Management Organization (DMO). Recipients with a co-morbidity, will be enrolled in the DMO responsible for the more life threatening disease condition.

The first four disease states being addressed in the disease management initiative are asthma, diabetes, hemophilia, and AIDS. The Disease Management Organizations (DMOs) currently involved are:

Disease Management Organization	Disease Group	Areas of the State Affected
Integrated Therapeutic Group	Asthma	Statewide implementation
Coordinated Care Solutions	Diabetes	Statewide implementation
Accordant Health Services	Hemophilia	Areas 7 through 11
Caremark, Inc.	Hemophilia	Areas 1 through 6
AIDS Healthcare Foundation	AIDS	Areas 1 through 9 & Monroe County
South Fla Community Care Network	AIDS	Areas 10 and 11

The main focus of the disease management initiative is nursing care management. DMO nurse care managers work with the primary care physician, the MediPass recipient and the recipient’s family, as well as specialists and case management agencies. Care managers provide disease-specific education to the recipient and family and monitor compliance with the physician’s treatment plan. They also provide feedback to the primary care physician/specialist on a regular basis. Care managers become an extension of the physician’s services by helping the recipient better understand the disease and make necessary life style and behavioral changes with the goal of self-management. This enhanced connection between the recipient and the physician is expected to make a significant impact on health outcomes and improved quality of life for MediPass recipients with chronic diseases.

In the near future, the Agency for Health Care Administration will be contracting with other DMOs to provide disease management services for congestive heart failure and end stage renal disease.

All services provided by DMOs are offered to MediPass recipients and physicians free of charge.

Medicaid is strongly encouraging health care providers to get involved with this new program. It is designed to help Medicaid recipients achieve better health outcomes and enhance health care provider efforts toward the same goal.

all providers

Crossover Claims

A crossover claim (x-over claim) is defined as any claim that is approved by Medicare and forwarded or sent to Medicaid for secondary payment. Unlike Medicaid, Medicare claims are not processed by a single fiscal agent but by *intermediaries*, who process Part A claims, and by *carriers*, who process Part B claims; *intermediaries* and *carriers* are collectively referred to as *contractors*. Before x-over claims are sent to Medicaid, the claims must be approved by Medicare. Approval by Medicare depends on a number of criteria: the charges must be covered by Medicare, the provider must be enrolled as a Medicare provider, and the beneficiary must be entitled to Medicare services. An approved claim does not necessarily mean that Medicare paid it. Medicare may apply the approved amount towards the deductibles. X-over claims are sent automatically to Medicaid, or the provider can file a paper claim.

Your Medicare provider number must be correctly cross-referenced to your Medicaid provider number in order for claims to crossover automatically. Call 1-800-289-7799 to verify your cross-reference file.

A paper claim must be filed if ANY of the following situations exist:

- There is no automated x-over arrangement with the carrier (see list to right),
- The carrier did not forward the claim to Medicaid (look for message code MA07),
- 45 days have elapsed since Medicare's payment and no remittance has been received from Medicaid,
- Medicare has adjusted the claim,
- There was payment by a Third Party insurer, or
- Medicare denied the claim.

If providers have any questions regarding Medicare claim processing or policy, they must follow Medicare's procedures for resolving those issues. If there are concerns or questions regarding Medicaid's payment or handling of x-over claims, please contact the fiscal agent, Consultec, or your local area Medicaid office for assistance.

Most x-over claims are submitted electronically by the Medicare contractor. The following contractors are automatically sending Medicare x-over claims:

- ✓ **AdminaStar Federal of Ohio,**
- ✓ **Blue Cross Blue Shield of Connecticut,**
- ✓ **Blue Cross Blue Shield of Florida (Part A & B),**
- ✓ **Blue Cross Blue Shield of Georgia,**
- ✓ **Blue Cross Blue Shield of South Carolina,**
- ✓ **Blue Cross Blue Shield of Tennessee (Rural Health),**
- ✓ **Blue Cross Blue Shield of Texas,**
- ✓ **Highmark of Pennsylvania,**
- ✓ **Mutual of Omaha,**
- ✓ **Palmetto Government Benefits Administrators (a.k.a. DMERC of South Carolina), and**
- ✓ **United Government Systems.**

You can contact your local area Medicaid office at:

ALACHUA	352-955-5192	FLAGLER	800-940-4803	LAKE	352-732-1349	PINELLAS	800-299-4844
BAKER	904-353-2100	FRANKLIN	800-226-7690	LEE	800-226-6735	POLK	800-226-2316
BAY	800-303-2422	GADSDEN	800-248-2243	LEON	800-248-2243	PUTNAM	352-955-5192
BRADFORD	352-955-5192	GILCHRIST	352-955-5192	LEVY	352-955-5192	ST. JOHNS	904-353-2100
BREVARD	877-254-1055	GLADES	800-226-6735	LIBERTY	800-248-2243	ST. LUCIE	800-226-5082
BROWARD	954-202-3200	GULF	800-226-7690	MADISON	800-248-2243	SANTA ROSA	800-303-2422
CALHOUN	800-248-2243	HAMILTON	352-955-5192	MANATEE	800-226-2316	SARASOTA	800-226-6735
CHARLOTTE	800-226-6735	HARDEE	800-226-2316	MARION	352-732-1349	SEMINOLE	877-254-1055
CITRUS	352-732-1349	HENDRY	800-226-6735	MARTIN	800-226-5082	SUMTER	352-732-1349
CLAY	904-353-2100	HERNANDO	352-732-1349	MONROE	305-499-2100	SUWANNEE	352-955-5192
COLLIER	800-226-6735	HIGHLANDS	800-226-2316	NASSAU	904-353-2100	TAYLOR	800-248-2243
COLUMBIA	352-955-5192	HILLSBOROUGH	800-226-2316	OKALOOSA	800-303-2422	UNION	352-955-5192
DADE	305-499-2100	HOLMES	800-226-7690	OKEECHOBEE	800-226-5082	VOLUSIA	800-940-4803
DESOTO	800-226-6735	INDIAN RIVER	800-226-5082	ORANGE	877-254-1055	WAKULLA	800-248-2243
DIXIE	352-955-5192	JACKSON	800-226-7690	OSCEOLA	877-254-1055	WALTON	800-303-2422
DUVAL	904-353-2100	JEFFERSON	800-248-2243	PALM BEACH	800-226-5082	WASHINGTON	800-226-7690
ESCAMBIA	800-303-2422	LAFAYETTE	352-955-5192	PASCO	800-299-4844		

Electronic Data Interchange (EDI) Information

Today, the electronic environment extends far beyond just Electronic Claims Submission (ECS). Consultec encourages providers to use all aspects of EDI: claim submission, electronic remittance vouchers and reports, eligibility verification and Internet access. In keeping with the rapid growing pace in the electronic environment, new and exciting options will be available in the near future.

Consultec's EDI Support Unit can direct you in determining which method of electronic submission is best for you. Many providers will use WINASAP2000, the new Windows-based software product. Those who submit large numbers of claims choose to use a vendor software, billing agent, or clearinghouse. Appealing to this group will be the acceptance of the National Standard Format (NSF). Choosing this option allows providers who submit to carriers such as Medicare or Blue Cross Blue Shield to save money by supporting one format for electronic claims submission.

Conversion to NSF/UB92 Formats

Consultec will convert all users of the current proprietary format to the NSF or UB92 version 5. Consultec will continue to accept the proprietary format until the spring of 2000. All new submitters must submit using the NSF or UB92 version 5 formats.

If you or your vendor, billing agent, or clearinghouse have questions, call the EDI Support Unit at 1-800-829-0218. Specifications and WINASAP2000 are available on the web site at <http://floridamedicaid.consultec-inc.com>. Remember, providers can submit voids, adjustments, and crossover claims electronically.

Tape Submission

Some providers submit claims via tape or cartridge. This fall, Consultec will be working with providers who submit claims on tape or cartridge to move them to an electronic submission environment.

If you submit on tape or cartridge, the Consultec EDI Support Unit can furnish you with information regarding possible electronic options that are very cost effective. The EDI Support Unit can also assist you with conversion issues. For more information call the EDI Support Unit at 1-800-829-0218 Monday through Friday, 8am to 7pm. Please have your provider number or submitter number available when you call.

NOTICE OF CHANGE

Vendors for Medicaid Eligibility Verification Services (MEVS)

Authorized Vendors as of 7/1/99

Please update your records
and other materials now!

Consultec, Inc.
1-800-829-0218

ENVOY Corporation
1-800-366-5716

Healthcare Data Exchange Corporation
1-610-219-1784

HealthNet Data Link, Inc.
1-800-486-7352

Insurance Benefit Spot Check, Inc.
1-800-233-7768

MedE America Corporation
1-888-633-3888

MediFAX / The Potomac Group, Inc.
1-800-444-4336

National Data Corporation
1-800-218-1500

FaxBack

FaxBack is a Medicaid eligibility verification system that allows a provider to verify the eligibility of a Medicaid recipient via a touch-tone phone and receive a response that is faxed to the provider's office. The FaxBack number is an 800 number and users will be charged per transaction, plus a small monthly administrative fee.

To enroll in the FaxBack program, call the Consultec EDI Support Unit at 1-800-829-0218 and press option 1. Once enrolled, you will receive a billing ID number. This billing ID number authorizes Consultec to bill for the provider transactions.



The following script will help guide a provider when entering data for a FaxBack response:

Greeting: “Welcome to Consultec’s Eligibility FaxBack System for Florida Medicaid.”

Provider ID Prompt

(Prompt) “Please enter your 9-digit Medicaid provider number.”

(Response) You enter _____ {provider ID}.
“If correct, press 1; otherwise, press 2.”

Billing ID Prompt

(Prompt) “Please enter your 6-digit billing ID number.”
(Response) You enter _____ {billing ID}.

PIN # Prompt

(Prompt) “Please enter your 4-digit PIN number.”
(Response) You enter _____ {PIN number}.

Recipient Access Method

(Prompt) “For eligibility using an 8-digit plastic card control number, press 1.”

(Prompt) “Please enter the 8-digit plastic card control number.”
(Response) You enter _____ {card control number}.

(Prompt) “For 10-digit recipient number, press 2.”

(Prompt) “Please enter the recipient’s 10-digit Medicaid recipient ID.”
(Response) You enter _____ {recipient ID}.

(Prompt) “For 9-digit social security & date of birth in month, day, century, and year format, press 3.”

(Prompt) “Please enter the recipient’s 9-digit social security number.”

(Response) You enter _____ {social security number}. Enter the date of birth in 2-digit month, 2-digit day, and 4-digit year format ____ - ____ - ____.”

Date of Service

(Prompt) “Enter the 8-digit date of service in 2-digit month, 2-digit day, and 4-digit year format, or press 9 for today’s date.”

(Response) You enter _____ {8-digit date of service}.

(Response) The audit number for this transaction is
_____.

FaxBack Request

(Prompt) “Press 1 to listen to verify your FAX number.”
“Press 2 to order a FAX.”

Verify Provider FAX Number

(Prompt) “The fax number on file for {provider ID number} is {provider fax number}. Press 1 if this number is correct; press 2 if this number is incorrect.”

Send Fax

(Response) “Your fax is being forwarded.”

Termination Menu

(Prompt) “Press 6 to inquire on another recipient.”
“Press 7 to inquire on another recipient using a different provider.”
“Press 8 to end this call.”

Terminate

(Response) “Thank you for calling Consultec’s Florida Medicaid Eligibility FaxBack System. Goodbye.”

Important Telephone Numbers for CONSULTEC: Effective July 1, 1999

*** BOLDED TEXT: REPRESENTS NEW TELEPHONE NUMBERS**

Provider Support

- *Recipient Eligibility & Provider Check Amount Information (AVRS).....**1-800-239-7560 (24 hours)**
- *Recipient Eligibility & Provider Check Amount Information (AVRS) in Tallahassee...**1-850-201-1500 (24 hours)**
- Provider Inquiry (in-state).....1-800-289-7799 (7am-6pm EASTERN TIME)
- Provider Inquiry (out-of-state providers).....1-800-955-7799 (7am-6pm EASTERN TIME)
- ***Provider Inquiry (in Tallahassee).....1-850-201-1300 (7am-6pm EASTERN TIME)**
- ***Provider Enrollment (in Tallahassee).....1-850-201-1400 (8am-5pm EASTERN TIME)**
- Provider Enrollment.....1-800-377-8216 (8am-5pm EASTERN TIME)

Electronic Data Interchange (EDI) Services

- EDI Technical Support.....1-800-829-0218 (8am-7pm EASTERN TIME)
- ***Electronic Claims Transmission1-850-201-1200 (24 hours)**

Pharmacy Services

- ***Pharmacy Help Desk.....1-800-603-1714 (7am-6pm EASTERN TIME)**
- ***Pharmacy Prior Authorization(PA) Fax.....1-877-614-1078 (8am-5pm EASTERN TIME)**

Important Addresses

Consultec Provider Enrollment P.O. Box 7070 Tallahassee, FL 32314-7070	Consultec Non-Institutional Other P.O. Box 7050 Tallahassee, FL 32314-7050	Consultec Hospital Crossover P.O. Box 7064 Tallahassee, FL 32314-7064
Consultec Claims Inquiry P.O. Box 7070 Tallahassee, FL 32314-7070	Consultec Pharmacy P.O. Box 7082 Tallahassee, FL 32314-7082	Consultec UDR/DER/PA P.O. Box 7090 Tallahassee, FL 32314-7090
Consultec HCFA 1500 P.O. Box 7072 Tallahassee, FL 32314-7072	Consultec Transportation P.O. Box 7052 Tallahassee, FL 32314-7052	Consultec Member 88/2014s/Buy-In/SLMB/PBMO P.O. Box 7092 Tallahassee, FL 32314-7092
Consultec Hospital P.O. Box 7062 Tallahassee, FL 32314-7062	Consultec Nursing Home TADS P.O. Box 7054 Tallahassee, FL 32314-7054	Consultec Adjustments and Voids P.O. Box 7080 Tallahassee, FL 32314-7080
Consultec CHC-Up▲/Dental/RPICC P.O. Box 7084 Tallahassee, FL 32314-7084	Consultec HCFA 1500 Crossover P.O. Box 7074 Tallahassee, FL 32314-7074	Consultec* 2308 Killearn Center Blvd. Suite 100 Tallahassee, FL 32308

▲ Child Health Care Check-Up (CHC-Up) formerly known as EPSDT

* **ONLY** for deliveries such as FedEx, UPS, etc.

Consultec Fiscal Agent Tips

When calling Consultec, please enter your Medicaid provider ID number before reaching an associate. In order to expedite each call quickly, please have all claims, recipients' IDs, dates of service, procedure codes or other information available before speaking with an associate.

Provider Enrollment

QUICK CALL RESPONSE TIMES ARE:

Monday - Thursday
8:00am to 9:00am



Friday
3:00pm to 5:00pm

Provider Inquiry

QUICK CALL RESPONSE TIMES ARE:

Monday - Wednesday
7:00am to 9:00am
5:00pm to 6:00pm



Thursday - Friday
7:00am to 10:00am
3:00pm to 6:00pm

Pharmacy Help Desk

QUICK CALL RESPONSE TIMES ARE:

Monday - Friday
7:00am to 8:30am

EDI Technical Support

QUICK CALL RESPONSE TIMES ARE:

Monday - Friday
8:00am to 11:00am

See previous page for telephone numbers and hours of operation.

Top 10 Enrollment RTP (Return to Provider) Reasons

1. Practice type missing or incorrect
2. Custodian of records left blank
3. Fingerprint card incomplete
4. EFT information does not match, i.e. account number on voided check does not match account number recorded on EFT forms
5. Voided check/deposit information for EFT missing
6. Proof of tax ID#-W9 missing
7. Medicaid Provider Agreement missing
8. Ownership codes missing or incorrect
9. Category of services, or required documentation for enrollment, i.e. certificates/license missing or invalid
10. Requesting to be linked to an individual provider's practice instead of a group practice
11. \$39.00 check for fingerprint card missing
12. Location code application missing EFT information

Adjustment and Void Billing Tips

- Only a PAID claim can be adjusted or voided. A DENIED claim should be resubmitted as a new claim.
- If you need to return the total payment for a claim, you will need to file a VOID claim.
- If you were paid an incorrect amount and either need to return money to Medicaid or if you are due more money, you will need to file an ADJUSTMENT claim.
- An adjustment or void claim will be processed as a replacement to the original, incorrectly paid claim.
- An adjustment or void claim must be for the entire amount not just for the remaining unpaid amounts or units.
- When filing an adjustment, please circle in **black** ink the field(s) on the claim which require a correction, change, or addition.
- There is no time limit on submitting a VOID claim.
- An ADJUSTMENT claim must be received within 1 year of the date of payment.

For more information on adjustments and voids, refer to your Medicaid Provider Reimbursement Handbook, Chapter 8.

Automated Voice Response System (AVRS)

The Automated Voice Response System (AVRS) allows the provider to verify eligibility of a Medicaid recipient and receive check amount information via a touchtone phone, receive a response, and audit number. AVRS will allow the user to verify up to five transactions per telephone call.

The following script will help guide a provider when entering data for an AVRS response.

Greeting: “Welcome to Consultec’s Automated Inquiry Service for Florida Medicaid.”

MAIN MENU

(Prompt) “For information on a provider check, press 1. For information concerning recipient eligibility, press 2. For information concerning eligibility history, press 3.”

Provider ID

(Prompt) “Please enter your 9-digit Medicaid provider number.”

(Response) You enter provider ID _____ {provider number}.

“If correct, press 1. Otherwise, press 2.”

PROVIDER CHECK

Provider Payment Response

(Prompt)

“Press 1 for your most recent check issued.”

“Press 2 for your 2nd most recent check issued.”

“Press 3 for your 3rd most recent check issued.”

“Press 7 to return to the Main Menu.”

“Press 8 to obtain an audit number and end this call.”

(Response) The audit number for this transaction is _____.

(Response) “The date of your most recent (or 2nd most recent or 3rd most recent) check is _____. The amount of your most recent (or 2nd most recent or 3rd most recent) check is _____. The check number is _____.”

RECIPIENT ELIGIBILITY

(Prompt) “For eligibility using an 8-digit plastic card control number, press 1.”

(Prompt) “Please enter the 8-digit plastic card control number.”

(Response) You enter _____ {card control number}.

(Prompt) “For 10-digit recipient number, press 2.”

(Prompt) “Please enter the recipient’s 10-digit Medicaid recipient ID.”

(Response) You enter _____ {recipient ID}.

(Prompt) “For 9-digit social security & date of birth in 2-digit month, 2-digit day, and 4-digit year format, press 3.”

(Prompt) “Please enter the recipient’s 9-digit social security number.”

(Response) You enter _____ {social security number}. Enter the date of birth in 2-digit month, 2-digit day, and 4-digit year format ____ - __ - ____.

(Prompt) Enter the date of service in 2-digit month, 2-digit day, and 4-digit year format or press 9 for today’s date.

Eligibility Information

(Response)

“Recipient ID number ____ has limited eligibility under program code ____ for Medicaid services on ____ and has coverage for emergency hospital care only. Refer to the reimbursement handbook.”

“Recipient ID number ____ has limited eligibility under program code ____ for Medicaid services on ____ and is limited to Family Planning Services.”

“Recipient ID number ____ has limited eligibility under program code ____ for Medicaid services on ____ and is covered for Non-Institutional Care Services only.”

“Recipient ID number ____ has limited eligibility under program code ____ for Medicaid services on ____ and is limited to Non-Institutional Care only. Refer to the reimbursement handbook.”

“Recipient ID number ____ has limited eligibility under program code ____ for Medicaid services on ____ and is limited to Prenatal Outpatient Services only. Refer to the Reimbursement Handbook.”

“Recipient ID number ____ has limited eligibility under program code ____ for Medicaid services on ____ and is limited to Medicare premiums and deductibles. Refer to the reimbursement handbook.”

Automated Voice Response System (AVRS)

“Recipient ID number ___ has limited eligibility under program code ___ for Medicaid services on ___ and is limited to Part A Medicare premium only. Refer to the reimbursement handbook.”

“Recipient ID number ___ has limited eligibility under program code ___ for Medicaid services on ___ and is limited to Part B Medicare premium only.”

“Recipient ID number ___ has eligibility for Medicaid services under program code ___ on ___.”

(Response) The audit number for this transaction is
_ _ _ .

Eligibility Menu

(Prompt) “Press 1 to hear Medicare information.”

(Response)

“The recipient’s Medicare ID number is ___ and is covered under Medicare part A and part B for service on ___.”

“The recipient’s Medicare ID number is ___ and is covered under Medicare part A for service on ___.”

“The recipient’s Medicare ID number is ___ and is covered under Medicare part B for service on ___.”

“The recipient is not covered under Medicare on ___.”

(Prompt) “Press 2 to hear Managed Care information.”

(Response)

“The recipient is enrolled in the MEDIPASS program. Before providing Non-Emergency Services. Please contact the primary care physician at ___.”

“The recipient was enrolled in an HMO. Before providing Non-Emergency Services, please call ___.”

“The recipient is enrolled in the lock-in program. Please contact the primary care physician at ___.”

“The recipient is enrolled in the Prepaid Mental Health Program. Please contact the primary care physician at ___.”

“The recipient is enrolled in both the MEDIPASS and mental health programs. Before providing Non-Emergency Services, please contact the primary care physician at ___.”

“The recipient is not enrolled in a Medicaid managed care program on ___.”

(Prompt) “Press 3 to hear Nursing Home information.”

(Response)

“The recipient was in a long term care facility on ___.”

“The recipient’s last Child Health Check-Up screening was on ___.”

“The recipient was not in a long term care facility on ___.”

(Prompt) “Press 4 to hear Third Party Liability information.”

(Response)

“Our files indicate that the recipient may have 3rd party insurance coverage for ___. To review the recipient’s third party insurance policies, press 9. If not, press 6.”

“Third party coverage is provided by carrier number ___ under policy number ___.”

“This recipient has additional third party coverage. To obtain this information call provider services at ___.”

“This recipient did not have third party coverage on ___.”

(Prompt) “Press 5 to hear service limitation information.”

(Response)

Dental Information

(If recipient’s age in years less than 21) “Our records indicate the recipient is under 21 years of age.” OR “The recipient has never received upper dentures.” OR “The recipient last received upper dentures on ___.” AND/OR “The recipient has never received lower dentures.” OR “The recipient last received lower dentures on ___.”

Hearing Information

“The recipient has never received a hearing aid.” OR “The recipient last received a hearing aid on ___.”

Vision Information

“The recipient has never received eyeglass frames.” OR “The recipient last received eyeglass frames on ___.”

(Prompt) “Press 1 if you do not wish to review the recipient’s service limitations status.”

(Response) AVRS will return to the Eligibility Menu.

(Prompt) “Press 2 to review limitations.”

(Response)

Pharmacy Information

“From a limit of ___ prescriptions for ___, the recipient has received ___ prescriptions.”

(Automated Voice Response System (AVRS), continued)

Hearing Information

“The recipient has never received a hearing aid.” OR
“The recipient last received a hearing aid on ____.”

Vision Information

“The recipient has never received eyeglasses.” OR “The recipient last received eyeglass frames on ____.”

Hospital Information

“From a limit of ____ days of inpatient services, the recipient has received ____ days of services. From a limit of ____ dollars of outpatient services, the recipient has received ____ dollars of services.”

Hospice Information

“From a limit of ____ days of hospice services, the recipient has received ____ days of services.”

Dental Information

“The recipient has never received upper dentures.” OR
“The recipient last received upper dentures on ____.”
AND/OR “The recipient has never received lower dentures.” OR “The recipient last received lower dentures on ____.”

(Prompt) “Press 6 to inquire on another recipient.”
“Press 7 to return to the Main Menu.”
“Press 8 to end this call.”

(Response) You enter _____ {social security number}. Enter the date of birth in 2-digit month, 2-digit day, and 4-digit year format __ __ - __ - ____.”

Eligibility History Information

(Response) “Recipient ID number ____ is eligible for the entire month of ____.”

“Recipient ID number ____ is not eligible for the entire month of ____.”

“Recipient ID number ____ is partially eligible for the month of ____.”

“The recipient is eligible for the entire month of ____.”

“The recipient is not eligible for the entire month of ____.”

“The recipient is partially eligible for the month of ____.”

(Response) The audit number for this transaction is
- - -.

(Prompt) “Press 6 to inquire on another recipient.”
“Press 7 to return to the Main Menu.”
“Press 8 to end this call.”

RECIPIENT ELIGIBILITY HISTORY (SPANS)

(Prompt) “For eligibility using an 8-digit plastic card control number, press 1.”

(Prompt) “Please enter the 8-digit plastic card control number.”

(Response) You enter _____ {card control number}.

(Prompt) “For 10-digit recipient number, press 2.”

(Prompt) “Please enter the recipient’s 10-digit Medicaid recipient ID.”

(Response) You enter _____ {recipient ID}.

(Prompt) “For 9-digit social security & date of birth in month, day, century, and year format, press 3.”

(Prompt) “Please enter the recipient’s 9-digit social security number.”

TERMINATE

(Prompt) “Thank you for calling Consultec’s Florida Medicaid automated inquiry service. Goodbye.”

(Response) AVRS will hang up.

Medicaid ON-LINE

<http://floridamedicaid.consultec-inc.com>

Publication Updates

Medicaid Provider Handbooks and the **Medicaid Provider Enrollment Application, Provider Agreement and Enrollment Forms** are available on the Florida Medicaid fiscal agent homepage. Also available on the website are Bulletins, the Medicaid Summary of Services and Electronic Data Interchange (EDI) Information.

Area Medicaid Offices Offer Provider Training

If you want to learn about Medicaid; the basics of MediPass; get an explanation on current changes; or share your questions, problems and solutions with area Medicaid staff and other Medicaid or MediPass providers, just check the training schedules listed below for opportunities in your area:



Area 1: Serving Escambia, Santa Rosa, Okaloosa and Walton counties. HCFA-1500 training for new billers is presented on the third Wednesday of each month from 10:00 A.M. to 12:00 P.M. For reservations call (850) 494-5840 or (800) 303-2422, ext. 139. MediPass training is presented on the second Thursday of each month from 10:00 A.M. to 12:00 P.M. For MediPass reservations call (850) 494-5840 or (800) 303-2422, ext. 150.



Area 2A: Serving Bay, Franklin, Gulf, Holmes, Jackson, and Washington counties. Conducts ongoing provider training. Providers can call (850) 872-7690 or (800) 226-7690 for date, times and details.

Area 2B: Serving Calhoun, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla counties. Conducts ongoing provider training. Providers can call (850) 921-8472, ext. 144 for date, times and details.



Area 3A: Serving Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee and Union counties. Conducts ongoing provider training. Providers can call (352) 955-5192 for dates, times and details.

Area 3B: Serving Citrus, Hernando, Lake, Marion and Sumter counties. Conducts ongoing provider training. Providers can call (352) 732-1349 for dates, times and details.



Area 4: Serving Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia counties. Conducts workshops for all Medicaid billers on the second and fourth Wednesday of each month as well as on a request basis. MediPass, Child Health Check-Up (formerly EPSDT) and other specialty area training are furnished. To obtain additional information or to register, please call (904) 353-2100, ext. 129.



Area 5: Serving Pasco and Pinellas counties. Conducts ongoing provider training. General and specialty training and workshops are furnished. For more information, providers can call (813) 588-6857, ext. 108 for dates, times and details.



Area 6: Serving Hardee, Highlands, Hillsborough, Manatee and Polk counties. Conducts MediPass training on the second Tuesday of every month. HCFA-1500 training is held monthly and specialty training and workshops are held on alternating months. Information concerning times is available when you call for reservations at (813) 871-7600, ext. 130.



Area 7: Serving Brevard, Orange, Osceola and Seminole counties. Conducts weekly claims resolution workshops. HCFA-1500 training is held monthly and specialty training and workshops are furnished. For more information, please call (407) 245-0862.



Area 8: Serving Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota counties. Conducts ongoing provider training. HCFA-1500 training and specialty training and workshops are furnished. Providers can call (941) 338-2620, ext.233 or (800) 226-6735 for dates, times and details.



Area 9: Serving Indian River, Martin, Okeechobee, Palm Beach and St. Lucie counties. Conducts specialty provider training. HCFA-1500 training for new billers and technical assistance for all providers is available every second Wednesday of each month. Providers can call (561) 881-5080 for dates, times and details.



Area 10: Serving Broward county, offers HCFA-1500 training on the fourth Thursday of each month (except November and December). Information concerning dates and times is available when you call for reservations at (954) 202-3200, ext. 131.



Area 11: Serving Dade and Monroe counties. Offers regular individual claims assistance for physician and hospital billers. Providers may come to the area office in Miami, at 8355 NW 53rd Street, from 10:00am to 12:00 noon, on the second Tuesday of each month. Physician seminars are also furnished. Reservations are no longer necessary. Please arrive early to assure a seat. For questions, please call (305) 499-2100.

Call your area Medicaid office for information concerning the details of provider training offered in each Medicaid area. See Appendix C of your provider reimbursement handbook for the addresses and telephone numbers for area Medicaid offices.

Guidelines for Submitting Paper Claims, Prior Authorizations and Crossover Claims

Medicaid and Consultec strongly encourage providers to follow the instructions listed below to keep the claims and prior authorization process flowing smoothly. When these instructions are not followed, claims, in most cases, will be returned unprocessed. Help us help you!

When submitting claim for prior authorizations:

DO:

- Put one staple (or paper clip) at the top when enclosing attachments.
- Tear apart perforated forms.
- Put the provider's name and address and recipient's name on all photos. (Staple photos to the claim; photos that are not stapled to a claim can become separated from the form they belong to, and cannot be identified or used in processing the claim.)

DO NOT:

- Do not hole-punch the papers.
- Do not use fax copies of claims or attachments (they cannot be imaged).
- Do not use a highlighter, circle name on EOMBs in black ink ONLY.
- Do not use peel-off labels on the claim form.

When submitting crossover claims:

DO:

- Use only one EOMB per claim total on crossover claims (no split balances).

DO NOT:

- Do not submit crossover claims when there are zero ("0") dollar amounts in EOMB fields 5, 9, or 11 for physician providers.
- Do not submit crossover claims when there are zero ("0") dollar amounts in the Medicare allowed, deductible, and Medicare paid fields of any EOMBs.

When zero dollar amounts appear in the above fields of crossover claims, either the claim is not covered by Medicare, or Medicare has paid the claim in an amount that equals or exceeds Medicaid's rate.

all providers

Do You Have A Billing Agent?

A Medicaid provider may retain a billing agent to submit claims on the provider's behalf. To bill for Medicaid services, the billing agent must meet the following requirements:

A billing agent that prepares or submits claims on behalf of Medicaid providers must enroll in the Medicaid program as a provider type 99.

If a billing agent is not already enrolled in Medicaid, the billing agent must enroll and be assigned an active Medicaid provider number before submitting claims on behalf of providers.

If a provider contracts with a billing agent, he or she must complete, sign and send a Florida Medicaid Provider/Billing Agent Agreement to Consultec. The Medicaid Provider/Billing Agent Agreement is a contract that defines the liability for information transferred between the provider and the billing agent as reported to the state of Florida and the Medicaid fiscal agent. The provider can obtain a Medicaid Provider/Billing Agent Agreement from Consultec by calling 1-800-377-8216 or from the Consultec Florida Medicaid web site at <http://floridamedicaid.consultec-inc.com>.

Claims must be paid in the name of the provider or provider group that renders the services, not in the name of the billing agent. If designated in writing by the provider, payment may be made in the name of the provider to the provider's billing agent. The letter must contain an original signature. Faxed letters will not be accepted.

Payment for billing services must be made based on an administrative fee per claim related to the cost of processing the billing. Federal regulation (42 CFR 447.10, Subpart A) prohibits billing agents from charging for their services based upon a percentage of the total dollar value of claims billed.

Medicaid payments cannot be reassigned to a factor. A factor is an individual or organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. A factor does not include a billing agent as described above.

It is the provider's responsibility to ensure that the billing agent is following Medicaid policy and billing claims correctly.

Have You Stopped Providing Medicaid Services?

If you plan to, or have already stopped providing Medicaid services for any reason (e.g. retirement), you or your authorized representative must notify Consultec, Medicaid's fiscal agent, and request that your Medicaid provider number be terminated.

To request termination of your provider number, you or your authorized representative must send on letterhead stationery, the following information:

- ✓ Provider name
- ✓ Provider address
- ✓ Provider Medicaid number
- ✓ Reason for cancellation
- ✓ Effective date of termination

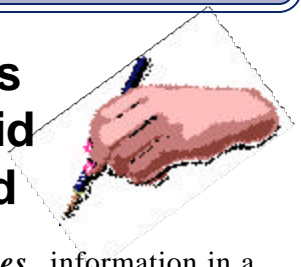


The letter must have an original signature from the provider or the authorized representative.

Send the letter to:

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

Making Changes To Your Medicaid Provider Record



Except for address changes, information in a provider's record can be changed by the provider submitting a written, signed and dated request on letterhead stationery to the Medicaid fiscal agent. Faxed or copied letters will not be accepted.

Requests for all changes to a provider record should be sent to:

Consultec Provider Enrollment
P. O. Box 7070
Tallahassee, Florida 32314-7070

The provider's Medicaid identification number must be included on all requests for change.

all providers, home health, therapists, utilization review

AI Providers

Improvements Under Way for Florida Medicaid Recipients

A recent study conducted by Florida Medical Quality Assurance Inc. (FMQAI) on behalf of the Agency for Health Care Administration (AHCA) found that 28 percent of Medicaid MediPass recipients diagnosed with asthma are treated only with bronchodilators, rather than with inhaled corticosteroids, as is recommended in the National Institutes of Health (NIH) 1997 Guidelines for Diagnosis and Management of Asthma (“NIH Guidelines”).

The study also discovered only about two thirds of the recipients had documentation of an asthma history anywhere in their medical record. Additionally, it was found recipients were not provided adequate advice about the disease nor were they given educational information or assistance in learning about the disease at the physician’s office. The findings from the baseline measurement, along with current medical literature, indicate that primary care physicians throughout the nation (including Florida) have not yet embraced the NIH recommended asthma practice guidelines.

The NIH Guidelines are the most current national clinical practice guidelines in use. Compared to the 1991 guidelines, they emphasize better diagnosis and stricter control in the management of asthma. The guidelines also build upon the 1991 guidelines in suggesting the critical role of inflammation in asthma and the importance of a physician/patient partnership in managing the disease.

AHCA’s approach to improving care and decreasing costs also involved collaborating in a demonstration project with an asthma disease management organization (DMO) to case manage Medicaid asthma patients. The DMO is able to use the findings from FMQAI’s baseline measurement to identify providers giving less than optimal care to their asthma patients. In turn, AHCA and the DMO will partner to emphasize patient education regarding appropriate treatment and follow-up for Medicaid asthma patients as well as provide physician offices with asthma disease management and educational interventions.

As a result of the study, AHCA may conduct a subsequent cost/benefit analysis of asthma care provided by primary care physicians versus asthma specialists. This analysis will determine cost-effectiveness and appropriateness of the DMO case management role as well as promote accuracy in diagnosis coding. AHCA feels strongly that “best practice” for Medicaid primary care providers should incorporate the NIH guidelines and asthma disease management practices.

Home Health

Plan of Care Certification Period

Effective October 1, 1998, the FROM and TO dates identify the period covered by the plan of care. The FROM date is the first day the POC covers. The TO date means UP TO, BUT NOT INCLUDING this stated day. The TO date can never exceed 62 days. Repeat the TO date on subsequent recertifications as the next sequential FROM date. Florida Medical Quality Assurance, Inc. will authorize precertification requests based on this interpretation. This is the same policy utilized by Medicare.

Home Health

Policy Clarification - Physician Order For Home Health Services

Effective November 13, 1998-A physician order is required to initiate or to continue home health services. At a minimum, the order must describe the (1) frequency and duration of the needed services, and (2) the minimum skill level (discipline) of staff who can provide the services. Medicaid will reimburse home health services ordered by an ARNP or physician assistant only if the order has been countersigned by the attending physician.

Home Health, Therapists

Home Health Agencies & Respiratory Therapy Services

Home health agencies may be reimbursed for respiratory therapy services only if they are enrolled with Medicaid as group providers of respiratory therapy services. Home health agencies must employ or contract with two or more Medicaid enrolled registered respiratory therapists in order to enroll as group providers of respiratory therapy services. All non-institutional respiratory therapy services must be personally rendered by a Medicaid enrolled registered respiratory therapist. Services provided by respiratory care practitioners (certified respiratory therapists) are not reimbursable by Medicaid even when provided through a home health agency or supervised by a registered respiratory therapist.

Registered respiratory therapists and home health agencies may obtain enrollment information and applications by calling 1-800-289-7799. This information is also available on Consultec’s Florida Medicaid website at <http://floridamedicaid.consultec-inc.com>.

Need To Know Medicaid Policy Changes

Physicians



Magnetic Resonance Angiography

Effective for dates of service after April 30, 1999, Medicaid will no longer reimburse for the following magnetic resonance angiographies (MRA):

- Chest MRA, procedure code 71555;
- Spinal canal MRA, procedure code 72159;
- Pelvis MRA, procedure code 72189;
- Upper extremity MRA, procedure code 73225;
- Abdomen MRA, procedure code 74185.

These codes are now included on the Medicare national non-covered list.

Physicians



Computerized Topography (CT) Diagnoses

The following diagnoses are valid for the procedures listed:

Diagnosis	Procedure Code
868.00	
Injury to intra-abdominal organs	74150 (CT abdomen)
863.0-863.95	
Injury to GI sites	72192 (CT pelvis)
959.09	
Injury to head, face and neck	72125 (CT spine)

Physicians



Insertion of Vagus Nerve Stimulators

Florida Medicaid reimburses the physician fee for the insertion, removal, and/or reinsertion of the vagus nerve stimulator. The reimbursement of the device is not a separately billable item by the physician or the hospital. This cost is included in the per diem rate reimbursed to the facility where the surgery is performed.

Diagnosis codes are restricted to those recipients with an ICD-9 diagnosis of 345.41 (partial epilepsy, with impairment of consciousness; intractable) or 345.51 (partial epilepsy, without mention of impairment of consciousness; intractable).

Only those recipients age 12 and older have been approved by the FDA and the manufacturer for implantation of this device for therapy. Medicaid will not reimburse for any recipient receiving implantation of the Vagus Nerve Stimulator under 12 years of age at the time of surgery.

Physicians



Myocardial Perfusion Imaging

Myocardial Perfusion Imaging, CPT procedure codes 78460-78465, 78478-78480, are limited to those ICD-9 diagnosis codes that support medical necessity. Listed below are ICD-9 diagnoses that support medical necessity under Medicaid.

FROM	TO	FROM	TO
411.0	411.0	426.50	426.54
411.1	411.1	426.6	426.6
411.81	411.81	426.7	426.7
411.89	411.89	427.31	427.31
412	412	428.0	428.0
413.0	413.0	428.1	428.1
413.1	413.1	428.9	428.9
413.9	413.9	440.21	440.24
414.00	414.05	794.31	794.31
414.10	414.11	960.7	960.7
414.19	414.19	995.2	995.2
414.8	414.8	E942.0	E942.0
414.9	414.9	E942.1	E942.1
424.0	424.0	V67.0	V67.0
426.2	426.2	V67.51	V67.51
426.3	426.3	V67.59	V67.59
426.4	426.4		

Physicians, ARNPs



Labor Epidural Increase for Anesthesia Providers

The 1999 Florida Legislature approved funding to increase anesthesia time for labor epidural procedures. The appropriation will increase the allowed time for labor epidural procedures from one hour of anesthesia time to a maximum of six hours of anesthesia time. ***This new rate of reimbursement will apply to claims with dates of service on or after November 1, 1999.***

Reimbursement for claims with dates of service prior to November 1, 1999, are still limited to one hour of anesthesia time.

This new legislation will improve both access to the service and reimbursement.

Need To Know Medicaid Policy Changes

Physicians, ARNPs

Monitored Anesthesia Care



A certified registered nurse anesthetist (CRNA) providing monitored anesthesia care (MAC) must bill with his or her treating provider number.

Be sure to note:

The anesthesiologist may not bill for the supervision of MAC.

Physicians, ARNPs, PAs

Legislative Budget Increases



The 1999 Florida Legislature approved funding to increase reimbursement to physicians providing care to Florida Medicaid recipients.

The Legislature appropriated \$1,440,000 from the Tobacco Settlement Trust Fund and \$1,819,393 from the Medical Care Trust Fund to increase reimbursement rates for physician services to children ages 0 through 19 billed under procedure codes 99212, 99213, and 99214. **The effective date is January 1, 2000.**

The Legislature also appropriated \$810,000 from the Tobacco Settlement Trust Fund and \$1,023,408 from the Medical Care Trust Fund to increase reimbursement for certain procedure codes determined by the Agency for Health Care Administration after consultation with the Florida Association of Pediatric Surgeons for services rendered to children by physicians who are board-certified in pediatric surgery or urology. **The effective date is January 1, 2000.**

The Legislature appropriated \$672,741 from the Tobacco Settlement Trust Fund and \$849,642 from the Medical Care Trust Fund to increase the reimbursement rates for emergency physician evaluation and management codes to a minimum of the December 31, 1998 level of such rates. **The effective date is July 1, 1999.**

Physicians, ARNPs

Anesthesia Does Not Require Prior Authorization



There is an incorrect statement in the Medicaid Physician Coverage and

Limitations Handbook, January 1999, on page 2-12, under the heading "Prior Authorization."

Medicaid is no longer requiring anesthesia providers to obtain prior authorization from Medicaid when the surgery has a PA on the Physician Fee Schedule. Only the surgeon and any assisting surgeon or co-surgeons must obtain the Prior Authorization for reimbursement.

Physicians, ARNPs, PAs, BCs, CHDs, FQHCs, RHCs

Diagnosis for Family Planning

The diagnosis to use for general counseling and advice with family planning services is V25.01-V25.9.

ARNPs



Observation Discharge Day Management

Effective for dates of service on or after March 1, 1999, advanced registered nurse practitioners can be reimbursed for observation discharge day management, procedure code 99217. Reimbursement is \$28.80.

LMWs, Birth Centers



Clarification of Child Health Check-Up Policy

The Fall 1998 Medicaid Bulletin contained an article on page 18 regarding licensed midwives and birth centers enrolling as Child Health Check-Up providers. Licensed midwives and birth centers may bill W9881, Child Health Check-Up, only for the INITIAL newborn examination.

Currently licensed midwives or birth centers use a newborn assessment code (99432 or 99435). Procedure code W9881 replaces the newborn assessment code when all components of the INITIAL examination are completed and documented.

Hospitals

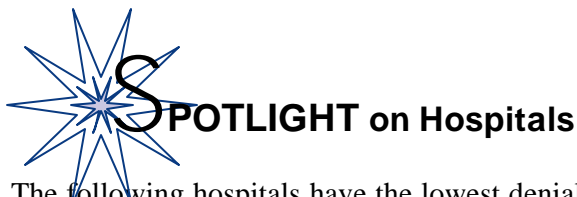
1999 ISD-AC Criteria

In a July 13, 1999 letter, Florida Medical Quality Assurance, Inc. (FMQAI) notified hospital providers that the 1999 version of the ISD-AC Criteria would become effective with admissions on and after August 1, 1999. That letter also included the Florida Medicaid Modifications, which also went into effect on that date.

The Clinical Exceptions will continue to be used at the on-site medical units at A.G. Holley State Hospital, Florida State Hospital, Tacachale Center of Excellence, and Cox Medical Services Center.

The *IS is not applicable to pediatric cases except where IV antibiotics can be given in a less acute setting if resources are available. The unavailability of such resources should be documented in the medical record.

The UB-92 is no longer required for inpatient hospital selections, but continues to be required for outpatient hospital selections.



The following hospitals have the lowest denial rates with 30 or more medical record reviews during the first and second quarters of 1999 and deserve special recognition:

Columbia Northwest Medical Center, Margate	117	0.23%
NME Hospital, Inc., Boca Raton	40	1.37%
Miami Children's Hospital	499	1.58%
Galen Health Care, Inc., St. Petersburg	139	1.63%
All Children's Hospital, St. Petersburg	499	1.80%

The denial rates are calculated on the total number of days denied for both admission and length of stay denials.

Hospitals

Utilization Review Contract FY 1999-2000

Listed below are the provider types and number of reviews that will be conducted by Florida Medical Quality Assurance, Inc. (FMQAI) for FY 1999-2000.

July 1, 1999 - June 30, 2000

Inpatient Hospital	40,000*
Outpatient Hospital (ER)	1,500
HMO	2,160*
MediPass	3,200
County Health Departments, Rural Health Clinics and Federally Qualified Health Centers	3,000
Home Health Pre-Certification	32,500
Home Health Retrospective	1,000
Hospice	500
PAC Waiver	500
Quality Improvement Projects	4

* 2% are Medicare Crossovers

* With a minimum of 2 Quality Improvement Projects

Hospitals

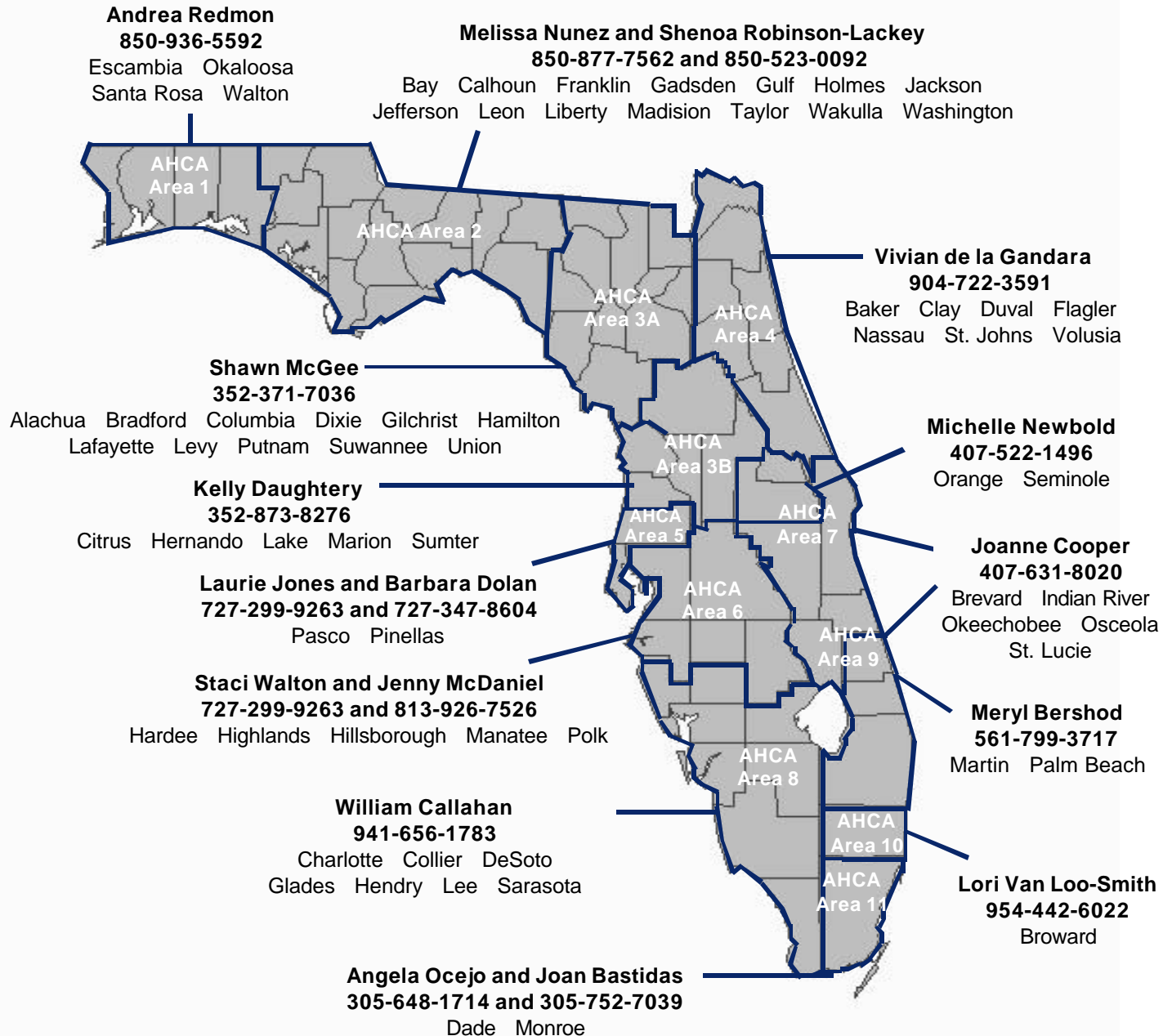
Interim Billing

Florida Medical Quality Assurance, Inc. (FMQAI) inadvertently requested medical records from hospitals that billed for services while the patient was still in the hospital. The problem can be averted by correct coding on the UB-92. When the hospital sends in a Medicaid UB-92 interim bill, the "patient status" indicator in form locator 22 should be coded with a "30" which indicates that the patient is still in the hospital. When the PRO runs the sample program against the paid claims, these cases will automatically be excluded from review.



CONSULTEC Field Representative Map

Field Representatives, Counties Covered and Telephone Numbers



Dialing the number “1” before the area code may be necessary to complete your telephone call.

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