

Medicaid Bulletin

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

Prescribed Drug Program Changes

Medicaid's pharmacy program is undergoing a number of changes this year. Some began July 1; others will be phased in over the next few months. Two involve new programs to help seniors with the cost of their prescriptions (see related articles on pages 8 and 9). The rest seek to reduce the cost of the Medicaid prescribed drug program by \$244 million.

The 2000 Legislature reduced the Medicaid drug program budget by \$244 million for fiscal year 2000-2001. The reduction is part of an effort to fight what has become annual double-digit increases in Medicaid drug costs. Without such reductions forecasts were that Medicaid drug spending would top \$1.5 billion this fiscal year.

Medicaid is asking providers to help implement these changes. Below are details about the reductions.

Brand-Name Drug Limits

All Medicaid recipients 21 years of age and older who are not in a nursing home or institution are limited to four brand-name drugs per month. The following are exemptions to this limit:

- Anti-retroviral agents for treatment of HIV;
- Multi-source (generic) drugs;
- Insulin and diabetic supplies;
- Contraceptive agents; and
- Mental health drugs (i.e., antipsychotic, antidepressant, and anticonvulsant agents)

Prescribers may request exemptions to the four brand-name drug limit through the Therapeutic Consultation Program when an exemption is medically appropriate and non-brand alternatives are not available. Exemption requests need to include the prescriber's license number, the Medicaid recipient's ID number, and relevant diagnosis(es) or explanation. Exemptions may be approved for periods of one to 12 months.

The Therapeutic Consultation Program (TCP) operates through a toll free number at Consultec, the Medicaid fiscal agent, which also has been selected to be the Medicaid pharmacy benefits manager (PBM). The phone line is staffed by clinicians (Pharm.D. and R.Ph. practitioners) who assist prescribers in the exemption process. The line operates from 8 a.m. to 8 p.m. Monday through Friday and on Saturday from 10 a.m. to 4 p.m.

When the toll-free line is closed, pharmacies may dispense a 72-hour emergency supply of medication. This may be repeated once for a total of two overrides within a month, but payment will reflect only the ingredient cost for these 72-hour overrides with no dispensing fee.

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All Providers

MediPass Disease Management

Florida Medicaid's disease management program has been operating for more than a year and has identified more than 100,000 people eligible to participate in one of its six initiatives. This represents 20 percent of MediPass enrollees.

Existing programs serve recipients with HIV/AIDS, hemophilia, diabetes, asthma, end stage renal disease and congestive heart failure. The HIV/AIDS program, which has been operating in 65 of Florida's 67 counties will be expanding to the two remaining counties—Dade and Broward.

All MediPass enrollees who meet the definition for one of the target disease states are eligible to participate in a program. Medicaid identifies potential participants through reviews of paid claims.

Once identified as a potential disease management participant, a person remains with the management organization throughout the Medicaid eligibility period. However, no recipient is required to take part in disease management. People enrolled with Children's Medical Services and those who are found to be inappropriately diagnosed or whose Medicaid claim listed an incorrect diagnosis are disenrolled from disease management.

For all the disease management programs the Agency notifies MediPass primary care physicians about their patients who are eligible for each program. Providers also may notify the disease management organizations (DMO) about patients who have a particular disease but who may not have been identified through paid claims. Providers receive progress reports from the DMOs on their patients along with relevant clinical practice guidelines developed by leading experts in the treatment of each disease. All DMOs provide similar services that must include:

- Recipient/provider orientation;
- Recipient screening/assessment;
- Recipient education;
- Recipient outreach and compliance;

- Intensive case management/care coordination;
- Patient satisfaction surveying;
- Provider education;
- Clinical practice guidelines;
- Provider profiling;
- Utilization management; and
- Health outcomes measurement.

“We strongly encourage MediPass providers to work closely with the disease management organizations to make this a successful program,” says Bob Sharpe, Acting Deputy Secretary for Medicaid. “Primary care providers can facilitate the efforts the DMOs are making by cooperating with DMO clinical staff when they contact provider offices to review existing care plans, medical records, and other pertinent recipient information. A strong partnership among providers, Agency staff, and the DMOs will help to ensure that we realize the expected benefits of improved health outcomes and reduced Medicaid expenditures with the disease management initiative.”

**For more information,
please visit the AHCA
website at:
www.fdhc.state.fl.us**

**Click on Medicaid and then
click Disease Management**

Disease Management Contractors

Contractor	Telephone	Company Headquarters	Disease State
Currently in operation:			
AIDS Healthcare Foundation	Positive Healthcare 800-832-0778	Jacksonville	HIV/AIDS
Caremark, Inc.	800-225-5967	Redlands, CA	Hemophilia, Areas 1-6
Accordant Health Services	800-948-2497	Greensboro, NC	Hemophilia, Areas 7-11
Coordinated Care Solutions	888-721-9797	Coral Springs	Diabetes
New contractors:			
Renal Management Strategies, Inc.	800-767-0063	McGraw Hill, IL	End Stage Renal Disease
Lifemasters Supported SelfCare	650-873-6000, ext. 606	Newport Beach, CA	Congestive Heart Failure Areas 1-7
Integrated Therapeutics Group	800-498-1079	Tallahassee	Asthma

Medicaid Provider Re-Enrollment

To streamline provider records and double check their accuracy, Medicaid re-enrolls non-institutional providers every five years.

Re-enrollment began July 1 with transportation, home health, DME and independent laboratory providers and will add new groups each quarter through June 2003. Physician providers will re-enroll in three separate quarters. Before October 1 all physician groups should have received re-enrollment packets. Only group provider numbers are being re-enrolled beginning in October. Individual physicians—both solo practitioners and group members—will receive their individual re-enrollment packets in either July or October 2001. Banner messages will appear in Medicaid remittance vouchers to remind physicians of their individual re-enrollment.

To receive a re-enrollment packet, providers must have an accurate address on file. This includes both the physical business address as well as the mailing address. Any provider who has changed addresses or anticipates an address change should call Consultec at 1-800-289-7799 or 1-800-377-8216 to request a sequentially numbered change of address form. A provider who does not receive a re-

enrollment packet will need to request a packet from Consultec. Re-enrollment packets cannot be copied, and blank forms will not be distributed. Only the pre-printed form specific to each provider will be accepted.

Providers have 60 days to complete their re-enrollment packets and return them to Consultec. If possible they should return them early to leave time to correct any errors within the 60-day period.

We know that re-enrollment may be an inconvenience for providers,” said Bob Sharpe, Acting Deputy Secretary for Medicaid, “but it has proven to be an effective mechanism for ensuring the accuracy of our files and helping us remove abusive and fraudulent providers from the system. We are committed to providing health care to Florida’s neediest people, and with the help and cooperation of the provider community, we can protect the funding needed to support these services.”

For answers to questions about re-enrollment, providers may contact the Consultec Provider Enrollment Unit at 1-800-377-8216 or their area Medicaid offices.

All Providers

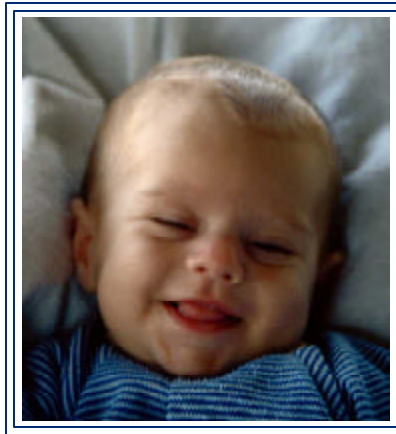
Universal Newborn Hearing Screening



The 2000 Florida Legislature authorized a statewide comprehensive and coordinated interdisciplinary program of early hearing impairment screening, identification and follow-up care for newborns, effective July 1, 2000. The goal is to screen all newborns for hearing impairment in order to alleviate the adverse effects of hearing loss on speech and language development, academic performance, and cognitive development. The screening is a test or battery of tests administered to determine the need for an in-depth hearing diagnostic evaluation. All Medicaid eligible newborns must be tested. Medicaid will reimburse Medicaid enrolled hearing services and hospital providers for newborn hearing screenings for all eligible recipients from birth through age 12 months.

Who May Perform Screenings?

All newborn and infant hearing screenings must be conducted by a licensed audiologist, physician licensed under Florida Statutes Chapter 458 or Chapter 459 (1999), or a directly supervised individual who has completed documented training specifically for newborn hearing screening.



Reimbursement

All Medicaid newborn screening services are reimbursed under Medicaid fee-for-service whether or not the newborn is enrolled in MediPass, a health maintenance organization (HMO) or a provider service network (PSN). Medicaid reimbursement for hospitals is supplemental to the hospital's per diem rate.

Authorized conductors who perform tests in a facility using their own equipment or equipment they lease may bill for a complete procedure, including both the technical and professional components, and receive full reimbursement. Authorized conductors who perform tests in a facility using facility equipment may bill only the professional component.

Procedure codes applicable for screenings include 92585, 92587, and, in some cases, 92588. A diagnosis code of

V72.1 must be used on all claims. Hospitals will be reimbursed at the fees established for these codes.

Refusal of Service

If the parent or legal guardian of the newborn objects to the screening, the screening must not be completed. In such a case, the physician, midwife, or other person attending the newborn must record that the screening has not been performed and attach a written objection that is signed by the parent or guardian.

Documentation for the Medical Record

Appropriate documentation of each referral received, screening completion, results, interpretation of results, recommendations and follow-up referrals for treatment, or the parent's or guardian's written refusal of screening must be placed in the recipient's medical record within 24 hours after completion of the screening procedure or within 24 hours of the parent's or guardian's signed refusal of the screening.

Impairment Referral

Any child who is diagnosed as having a permanent impairment must be referred to the primary care physician for medical management, treatment, and follow-up services. In accordance with Public Law No. 105-17, The Infants and Toddlers Program, Individuals with Disabilities Education Act, any child from birth to 36 months of age who is diagnosed as having a hearing impairment that requires ongoing special hearing services must be referred to the Children's Medical Services (CMS), Early Intervention Program serving the geographical area in which the child resides.

Birth Centers

Each state licensed birth center that provides maternity and newborn care services must ensure that all newborns are referred to an authorized conductor of hearing screenings prior to discharge. The referral for appointment must be made within 30 days after discharge.

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Written documentation of the referral must be placed in the newborn's medical chart. Each birth center must designate a licensed health care provider to provide programmatic oversight to ensure that the appropriate referrals are being completed.

Licensed Midwives

For home births, the health care provider in attendance is responsible for coordination and referral to an authorized conductor of hearing screenings. The referral for appointment must be made within 30 days after the birth.

Hospitals

By October 1, 2000, newborn screening must be conducted on all newborns in Florida hospitals on birth admission.

Reimbursement will be made at the rates established for the procedure codes. Every licensed hospital that provides maternity or newborn care services must obtain the services of an authorized conductor through employment or contract or written memorandum of understanding, for the purposes of appropriate staff training, screening program supervision, monitoring the scoring and interpretation of test results, rendering appropriate recommendations, and coordination of appropriate follow-up services. Every licensed hospital must formally designate a lead physician responsible for programmatic oversight of newborn hearing screenings.

The screening should be completed before the newborn is discharged from the hospital. If not completed, due to scheduling or temporary staffing limitations, the screening must be completed within 30 days after discharge by an authorized conductor.

How to Get Reimbursed for Vaccines for MediKids Enrollees



Most providers are familiar with the widely known Vaccine For Children (VFC) Program, established in 1993. Many children have received vaccines through the VFC program who otherwise might not have been vaccinated. However, not all children fall within the guidelines to receive vaccines through the VFC program. The VFC program serves children who are defined as "Federally vaccine eligible." This includes children who are Medicaid enrolled, uninsured, American Indian, Alaskan native, or underinsured. Many well-intentioned practitioners believe that children enrolled in MediKids program fall under the Vaccine For Children (VFC) Program guidelines. This is not correct. Children in the MediKids program are not considered Medicaid eligible and are not considered uninsured.

However, children enrolled in MediKids are still eligible to receive vaccines through MediKids' services. Providers are reimbursed for their services and for the costs of the vaccines. If a MediKids child enrolled in an HMO comes to you for vaccines, you may vaccinate the child using your private stock of vaccines and request reimbursement from either AHCA or the child's HMO.

If you're not sure if a child is enrolled in MediKids or Medicaid, you can access their eligibility category on MEVS. MediKids recipients are designated as MKA or MKB. Remember that the child's HMO is responsible for forwarding this information to treating providers.

Once you have administered the vaccines, there are two options for reimbursement:

- You can send the HCFA-1500 form directly to the fiscal agent for payment; or
- The HMO can bill the fiscal agent and pay you.

Note: HMOs are able to establish alternate procedures where the provider sends the HCFA-1500 form directly to the fiscal agent instead of to the HMO.

Providers with HMOs may want to consider obtaining "Policy Transmittal 99-03, Re: VCF and Title XXI Recipients," from the Agency's Bureau of Managed Care at: http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/HMO/medprovs.html

Providers who are not affiliated with an HMO, can fill out the HCFA-1500 form and send it directly to the fiscal agent.

All Providers

Agency Develops HIV/AIDS CD-ROM Training Program

Seminars, case studies and references are available on CD-ROM for providers who treat patients diagnosed with HIV/AIDS. The Florida Agency for Health Care Administration developed the interactive program as a convenient single source for the most up-to-date information.

Included in the references are classic articles as well as Internet links to other HIV/AIDS resources. Besides getting state-of-the-art training at home or in the office, practitioners are eligible for six hours of CEU or CME credits.

At the click of a mouse, you can see and hear the latest seminars starting with a video overview of this disease state. Then, review up-to-date presentations covering the viral life cycle, a new model of pathogenesis, viral load assays, and a new paradigm for therapy. There is also information on the law and ethics important in the management of patients with HIV/AIDS. Presenters include several top U.S. practitioners in the HIV/AIDS field, such as Drs. Margaret Fischl from the University of Miami and Scott Folk with Heartland Health Systems in St. Joseph, Missouri.

If time constraints prevent you from staying current with the rapid evolution in the treatment of HIV-infected people, try this practical, on-the-job learning tool. The case studies section offers a problem-oriented records approach. Practitioners are encouraged to make decisions about the care and treatment of various patient types. User responses are

compared to the recommendations from the most recent clinical practice guidelines available from the National Institutes of Health, the Centers for Disease Control and Prevention, and the International AIDS Society. Individual cases illustrate varying degrees of infection to take the practitioner step-by-step through diagnosing and treating the HIV/AIDS patient, including special issues such as pregnancy.

The reference section includes both abstract and full-text versions of the various clinical practice guidelines, as well as numerous full-text reference articles, a dictionary, and pharmacopoeia illustrating the drugs relevant to treatment of HIV/AIDS patients. A practitioner with access to the Internet can instantly link with HIV/AIDS-specific sites for further resources or to periodically update the CD with the most current information. Included is a link to information about how to receive approval of CEU or CME credits.

For further information, call 1-850-487-2355, or visit AHCA's Internet site at www.fdhc.state.fl.us. Click on Medicaid, and then click on Disease Management.

Your cost is only \$11.00 plus \$2.00 for shipping and handling. For each copy ordered, send a check or money order, made payable to AHCA, and mail your request and payment to the address below:

AHCA MediPass Unit
2727 Mahan Drive, Bldg. 3
Room 2228, Mail Stop #20
Tallahassee, FL, 32303

System Requirements

IBM-Compatible

Minimum: 486/33 MHz processor, 8 MB RAM, 2X CD-ROM Drive, 8-bit sound card/external speaker, 256 color @ 640 X 480 monitor resolution, mouse

Recommended: Pentium 90 or higher processor, 32 MB RAM, 4X CD-ROM, 8-bit sound card with external speaker, 16-bit color @ 800 X 600 monitor resolution, 28.8 Baud modem, Dedicated phone line and Internet account, Windows 95, 98 or NT operating system, Mouse

Macintosh

Minimum: 68030 processor, 8 MB RAM, 2X CD-ROM Drive, 256 color @ 640 X 480 monitor resolution, System 7.0 operating system, Mouse

Recommended: 680400 processor, 32 MB RAM, 4X CD-ROM Drive, 16-bit color @ 800 X 600 monitor resolution, System 7.1 or higher operating system, 28.8 Baud modem, Dedicated phone line and Internet account, Mouse

New Medicaid State Plan Service for Assistive Care

Beginning in January 2001, assistive care services will be available to Optional State Supplementation (OSS) recipients in assisted living facilities (ALFs). In July 2000, the program will expand to include residents of adult family care homes. In October, the Agency and the Department of Children and Families and Department of Elder Affairs staff will train ALF providers statewide. The goal is to enroll more than 1,000 ALFs by the end of November.

Currently, specially licensed assisted living facilities provide services to residents who are eligible for help through the assisted living for the elderly (ALE) waiver. To be eligible, the resident must be at least 60 years old and meet nursing facility level-of-care criteria. The new assistive care state plan service will be available to all OSS recipients who live in any licensed ALF enrolled in Medicaid. As of May, the ALE waiver caseload was 1,740. The Agency estimates an additional 8,000 ALF residents will be eligible for Medicaid assistive care services.

The services to be provided will be based on care plans developed from client assessments and will include daily supervision, assistance with activities of daily living, medication assistance, health monitoring, and arrangements for health care. These services usually are provided in standard licensed ALFs and family care homes. Medicaid will pay facilities a daily rate for each day an eligible resident is in the facility.

The 2000 Florida Legislature authorized the Department of Children and Families to transfer up to \$14.3 million in OSS funds to the Agency for fiscal year 2000-01 so the Agency could obtain federal matching funds for assistive care services. Providers have previously complained that existing OSS subsidies are inadequate to cover the cost of care they provide to low income residents.

By using OSS funds to draw additional federal match, state officials soon will be able to increase reimbursement rates for residential facilities caring for low-income residents.

Submitting Paper Claims

Effective January 1, 2001, all paper claims must be submitted to Consultec on forms pre-printed in "drop out" red ink.

Consultec is offering free replacement of several types of black Medicaid claim forms, whether you purchased them from Consultec or Unisys. The Florida Medicaid claim forms that are eligible for free replacement are 061, 081, 111, 131, 131-A, 141, and 221. To receive the current red forms, return the old black forms to:

Consultec
Black Forms Replacement
2308 Killearn Center Blvd., Suite 100
Tallahassee, FL 32308

We allow exact reproduction of claim forms as long as they perfectly match the current Consultec versions. Important elements to reproduce are field layout, OCR drop-out red color, form numbers in the top corner, and black form ID number and date.

Copies of forms will only be accepted for submission of adjustments or voids. Claims that are submitted on the incorrect forms will be returned to the provider.

**Order your Florida
Medicaid claim forms
from Consultec.**

**Download the order
form from the
Consultec website at:**

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

Click on Provider Support

Prescribed Drug Program Changes

Therapeutic Consultation for Brand-Name Exceptions

1-877-553-7481 (Toll Free)

Monday through Friday

8 AM-8 PM, EST

Saturday

10 AM-4 PM, EST

34-Day Supply Limit

The maximum amount of a prescribed drug that can be dispensed is a 34-day supply unless the minimum marketed package size is greater than 34 days (*e.g.*, Depo Provera's 90-day single dose).

Voluntary Preferred Drug List (PDL)

A nine-member pharmacy and therapeutics committee appointed by the Legislature and Governor will supply information to prescribers about appropriate and cost effective drug therapies. This information will include a voluntary list of drugs preferred by Medicaid, based on therapeutic efficacy and net cost to Medicaid.

Drug Benefit Management

Medicaid will review drug therapies for recipients who are using a significant number of prescribed drugs each month. This may include review of medical records and claims conducted by the Medicaid pharmacy benefits manager, Consultec.

Counterfeit-Proof Prescription Pad

Medicaid prescribers will be required to use special prescription blanks. These prescription blanks are designed to prevent forged or copied prescriptions.

Ingredient Cost Reduction

Reimbursement to pharmacies for Medicaid prescribed drugs will be set at the average wholesale price less 13.25 percent unless federal or state pricing limits or the usual and customary charge is lower.

Pharmacy Network Controls

The Legislature authorized Medicaid to limit its pharmacy network based on need, competitive bidding, price negotiations, credentialing or similar criteria. The Legislature also authorized the Agency to impose a moratorium on pharmacies seeking to enroll as Medicaid providers.

Supplemental Generic Drug Rebate and HMO Capitation Rate Adjustments

Manufacturers of generic drugs are required to provide rebates of at least 15.1 percent of average manufacturer price. Since HMO contracts include pharmacy services, HMO capitation rates also have been adjusted to reflect prescribed drug program funding reductions.

Cytogam Limit

Prior authorization is required for cytogam, and its use will be limited to the labeled indications for transplant-related therapy.

Other Initiatives

The Agency is pursuing a vigorous fraud and abuse prevention effort through its contract with Heritage Information Systems, a high-tech specialist in detecting fraud in large prescription benefit programs. Several fraudulent pharmacy providers already have been eliminated from the program through these efforts.

The Prescribing Pattern Review Panel is actively conducting physician profiling and is sending intervention letters to outlier prescribers in the Medicaid program. These efforts have identified a small number of prescribers who account for the greatest spending per patient. The Panel is working to educate these prescribers for improved clinical outcomes as well as cost savings to the Medicaid program.

AHCA Becomes an "Official" State Agency Under New Law

The Agency for Health Care Administration, created in 1992 by the Legislature, has become an official Florida department with legislation passed in the 2000 session. Prior to the new legislation, AHCA was placed administratively under the Department of Business and Professional Regulation and was headed by an executive director. Under the new law which took effect October 1, 2000, AHCA retains its original name and is headed by a Secretary (Ruben J. King-Shaw, Jr.) identical to all other agencies under control of the Governor.

Prescription Drug Benefit for Low-Income Seniors

Beginning January 1, 2001, a new program will take effect to help low-income seniors with their drug costs.

To qualify for the program, a person must:

- Be a Florida resident age 65 or over;
- Be eligible for both Medicare and Medicaid;
- Not be enrolled in a Medicare HMO that provides a pharmacy benefit or receiving pharmacy benefits through Medicaid (eligible individuals already have a Medicaid ID card, but do not receive prescription benefits);
- Have income between 90-120% of the federal poverty level; and
- Complete a one page application to be mailed to them in November.

Eligible participants will be entitled to an \$80 monthly prescription drug benefit and will need to make a 10 percent coinsurance payment for each prescription. Generic substitutions comparable to regular Medicaid are required. Pharmacy reimbursement will be at the same level as paid by Medicaid.

The Agency for Health Care Administration and the Department of Elder Affairs will jointly administer the program. More information will be going to providers and recipients before the January 1 start date.

To read the full provisions of Senate Bill 940 that created these programs, go to the Legislative Internet site at www.leg.state.fl.us

Prescription Discount Program for Seniors

Beginning July 1, 2000, all Medicaid-participating pharmacies began offering Florida residents on Medicare a new drug discount.

The program is available to seniors who pay privately for their prescriptions and is also available to private-pay Medicare recipients living in nursing homes. The discount equals the average wholesale drug price minus nine percent plus a dispensing fee of \$4.50.

Many seniors may expect to receive the discount on every prescription they have filled. Providers need to explain that voluntary store discounts may exceed the senior discount. The pharmacy may provide its own private, voluntary discount to its senior customers if the resulting price is at or below the legislatively mandated discount.

While pharmacies are not required to enroll in the senior discount program, all Medicaid pharmacies must participate.

MediPass Patient Lists on the Internet

Did you know that you may access your monthly MediPass patient enrollment list through the Internet? The Medicaid fiscal agent maintains a secure website that enables MediPass primary care providers to retrieve an electronic version of the MediPass enrollment report.

This system enhancement allows you to access your patient enrollment lists within the first few days of each month. In addition, the electronic version of the enrollment report may be downloaded, sorted, and saved (using a variety of software such as Microsoft Word, Excel, or Access) to suit your specific data needs.

Please contact the MediPass Coordinator in your local Medicaid office for additional information.

Medicaid Area Office

Medicaid Area Offices offer a variety of trainings for providers. Check the schedules listed below for opportunities in your area.



Area 1: Serving Escambia, Santa Rosa, Okaloosa and Walton counties. Area 1 is offering the following trainings during the month of November: Medipass provider training on 11/9/00 from 10:00 AM-12:00 PM, HCFA-1500 training on 11/15/00 from 10:00 AM-12:00 PM, and Ambulatory Surgical Center training on 11/15/00 from 1:30-3:30 PM.

These trainings will take place in Pensacola at the Area 1 Medicaid Program Office, 6245 Pensacola Blvd., Building 2, Suite 1. For more information, please call (850) 494-5840, ext. 150 for MediPass training and ext. 139 for HCFA-1500 and Ambulatory Surgical Center Training, or (800) 303-2422.



Area 2A: Serving Bay, Franklin, Gulf, Holmes, Jackson and Washington counties. Area 2A offers MediPass provider training on the second Thursday of each month from 9:00 AM-12:00 PM. Please call Linda Sefert at (850) 872-7690 for location and further information.

Area 2A is also offering the following trainings in November and December: Claims and Re-Enrollment workshop for all provider types on 11/8/00 from 9:00-11:00 AM, EST and from 1:00-3:00 PM, EST.

This training will be at Gulf County Community College, Apalachicola. Please contact Yvonne Johnson at (850) 872-7690 for further information.

New Biller training for all provider types on 12/12/00 from 9:00 AM-12:00 PM, CST. This training will be at the Area 2A Medicaid Office in Panama City. Please contact Yvonne Johnson at (850) 872-7690 for further information.



Area 2B: Serving Calhoun, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor and Wakulla counties. Area 2B is offering the following trainings from 9:00 AM to 12:00 PM, EST in the following months:

HCFA-1500 for Assisted Living Facility Providers and Claims workshop for all providers. Please call (850) 921-8474, ext. 106 for specific dates and further details. Area 2B is also offering a Re-Enrollment Workshop on 12/7/00 from 9:00 AM-12:00 PM, EST for Physician Group providers. Please call (850) 921-8474, ext. 106 for further information. Area 2B provider training are located at the Area 2B Medicaid Office in Tallahassee, 2639 N. Monroe St., Bldg. B.



Area 3A: Serving Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnum, Suwannee and Union counties. Area 3A is offering the following training in December: HCFA-1500

training for all providers who bill on the HCFA-1500, on 12/14/00 from 9:00 AM to 12:00 PM and 1:30 PM to 4:30 PM. This training will be located in Gainesville at 1150 NE 16th Ave. Please call (352) 955-5192, ext. 118 for more information.



Area 3B: Serving Citrus, Hernando, Lake, Marion and Sumter counties. Area 3B is offering HCFA-1500 training for all providers who bill on the HCFA-1500 on 11/14/00 from 9:00 AM-12:00 PM and 1:30 PM-4:30 PM. This training will be conducted in Ocala at 2441 W. Silver Springs Blvd. Please call (352) 732-1349 for further information.



Area 4: Serving Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia counties. Area 4 is offering a General Medicaid Policy and Claim Review for all providers on 11/8/00 and 11/22/00 from 10:00 AM-12:00 PM. This training will be conducted in Jacksonville at the Duval Regional Service Center, 921 N. Davis St., Bldg. A, Suite 160. Please call Dora at (904) 353-2100, ext. 129 for further information.

Provider Trainings



Area 5: Serving Pasco and Pinellas counties. Area 5 offers Medicaid policy and HCFA-1500 trainings the second week of each month for all providers who bill on the HCFA-1500. Please call (727) 552-1191, ext. 108 for times and further details. The Area 5 Medicaid Office also offers open training sessions for other claim forms or specific groups. If you need specialized training, please contact the Area Office at the number above.



Area 6: Serving Polk, Highlands, Hardee, Hillborough and Manatee counties. Area 6 provides MediPass training open to all providers on the second Tuesday of each month from 9:00 AM-12:00 PM. Area 6 is also conducting the following trainings in November and December: HCFA-1500 training open to all providers on 11/9 and 12/7/00 from 9:00 AM-12:00 PM, OB/GYN training for HCFA-1500 billers on 11/16/00 from 9:00 AM-1:00 PM. These trainings will be located in Tampa at 6800 N. Dale Mabry Hwy., Suite 220. Please call Carol Cullers at (813) 871-7600, ext. 131 for further information.



Area 7: Serving Brevard county. Area 7 will be conducting HCFA-1500 training for all new providers billing on the HCFA-1500 on 11/3/00 from 12:00 PM-2:00 PM. This training will be located at the Rockledge Health Department. For further information, please contact Laturia Lee at (877) 254-1055, ext. 167.



Area 8: Serving Collier, Lee, Charlotte, Sarasota, Hendry, Glades and Desoto counties. Area 8 conducts HCFA-1500 training each month in Ft. Myers, and every other month in Venice. For further information, please call (800) 226-6735 or (941) 338-2847.



Area 9: Serving Palm Beach, Martin, St. Lucie, Okeechobee and Indian River counties. Area 9 offers HCFA-1500 training for all providers on the second Wednesday of each month from 9:00 AM-1:00 PM. Area 9 is also offering the following training in November and December: MediPass training for all MediPass Primary Care providers and any other interested Medicaid providers on 11/9 and 12/14/00 from 10:00 AM-12:00 PM.

Area 9 trainings are conducted at the Area 9 Medicaid Program Office in West Palm Beach, 1710 E. Tiffany Dr. For further information, please call (561) 881-5080, ext. 120.



Area 10: Serving Broward county. Area 10 offers HCFA-1500 training for all providers billing on the HCFA-1500 on the fourth Thursday of each month, from 8:30 AM-4:30 PM. Training is located at the Area 10 Headquarters. For further information, please contact Maria Rivera at (954) 202-3200, ext. 131.



Area 11: Serving Dade and Monroe counties. Area 11 will be conducting a HCFA-1500 training for all providers billing on the HCFA-1500 on 11/16, and 12/14/00 from 1:30 PM-4:30 PM. This training will be located in Miami at the Koger Building, 8355 NW 53rd St. For further information, please contact Elucia at (305) 499-2164.

See Appendix C of your Provider Reimbursement Handbook for Medicaid Area Office Addresses and Telephone Numbers or visit AHCA's Website at:
<http://www.fdhc.state.fl.us/Medicaid/Area>

All Providers

Instant Claims Status with MEVS

With the addition of Claims Inquiry to the MEVS transaction, getting claim status is quick and easy. This claims inquiry feature offers real-time claim status and is now available to all Florida Medicaid Providers from MEVS vendors.

All you need is a Transaction Control Number, a Medicaid Provider number, or a recipient number and date of service to obtain the status of a claim. Contact a MEVS vendor listed on this page for more information.

Crossover Claims Using WINASAP2000



Consultec's WINASAP2000 software allows you to enjoy the benefits of submitting Medicaid crossover claims electronically. Electronic submission of crossover claims dramatically decreases the time spent waiting for claim payment.

What Do I Need To Know?

- Keep your Medicare EOB handy and use the EOB while entering the required data.
- Choose Medicare part A or Part B claim type.
- Transmit your claims by midnight on Wednesdays to meet the payment cycle deadline for that week.

To obtain the latest version of the WINASAP2000 software, visit Consultec's Website at <http://floridamedicaid.consultec-inc.com>, or call the EDI Technical Support Unit at 1-800-829-0218.

Authorized Vendors for Medicaid Eligibility Verification Services (MEVS)

Authorized Vendors as of 5/1/00

Consultec EDI Gateway Services
1-800-829-0218
Eligibility Verification
Claims Inquiry

ENVOY Corporation
1-800-366-5716
Eligibility Verification
Claims Inquiry

Healthcare Data Exchange Corporation
1-610-219-1784
Eligibility Verification

HealthNet Data Link, Inc.
1-800-486-7352
Eligibility Verification
Claims Inquiry

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

**Healthon/WebMD
(formerly MedE America Corporation)**
1-888-633-3888
Eligibility Verification

MediFAX/The Potomac Group, Inc.
1-800-444-4336
Eligibility Verification
Claims Inquiry

National Data Corporation
1-800-218-1500
Eligibility Verification

Physicians, PAs, Podiatrists, Chiropractors, ARNPs, Dentists, Optometrists

Four Percent (4%) Fee Increase Effective July 1, 2000



The 2000 Florida Legislature provided for a four percent (4%) increase to physician reimbursements effective 7/1/00. The following provider types are receiving the increase:

- Medical Physician
- Osteopathic Physician
- Physician Assistant
- Podiatrist
- Chiropractor
- Optometrist
- Advanced Registered Nurse Practitioner
- Dentist (CPT codes only, this does not include D codes)

The increase cannot result in any of the above listed provider types being paid in excess of the Medicare rate. All other procedure codes and provider types must price from the maximum allowed fee-on-file. Fees for Pediatric Surgery/Urology are NOT to be increased. The proviso

language does not allow any specialty group to exceed Medicare allowable rates. Pediatric Primary Care Visits to all physicians (25, 26) for care provided to children for visits 99212, 99213 and 99214 will increase 4%.

Until the increase is implemented on the Florida Medicaid Management Information System (FMMIS), which controls reimbursement of these procedure codes, all claims with dates of service 7/1/00 and after will be reprocessed for proper adjusted payment. We will advise you when the fee increase has been implemented and a claims reprocessing has begun.

If you have any questions please contact your Area Medicaid Office. To find the area office located closest to you, sign on to our AHCA Internet site at www.fdhc.state.fl.us. Click on Map of Office Locations. You can also check Appendix C of your Medicaid Provider Reimbursement Handbook, HCFA-1500 and Child Health Check-Up 221.

Anesthesia	
Provider type 25, 26, specialty code 03; provider type 30 with specialty code 84 only.	Increase the anesthesia conversion factor from \$13.94 to \$14.50 (4%)
HCPSC Procedure Codes	
Provider types: 25, 26, 27, 28, 29, 30, 35, 62	10000-69999 increase the max fee 4% 70000-79999 increase max, pc and tc 4% 90780-99199 increase max and pc 4% 99201-99440 increase max fee 4% G0004-G0171 increase max and pc 4%
W Codes	
W1700 W1900-W1993 W9759 W9850-W9851 W9881	Increase max 4%
Other	
RPICC increase OBCG and NCG 4%	
Primary Care Visits 99212, 99213, 99214 for provider type 25, 26, children age 0-19 (P Prim Care in FMMIS) increase 4%	
E Ped Surger - No increase in fees - already priced at 100% of Medicare allowable	

Hospitals, Physicians, CMH

Hospitals

Stop the “Zero Paid” UB-92 Claims

When a Medicaid recipient has Medicare coverage, Medicare is the primary payer and Medicaid is secondary. If Medicare denies certain hospital services for a Medicaid recipient, those services can be billed to Medicaid if Medicaid covers them. When these services are not billed to Medicaid in the appropriate billing format, the claims on which they are submitted may be denied by Medicaid with edit 318. This denial edit produces a claim that is shown as “paid,” but the payment is “0” (zero) dollars. These claims are referred to as “zero paid claims.” To avoid “zero paid claims,” follow the special billing instructions below:

- Enter the Medicare denied services on a brand new UB-92 claim form.
- Complete the new claim form as a “straight Medicaid” UB-92.
- Enter FC 100 in form locator 2 as the financial class code.
- Enter the appropriate bill type for the claim in form locator 4.
- Enter only “Medicaid” in form locator 50 as the payer on this claim. (There can be no references to Medicare on the claim form.)
- Enter your hospital Medicaid provider number in form locator 51.
- Enter the amount due from Medicaid in form locator 54.
- Enter only the recipient’s Medicaid ID number in form locator 60.
- Complete the remainder of the claim as required by Medicaid. (See Chapter 6 of the Medicaid Provider Reimbursement Handbook, UB-92 for claim completion instructions).
- Attach the Medicare Explanation of Medicare Benefits (EOMB) showing the denied services to the straight Medicaid claim. A written translation of the Medicare denial codes must be included with the EOMB.
- Prepare a cover letter requesting a 237 (Medicare present) override and send it with the newly completed straight Medicaid claim, the Medicare EOMB, and written translation of Medicare denial codes to your area Medicaid office.

Note: These instructions are not applicable to the billing of self-administered drugs, revenue code 637.

Hospitals

Outpatient Hospital Cap Increase



The 2000 Florida Legislature has approved an increase in the Medicaid outpatient hospital entitlement for adult recipients 21 years of age and older. Effective July 1, 2000, adult recipients have \$1500 instead of \$1000 toward outpatient hospital services, including emergency services, not otherwise exempt from the outpatient cap. Recipients under the age of 21 have no outpatient cap limit. All services to both groups of recipients must be medically necessary.

Hospitals, Physicians, Community Mental Health

Medicaid Area Six Prepaid Mental Health Plan

Effective July 1, 2000, AHCA has awarded a contract for prepaid mental health services for Medicaid’s Area Six to Florida Health Partners, Inc.

Florida Health Partners, Inc. is a joint venture between ValueOptions and a consortium of five community mental health centers. The contractor is responsible for managing and providing mental health services to approximately 55,000 MediPass recipients residing in Hardee, Highlands, Hillsborough, Manatee, and Polk Counties under a prepaid, capitated contract. The Agency had previously contracted with Florida Health Partners, Inc. to manage and provide mental health services in Medicaid’s Area Six from March 1, 1996 until June 30, 2000.

Effective January 1, 2001, the agency plans to amend its current contract with Florida Health Partners, Inc. to include substance abuse services, as required by CS/HB 1129.

FLORIDA HEALTH PARTNERS, INC.



Ophthalmologists, Optometrists, Opticians

Polycarbonate Lenses

Effective January 31, 2000, prior authorizations were no longer needed for polycarbonate lenses. Recipients must meet one or more of the following criteria in order to be eligible for Medicaid-reimbursed polycarbonate lenses.

- The recipient is monocular with the sight in the poor eye being 20/50 or worse;
- The recipient has significant amblyopia with the sight in the poorer eye being 20/50 or worse;
- The recipient has had a retinal detachment or is significantly at risk for retinal detachment; e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment, retinal holes, etc.;
- The recipient has a seizure disorder, Marfan's Syndrome, an ocular prosthesis, or keratoplasty; or
- The recipient is in an occupation where there is high risk of eye trauma, and the eyes must be protected beyond the usual plastic lens spectacle correction.

Providers may bill Medicaid for polycarbonate lenses for recipients who meet this criteria. The criteria is listed in Chapter 2 of the Visual Services Coverage and Limitations Handbook. Medicaid will perform routine audits of usage on polycarbonate lens procedure codes, W5401, W5402, and W5403.

If you have questions, please call your area Medicaid office. Area office telephone numbers are in Appendix C of your Medicaid Provider Reimbursement Handbook, HCFA-1500 and Child Health Check-Up 221.

Address Change

Area 5 Medicaid
525 Mirror Lake Dr., Suite 510
St. Petersburg, FL 33701
Phone: (727) 552-1191
Fax: (727) 552-1216

Hearing Services

Global Fees for Hearing Aid Reimbursement

Hearing aid manufacturers must now supply complete hearing aids at a single, fixed price, eliminating the previously contracted Medicaid price established for each manufacturer.

Category 1 is the standard category of single linear aids with one or no adjustment features. Procedure code W5980 must be used and is currently reimbursed at \$176.00.

Category 2 is for specialized linear aids and includes more powerful aids possessing unique features. Procedure code W5981 must be used and is currently reimbursed at \$228.00.

The manufacturer must determine the category of each hearing aid sold to a provider. The provider must maintain documentation of the category type and the warranty in the recipient's medical file.

Hearing Services

Binaural Hearing Aids for Children

Medicaid no longer requires prior authorization for binaural hearing aids for recipients under the age of 21 who meet the hearing loss criteria and need Category 1 or Category 2 hearing aids. Medicaid will reimburse for two earmolds, two hearing aids, one evaluation and up to two dispensing fees.

Providers must continue to obtain prior authorization for binaural hearing aids for recipients under the age of 21 who do not meet the hearing loss criteria, require special aids, or have lost an aid.



Physicians

Pneumococcal Conjugate Vaccine

The pneumococcal conjugate vaccine (procedure code 90669) was FDA approved 2/17/00. Medicaid will reimburse the cost of the vaccine and the administration fee for children 0-59 months. Coverage through the Vaccine for Children (VFC) Program is pending.

Until the vaccine is VFC approved, the reimbursement process for managed care providers for Pneumococcal Conjugate Vaccine given to Medicaid recipients enrolled in an HMO is to:

1. Complete the HCFA-1500 claim form using CPT code 90669.
2. Mail the claim to: **Immunization Coordinator, Medicaid Program Development, 2727 Mahan Drive, Mail Stop #20, Tallahassee, FL 32308.**

The Immunization Coordinator will price each claim at \$58.00 for dates of service after 7/1/00. Only edit 308 (Recipient is in HMO) will be forced. The provider is responsible for correcting any other edits that result in the claim being denied.

Physicians

Botox Changes

Effective 2/1/00, Medicaid coverage for J0585 was limited to the following diagnosis codes: 333.81-333.89, 378.00-378.9, 478.75, 530.0, 723.5, 728.85, 340, 342.11, 342.12, 343.0-343.9, 351.8. Medical documentation is no longer required for these diagnosis codes.

Physicians, ARNPs, PAs, RHCs, CMS

Oral Polio Vaccine

As of January 1, 2000, the Advisory Committee on Immunization Practices recommends exclusive use of inactivated poliovirus vaccine (IPV) for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at ages 2, 4, and 6-18 months and 4-6 years. Since OPV is no longer available for distribution, Medicaid stopped reimbursing for CPT code 90712 as of 7/1/00.

Physicians, ARNPs

Billing Appropriately for Labor Epidural Analgesia Procedure Codes 00857 and 00955

Effective for dates of service on or after November 1, 1999, labor epidural procedure codes 00857 and 00955 will reimburse a maximum of 6 hours of anesthesia time. To receive proper reimbursement, do not file claims in excess of 6 hours for the total anesthesia time. If you have received a denial for these procedure codes with edit 027, exceeds units of service, you may resubmit the denied claim line on the HCFA-1500 form with a maximum of 6 hours of anesthesia time billed in 15 minute units.

Physicians, ARNPs, PAs, CHDs, CMS

Diagnosis Code List for OB High Risk Delivery

Effective 1/1/00, Appendix B in the *Physician Coverage and Limitations Handbook* was revised to delete 654.21, classical cesarean section. This diagnosis code will reimburse at the low risk delivery fee. Also, the following codes were revised: 042.0 to 042, 648.33 to 648.31, 656.23 to 656.21. Asthma diagnoses 493.20 and 493.00 were added.

Licensed Midwives

Evaluation/Management Codes

Effective for dates of services 7/1/00 forward, licensed midwives may bill the following codes for recipients that have minor medical problems during pregnancy:

Code	Maximum Fee
99201	\$24.00
99202	\$26.62
99203	\$37.40
99211	\$9.60
99212	\$16.80
99213	\$20.00

These codes cannot be billed in the home setting.



Child Health Check-Up (formerly called EPSDT)

Reminders:

Blood lead testing is required for children at 12 months and at 24 months of age, and between the ages of 36 months and 72 months of age if they have not been previously screened for lead poisoning.

Blood lead tests reimbursable by Medicaid are:

- W9979 Blood lead (capillary) using collection tube or finger stick filter paper, and
- 83655 Blood Lead (venous).



Providers may only bill for one visit, a sick visit or a Child Health Check-Up. Provider discretion in evaluating the degree of illness should determine if a Child Health Check-Up should be performed. Please see page 2-3 of the updated Child Health Check-Up Coverage and Limitations Handbook, May 2000.

For any abnormal findings found during a Child Health Check-Up, providers must enter the appropriate diagnosis code and exam code on the Child Health Check-Up 221 claim form. This information is critical for case management.

Your patients may be eligible for free nutritious foods and nutrition counseling through the Women, Infants and Children (WIC) Program. Please refer all pregnant, postpartum and breastfeeding women, infants, and children under five years old to a WIC office or have them call the WIC toll-free number at 1-800-342-3556.

Recent Policy Changes

Physicians

CPT Code 90378 and W1933, Synagis

The CPT Editorial Panel has clarified CPT code 90378 to read: Respiratory Syncytial Virus Immune Globulin (RSV-IGIM), for intramuscular use, 50 mg, each with an effective date of 7/1/00. Therefore, the reimbursement for CPT code 90378 will be \$561.84. Maximum units = 5. If recipient is receiving the 100 mg vial, "2" units should be reported on the claim form. W1933, Palivizumab 50 mg vial, injectable (Synagis), was no longer valid after 9/30/00.

Physicians, PAs, ARNPs, Birth Centers

Billing Change for Cervical Cap

Effective for dates of services 7/1/00 forward, a paper claim with drug invoice attached is no longer required for procedure code A4261, cervical cap. Reimbursement for this code is \$55.00.

Physicians, ARNPs, PAs, Podiatrists, Lic. Midwives, Dentists, RHCs, FQHCs, Birth Centers, CMS

Price Changes for Injectable Medications

The 2000 Legislature enacted a Medicaid bill that requires reimbursement for injectable medications (J and W codes), including immunoglobulins (CPT-4 codes), be set at the average wholesale price less 13.25 percent. This may have resulted in a decrease in the Medicaid reimbursement rate for these codes effective 7/1/00.

Provider Service Network (PSN) Update

The Provider Service Network (PSN) operated by the South Florida Community Care Network (SFCCN) began operation March 1 in Miami-Dade County and April 1 in Broward County. The SFCCN is composed of the Public Health Trust of Miami-Dade County (PHT), Memorial Healthcare System (MHS), and the North Broward Hospital District (NBHD).

PSN enrollees are identified with an “S” in the managed care indicator field of the Medicaid Eligibility Verification System (MEVS). The name and telephone number of the primary care provider also is indicated on MEVS. In addition to the Medicaid gold card, SFCCN enrollees receive color-coded identification cards. The colors are green for Public Health Trust enrollees, red for Memorial Healthcare enrollees, or blue for North Broward enrollees. Important addresses and telephone numbers for service

authorization and billing purposes are listed on the back of the enrollee identification card.

SFCCN enrollees receive the majority of their health care through the PSN. Out-of-network care provided to PSN enrollees (for PSN-managed services) must be authorized by and claims must be submitted to the PSN in order for the claims to be paid by the Medicaid fiscal agent. All Medicaid-covered services are available to PSN enrollees. However, the SFCCN does not manage community mental health, targeted case management, hospice, nursing facility, dental, transportation, early intervention, medical foster care, prescribed pediatric extended care, school based, or waiver services. PSN enrollees may obtain these medically necessary services from any Medicaid provider. Providers may submit claims for non-PSN managed services directly to the Medicaid fiscal agent.

Claims for PSN managed services must be submitted to the PSN. Important addresses and contact numbers for the SFCCN are below:

North Broward Hospital District

Mental health/substance abuse inpatient certification
1-800-988-5640
Authorizations and/or admissions
1-800-988-5640

Send claims to:
South Florida Community Care Network
(NBHD)
P.O. Box 21128
Ft. Lauderdale, FL 33335-1128

The Public Health Trust of Miami-Dade County

Mental health/substance abuse inpatient certification
1-800-294-8642
Authorizations and/or admissions
1-305-575-3650

Send claims to:
South Florida Community Care Network
Attn.: Claims Dept. (PHT)
1801 NW 9th Ave., Suite 700
Miami, FL 33136

Memorial Healthcare System

Mental health/substance abuse inpatient certification

- Adult Psychiatric
1-954-987-2020 X4287
- Detoxification/Adolescent/Child Psychiatric
1-954-987-2020 X4623

Authorizations and/or admissions
1-954-985-2364

Send claims to:
South Florida Community Care Network (SFCCN)
P. O. Box 849029
Pembroke Pines, FL 33084

Providers may direct questions related to the PSN at one of the following numbers:

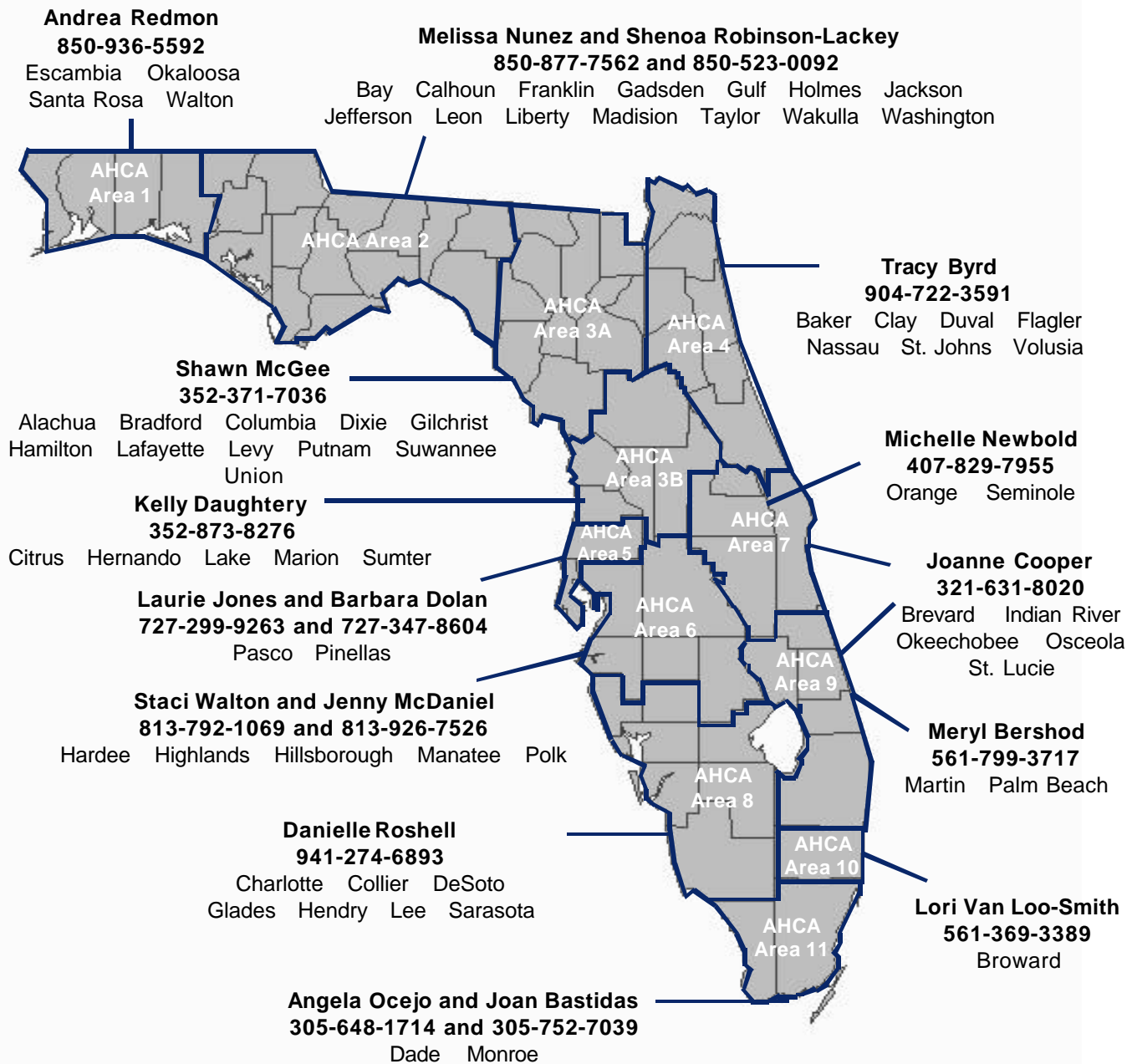
Public Health Trust
(305) 575-3680

North Broward Hospital District
(954) 767-5640, option 9

Memorial Healthcare System
(954) 985-2360, extension 9240 or 9242

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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Articles carrying this graphic contain important Medicaid Provider Handbook Information.



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