Agency for Health Care Administration

FLORIDA MEDICAID PROVIDER BULLETIN

Summer 2006 Volume VI, Issue 3

All Providers

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

FLORIDA MEDICAID REFORM

Articles with this graphic contain links to more information on the Internet.

During the 2005 Special Session, the Legislature authorized the implementation of the Medicaid Reform Plan as authorized by the Centers for Medicare and Medicaid Services.

The implementation of Medicaid Reform is expected to take place in July 2006 in Duval and Broward Counties. The targeted populations will include both traditional groupings, like Children and Families and Aged and Disabled, and specialty populations such as children with chronic illness and persons diagnosed with HIV/AIDS.

Florida's Reform approach recognizes that a "one-size-fits-all" benefit package does not adequately meet the needs of our diverse Medicaid populations, promote coordination of patient-specific care, or result in a delivery system that ensures flexible health care services. Medicaid Reform will result in the Agency contracting with Provider Service Networks (networks established, organized, and operated by a health care provider, or groups of affiliated health care providers), Health Maintenance Organizations, and other licensed insurers. These entities will have the ability to tailor their services and delivery systems in a manner that is most appealing to recipients and meets their needs in the changing medical marketplace. The state will evaluate these custom benefit packages to ensure they are actuarially equivalent to historical fee-for-service benefits and sufficient to meet the needs of the targeted populations. To incentivize more prevention and identification of chronic illnesses, rates will include a risk adjusted factor. As a result, plans are appropriately reimbursed based upon the health status of their population. This will lead to better coordination of services for those who most need them. In addition, by not requiring Provider Service Networks to accept risk, Florida expects that provider groups will emerge in currently underserved areas of the state and that access to health care for people living in those areas will be improved.

(continued on next page)

FLORIDA MEDICAID REFORM (continued from previous page)

Medicaid Reform will provide recipients with health care choices that are not currently available today. Under reform, Medicaid recipients will be able to choose among a variety of reform plans offering customized benefit packages or they may opt out of the Medicaid program and use their premium to participate in an employer-sponsored health insurance benefit, if available. Because plans will have the ability to create benefit designs tailored to specific target populations, recipients will have the ability to choose from a variety of benefit packages for the one that best meets their needs. The Agency will contract with a choice counselor to help individuals make a selection. The choice counselor will provide information about the available plans and the packages offered by each plan.

All plans will be measured based on outcomes, and that information will be shared with consumers as they make their choices. Information like consumer satisfaction with the plan, percentage of children in each plan that receive preventive dental and medical care, percentage of children in each plan that receive their vaccinations, and waiting times for customer assistance are all important measures that will help recipients make more informed choices about their health care.

All plans interested in participating in Medicaid Reform will be required to submit an application for review and approval by the Agency for Health Care Administration. As of May 19, the Agency has received 17 applications. The application process requires the potential plan to submit detailed information about their provider network. The Agency encourages all providers to visit the Medicaid Reform Web Site at http://ahca.myflorida.com to obtain more information about Medicaid Reform and to obtain a list of plans that have indicated a desire to participate in Medicaid Reform. Providers are being encouraged to contact these plans to obtain more information about their programs and opportunities for providers within their networks. Providers have the ability to join more than one reform plan. The method of payment for services provided will depend upon the type of plan a provider joins. Plans will be offering fee-for-service or capitated payment for services provided.

MEDICAID FEE SCHEDULES ARE ONLINE

This is a reminder to Medicaid providers that the latest 2006 Medicaid fee schedules are online. To access the schedules, please go to http://floridamedicaid.acs-inc.com. Click on “Provider Support,” and then click on “Fees” to obtain your downloadable copy of all fee schedules that pertain to your practice(s). All fees represented on these schedules are effective January 1, 2006. If you cannot access the web site to download your copy, you may obtain a paper copy of the fee schedule(s) by calling the Medicaid fiscal agent’s Provider Enrollment Line at 1-800-377-8216.

If your practice performs services described by CPT codes listed on the Physician Services (Surgical) Fee Schedule, please note the following: procedure codes listed on this fee schedule followed by an asterisk, have a separate fee based on site of service. In such cases, the same code is repeated in the listing, shown with and without an asterisk. The fees for the asterisked code represent reimbursement when the procedure is performed in the inpatient hospital, outpatient hospital, emergency department, and ambulatory surgical center settings. The asterisked fee is based on facility Relative Value Units (RVUs). The fees for codes without an asterisk are based on non-facility RVUs.

NATIONAL PROVIDER IDENTIFIER (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the adoption and use of a National Provider Identifier (NPI) for all health care providers. The NPI replaces all identifiers (provider numbers) currently in use, including Medicaid provider numbers. After May 23, 2007, the NPI must be used on all HIPAA transactions. Florida Medicaid and its contractor, Brandt Information Services, have designed a web site for providers to use for registration of the new NPI number, and plan to make the site available by June 15, 2006. Through staggered mailings over the next few months, providers will receive a letter containing instructions and a web site username and password. If you have more than one active Medicaid provider number, you will receive a letter for each number.

Florida Medicaid continues to work on crosswalk solutions for linking the new NPI numbers to one or more Medicaid provider numbers. **Please note: Providers can assign one NPI number to only one Medicaid number in order to create a unique one-to-one association for billing.** Institutional providers and group practices may need to consider obtaining separate subpart NPI numbers to assign to various Medicaid numbers if they are unable to crosswalk all their Medicaid numbers to one NPI.

Claims using an NPI number that has not been registered with Florida Medicaid will deny after May 23, 2007.

NPI Tips:

- For more information, check the Centers for Medicare and Medicaid Services (CMS) NPI web page at: http://www.cms.hhs.gov/NationalProvIdentStand/.

- Submit your NPI application NOW - the web site is https://nppes.cms.hhs.gov.

- When applying for your NPI, CMS urges you to include your legacy identifiers for all payors. If reporting a Medicaid number, include the associated State name (Florida). This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

- Contact your office practice management software vendors, billing agents, and clearinghouses to discuss any NPI changes or impacts.

NEW FLORIDA MEDICAID MANAGEMENT INFORMATION SYSTEM AND FISCAL AGENT

Following extensive research, analysis, and evaluation of proposals, Florida Medicaid has contracted with Electronic Data Systems (EDS) to design and implement a new, state-of-the-art computer system for claims processing, eligibility verification, provider enrollment, and Medicaid program management. EDS will operate the new Medicaid Management Information System (MMIS) starting March 1, 2008, for a five-year contract period as the state's fiscal agent.

The new system will offer more web-based features for providers and recipients. Look for updates and training opportunities over the next several months.

PHASE 1 OF THE HIPAA ONLY TRANSACTION PROJECT - FLORIDA MEDICAID NOW ACCEPTING STANDARD HIPAA COMPLIANT CLAIMS TRANSACTIONS

Effective April 5, 2006, Florida Medicaid discontinued the contingency plan for the submission of electronic claims. With the exception of Medicaid Crossover and Public Transportation claims, Florida Medicaid now accepts only standard HIPAA compliant claims transactions (X12N 837 transactions). This conversion to HIPAA compliant Florida Medicaid electronic claims submissions was not optional. Florida Medicaid now requires electronic submission of claims in the standard HIPAA format and no longer accepts electronic claim submissions in proprietary formats. Failure to submit electronic claim transactions in the proper format will result in denial of your claims. Your compliance is required to ensure that you are paid appropriately.

ACS, our Medicaid Fiscal Agent, continues to provide enhanced support to your efforts to become HIPAA compliant. Florida Medicaid expects each submitter's full cooperation with the Agency for Health Care Administration (AHCA) and ACS in this effort. The following ACS resources continue to be available to you:

- If you are a user of the ACS “WINASAP” and “ASAP-LTC” (2000) products, you can obtain, at no charge, the updated version of WINASAP (2003) from the ACS web site at http://floridamedicaid.acs-inc.com. The loading instructions are self-explanatory. You may contact ACS at 1-800-289-7799 to schedule a training session with an ACS Field Representative or if you have general billing questions. You may also contact your local Medicaid area office for referrals for ACS assistance. If you need assistance with the loading instructions or general questions about the software, please call the ACS EDI Call Center at 1-800-829-0218.

- Clearinghouses, billing agents, and software vendors will need to contact the ACS EDI Call Center to establish an ID and initiate testing. The EDI staff can be reached at 1-800-829-0218 and will be ready to provide support for the modification of existing claims-submission software and management systems, and support for the submission of electronic X12N 837 claims.

- Providers submitting claims through a clearinghouse, billing agent, or vendor will need to contact the submitting organization and work directly with them.

PHASE 2 OF THE HIPAA ONLY TRANSACTION PROJECT — FLORIDA MEDICAID TO BEGIN ACCEPTING STANDARD HIPAA COMPLIANT CLAIMS FOR ALL OTHER TRANSACTIONS

Effective July 1, 2006, Florida Medicaid will discontinue the contingency plan for the submission of all other electronic transactions (270/271, 276/277, 834 and 278). Submitters, providers and switch vendors must submit compliant transactions. Due to notification requirements, HMOs will continue to submit proprietary transactions until August. This conversion to HIPAA compliant Florida Medicaid electronic submissions is not optional. Florida Medicaid now requires electronic submission of standard HIPAA format and will no longer accept electronic submissions in proprietary formats. Failure to submit electronic transactions in the proper format will result in denial of your transaction. Your compliance is required to ensure that you are paid appropriately.

HIPAA AND OTHER FEDERAL REGULATIONS

The Department of Health and Human Services (HHS) has published its semi-annual agenda that identifies regulatory actions it intends to take. Several of the upcoming actions will affect HIPAA requirements and efforts to build a national health information network.

Deadlines for anticipated actions may change slightly. The regulatory agenda, however, gives a preview of certain issues that are HHS priorities. The regulating agenda may also indicate which issues are on hold, postponed, or withdrawn. For instance, the long-awaited proposed rule for a national payer identifier - mandated under HIPAA and finally expected early this year—has been withdrawn.

Other items of interest to the health care information technology industry include:

- August 2006 - The Centers for Medicare and Medicaid Services (CMS) anticipates publishing a detailed notice to describe data that will be available from the National Plan and Provider Enumeration System. The notice, with a comment period, will describe the Agency's data dissemination strategy, processes and applicable charges.

- August 2006 - A proposed rule from the Food and Drug Administration would require standard-based electronic submission of data regarding drug and biological studies. These include electronic submission of data to support new drug applications, biological license applications, and abbreviated new drug applications, plus their supplements and amendments.

- October 2006 - The HHS Office of Inspector General expects to publish a final rule establishing a safe harbor to anti-kickback laws permitting hospitals and others to assist physician practices in adopting information technology. But an accompanying final rule from CMS to give similar exceptions in the Stark Act regulating physician referral practices is not slated until October 2008. However, both rules should be out this year.

- January and February, 2007 - Proposed rules making periodic revisions to HIPAA transactions and code sets are expected.

- September 2008 - A final rule establishing standards for electronic claims attachments is expected. That would be three years following publication of the proposed rule.

The HHS semi-annual regulatory agenda is available in the April 24 issue of the Federal Register, at http://www.gpoaccess.gov/fr/index.html.

MEDICAID COVERAGE FOR ALIENS

Aliens granted lawful temporary resident status, or lawful permanent resident status under sections 245A, 210, or 210A of the Immigration and Nationality Act, who are not in one of the exempt groups and who meet all other requirements for Medicaid will be eligible for emergency services. Aliens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of the law must receive emergency services.

Emergency services are defined as those services required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably result in serious jeopardy to the patient's health or serious impairment to bodily functions or serious dysfunction of bodily organs or part. Labor and delivery services to pregnant women and dialysis services are considered emergencies, and therefore, covered for non-citizens.

Alien claims, except those submitted for payment of labor, delivery, and dialysis services, as noted above, are subject to medical review. Documentation submitted with the claim form must describe the medical condition that constituted the emergency and the treatment provided to alleviate or resolve the emergency. A copy of the emergency room report, physician consults and progress notes are necessary for medical review. Claims with place of service 11 (office setting) or 22 (outpatient hospital) must also be submitted to Medicaid with documentation supporting the emergency situation. Claims for labor, delivery, and dialysis can be submitted without documentation for automatic payment.

FLU VACCINE COVERAGE FOR 2005-2006 SEASON

Beginning December 8, 2005, when Vaccine for Children stock was unavailable, Florida Medicaid reimbursed physician providers who used influenza vaccine from their private stock to immunize Medicaid eligible recipients. Claims submitted for recipients 0-18 years of age identified with high-risk conditions as noted on the Vaccine Information Sheet (dated October 20, 2005), must be submitted with medical documentation identifying the high-risk factor and the use of private stock. Claims should be submitted within one year from the date of service on the CMS-1500 form using CPT code 90749. Without adequate documentation, these claims will be denied. These claims must be submitted to:

Agency for Health Care Administration
Bureau of Medicaid Services
2727 Mahan Drive, Mail Stop #20
Tallahassee, Florida 32308
ATTENTION: Immunization Coordinator

Reimbursement for code 90749 is $24.64 for physicians, $22.64 for Advanced Registered Nurse Practitioners (ARNPs) and Physician Assistants (PAs), and $19.64 for county health departments and federally qualified health centers. Medicaid will continue coverage for Medicaid eligible recipients, 19-20 years of age, utilizing the –HA modifier.

FluMist is not covered through the Vaccine for Children Program. Therefore, Medicaid reimburses for the cost of the vaccine and the administration fee using CPT code 90660 for Medicaid eligible recipients ages 5-20. This vaccine is not recommended for ages less than five. Reimbursement is $28.98 for physicians, $26.98 for ARNPs and PAs, and $23.98 for county health departments and federally qualified health centers. The Florida Medicaid Prescribed Drug Program provides coverage for the inactivated influenza vaccine for all Medicaid eligible recipients regardless of age.

MEDICAID ORGAN TRANSPLANT COVERAGE

Organ and bone marrow transplant services are performed by a specialized transplant physician or team of physicians in an Agency for Health Care Administration (AHCA) Medicaid-designated transplant hospital. These services are for the purpose of replacing a vital solid organ or bone marrow that is no longer functional with an organ or bone marrow from a human donor.

All transplants must be accepted by leading authorities as a standard medical practice for the diagnosis of the patient. Medicaid reimbursement is not available for any transplant that is in the research and investigational phase, or if the transplant protocol contains experimental or non-Food and Drug Administration approved medications.

Solid organ and bone marrow transplantation reimbursement guidelines are based on Medicare acceptance criteria, the United Network of Organ Sharing (UNOS) criteria, and the bone marrow transplant guidelines established in Florida Administrative Code 59B-12.001. These criteria have been adopted as coverage and reimbursement guidelines by the Medicaid Organ Transplant Advisory Council (OTAC).

For recipients of ages 20 and younger, Medicaid covers transplants that are determined medically necessary and appropriate by the Medicaid medical consultant and the OTAC council. Pediatric lung transplants are reimbursed by global payment and require prior authorization. Recipients of ages 20 and under should be enrolled in Children's Medical Services (CMS) for case management and assistance.

For recipients of ages 21 and over, Medicaid covers kidney, heart, lung, liver, cornea and bone marrow transplants that are determined medically necessary and appropriate by the Medicaid medical consultant and the OTAC council. Adult heart, liver, and lung transplants are reimbursed by global payment and require prior authorization.

Transplant services must be performed at one of the AHCA-designated transplant facilities listed below. A prior authorization process is available for out-of-state services when the requested transplant cannot be performed at a Florida designated transplant facility.

HOSPITAL	PEDIATRIC		ADULT
All Children's Hospital	Heart, Kidney, BMT-auto/allo		
Florida Hospital Medical Center	Kidney, BMT--auto		Kidney, BMT-auto
H. Lee Moffitt Cancer Center			BMT-auto/allo
Halifax Medical Center			BMT-auto/allo
Jackson Memorial Hospital	Heart, Kidney, Liver, BMT-auto/allo		Heart, Kidney, Liver, BMT-auto/allo
Jackson Memorial Hospital Liver Transplant Program @ Broward General Medical Center			Liver
Miami Children's Hospital	BMT-auto/allo		
Shands Hospital at the University of Florida	Heart, Kidney, Liver, Lung, BMT-auto/allo		Heart, Kidney, Liver, Lung, BMT-auto/allo
Shands Jacksonville/University Medical Center			BMT-auto
Wolfson Children's Hospital	BMT-auto/allo		
St Luke's Hospital			Heart, Liver
Tampa General Hospital			Heart, Liver

INDIVIDUAL PRACTITIONER BILLING REMINDER

When a provider entity enrolls in the Medicaid program, a provider number is issued to the entity that signed the agreement with Medicaid. A provider's unique Medicaid identification number cannot be utilized by any other person or entity. The individual whose provider number appears on the claim form assumes responsibility for the services reported and billed. The provider receiving payments from Medicaid must verify that all claims billed under his unique provider number are correct, accurate, and that documentation is maintained in the recipient's records to support the service(s) rendered and billed.

Individual Medicaid providers may not bill, or receive reimbursement, for services provided by other Medicaid providers, except in the following situations:

- When one or more enrolled providers form a group and the group is the pay-to-provider, or
- When direct supervision by a physician is allowed, and the physician has directly supervised the service(s) billed.

When more than one Medicaid-enrolled provider forms a group, the group's Medicaid provider number becomes the pay-to-provider. Medicaid payment is made to the group provider number. Individual members in the group are the treating providers and cannot receive direct payment from Medicaid for the services billed under the group provider number. All providers affiliated with group practice(s) must have individual Medicaid identification numbers and be enrolled as members of any group practice(s) under which they bill Medicaid for services.

NON-CLASSIFIED DRUGS BILLING REQUIREMENTS FOR J3490, J3590, AND J9999

When billing for J3490, J3590 and J9999 on the CMS-1500 claim form, Medicaid providers must identify the drug for reimbursement. The following information must be provided in the medical documentation attached to the claim form: a diagnosis, the name of the drug administered, the dosage of the drug, and the route of administration for the drug on the date of service. The documentation must be signed by the physician or nurse who provided the service. Without adequate documentation, claims will be denied with edit 909 (Claim Requires Documentation).

Reimbursement is based on the lesser of the average wholesale price, less 15.4%, or wholesale acquisition cost, plus 5.75%. Straight Medicaid claims must be sent to the Medicaid fiscal agent.

When billing Medicare crossover claims for reimbursement of the drugs noted above, the Medicare EOMB must be attached to the claim. These Medicare crossover claims must be mailed to:

Agency for Health Care Administration
Bureau of Medicaid Services
2727 Mahan Drive, Mail Stop #20
Tallahassee, Florida 32308
ATTENTION: Injectable Medications Program

PRIOR AUTHORIZATION FOR OUT-OF-STATE SERVICES

A Florida attending or specialist physician may refer a Medicaid recipient for medical treatment to an out-of-state hospital when medically necessary services requiring a level of medical expertise or sophistication of treatment are only available in out-of-state medical centers. Prior authorization must be obtained before the recipient receives services in an out-of-state facility.

The Florida physician requesting prior authorization for an out-of-state referral must certify in writing to the Medicaid office that the necessary treatment is not available in Florida. This document must accompany the physician's prior authorization request (PA 01 Form) for referral to an out-of-state facility. The physician must attach documentation to the prior authorization request that justifies the need for the service, such as medical history, lab reports, or other appropriate medical documents. The request must include the following:

- Name and address of the out-of-state facility; and
- Name and telephone number of the out-of-state facility's contact person.

The physician must send the completed prior authorization package to:

Agency for Health Care Administration
Bureau of Medicaid Services
Medicaid Prior Authorization Unit
2727 Mahan Drive, Mail Stop #20
Tallahassee, Florida 32308

The state Medicaid consultant will review and approve or deny the request. Approved authorizations are valid for three months from the date of the approval. The Prior Authorization Unit will notify the requesting provider of the decision in writing.

Florida Medicaid does not provide reimbursement for any non-prior authorized out-of-state service, except for treatment of emergencies encountered by recipients traveling outside the State of Florida.

THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION COVERAGE FOR CPT CODES 90772-90775

Effective July 1, 2006, Medicaid will provide coverage for CPT codes 90772-90775 with place of service 11 (office) only. Reimbursement for physician providers will be as follows: 90772 - $10.18, 90773 - $10.39, 90774 - $31.59, 90775 - $14.76. CPT code 90772 should not be used when injection is given without direct physician supervision.

Hospitals

HOSPITAL OUTPATIENT BILLING WITH THIRD PARTY CONTRACTED RATE

Articles carrying this graphic contain important Medicaid Provider Handbook Information.

As detailed in section 59G-7.056, Florida Administrative Code, if a hospital provider enters into a contract with a third party (e.g., an HMO or PPC) that stipulates the provider agrees to accept, as full payment, an amount less than its customary charges, Medicaid provides medical assistance only to the extent that there remains liability to the patient under the contract, such as a copayment or deductible, and only if the third party's payment plus Medicaid's payment does not exceed Medicaid's allowable reimbursement.

When the contract's allowable reimbursement is **less** than Medicaid's allowable reimbursement, the provider should follow the instructions below when completing the UB-92 claim form:

1. Compute the amount of patient responsibility (deductible, coinsurance, etc.).
2. Deduct this amount from the Medicaid rate.
3. Show the resulting amount as the third party payment in FL 54A.

If the EOB is not itemized for an outpatient claim, you must prorate the third party's contract allowable, the TPL payment, and the patient responsibility for each line item in Form Locator 48 using the steps above. An Excel worksheet is available to assist you. You may request an electronic copy of the Excel worksheet from your Area Medicaid Office.

To illustrate, let's use Figure A as our sample Explanation of Benefits (EOB) from the third party for an outpatient claim for date of service 03/31/06.

FIGURE A: Example of the EOB for the Prorated Outpatient Claim with Contractual Third Party Payment when the Contracted Payment Rate Is Less than the Medicaid Maximum Fee

EXPLANATION OF BENEFITS

Stanmark
121 TPL Street
Everywhere, FL 99999

NAME/ID
FLORIDA, RESIDENT A.
PATIENT NO. A1593237

PARTICIPATING EMPLOYER
YUMY SEAFOODS, INC
GROUP NO. 19191

DATE: 05/16/06

ABC Hospital
444 Payment Street
Anywhere, FL 33333

CHECK DESTINATION	
ABC HOSPITAL	1920.01
TOTAL	1920.01

DATES OF SERVICE-PROVIDER/SERVICE	AMOUNT CHARGED	AMOUNT INELIGIBLE	DISCOUNT	AMOUNT COVERED	ENCOUNTER FEE	DEDUCTIBLE	COINSURANCE	BENEFIT	CODE
	1	2	3	4=1 2 3	5	6	7	8=4 5 6 7	
3/31—3/31/06: ABC Hospital Hospital Outpatient	2227.61	0.00	0.00	2227.61	0.00	94.27	213.33	1920.01	
3/31—3/31/06: ABC Hospital Hospital Discount	742.54	0.00	742.54	0.00	0.00	0.00	0.00	0.00	CO
TOTALS	2970.15	0.00	742.54	2227.61	0.00	94.27	213.33	1920.01	

OTHER COVERAGE	0.00
ADJUSTMENTS	0.00
AMOUNT OF PAYMENT	1920.01

EXPLANATION OF CODES

MS 2, 6, 6 & 7 MAY BE BILLED TO PATIENT
0 DISCOUNTED RATE NEGOTIATED WITH THE PROVIDER
PATIENT IS NOT RESPONSIBLE FOR THIS AMOUNT.

(continued on next page)

HOSPITAL OUTPATIENT BILLING WITH THIRD PARTY CONTRACTED RATE

(continued from previous page)

Figure B is a blank copy of the Excel worksheet. (Figure C shows the completed Excel worksheet.) Simply fill in the shaded portions of the Excel worksheet and the calculations will be completed for you. Based on the sample EOB (Figure A), the total third party payment is $1920.01, the total provider charge is $2970.15, and the patient responsibility is $307.60. After entering these figures into the top portion of the worksheet, move to the shaded column labeled "CHARGE" and enter your facility's charge for each line item (the same figures reported in Form Locator 47 of the UB-92 claim form). You will notice as you enter each line item that the worksheet automatically calculates for you.

Next, in the shaded column labeled "MEDICAID ALLOWED," enter the allowable amounts for each line item based on Medicaid fee schedules or the facility's outpatient per diem rate. We'll assume this facility's outpatient per diem is $87.05. You will notice as you enter each line item that the worksheet automatically updates the calculated payment and the amount Medicaid will pay if updates are warranted.

Figure B

TOTAL TPL PAYMENT (TTP) =	1.00
TOTAL PROVIDER CHARGE (TPC) =	1.00
PATIENT RESPONSIBILITY (PR) = Deductible + Co-Insurance =	1.00
PRORATED PERCENTAGE COMPUTATION	
CONTRACTS ALLOWABLE (CA%) = (TTP + PR) / TPC =	2
TPL (TP%) = TTP / TPC =	1
PATIENTS RESPONSIBILITY (PR%) = PR / TPC =	1

	from claim	CHG X CA%	CHG X TP%	from FMMIS/Fee Schedules	CHG X PR%	see A	
LINE	(CHG) CHARGE	CONTRACT ALLOWED	TPL PAID	MEDICAID ALLOWED	PATIENT RESPONSIBILITY	CALCULATED PAYMENT	MEDICAID PAYS
1		0.00	0.00		0.00	0.00	0.00
2		0.00	0.00		0.00	0.00	0.00
3		0.00	0.00		0.00	0.00	0.00
4		0.00	0.00		0.00	0.00	0.00
5		0.00	0.00		0.00	0.00	0.00
6		0.00	0.00		0.00	0.00	0.00
7		0.00	0.00		0.00	0.00	0.00
8		0.00	0.00		0.00	0.00	0.00
9		0.00	0.00		0.00	0.00	0.00
10		0.00	0.00		0.00	0.00	0.00
11		0.00	0.00		0.00	0.00	0.00
12		0.00	0.00		0.00	0.00	0.00
13		0.00	0.00		0.00	0.00	0.00
14		0.00	0.00		0.00	0.00	0.00
15		0.00	0.00		0.00	0.00	0.00
16		0.00	0.00		0.00	0.00	0.00
17		0.00	0.00		0.00	0.00	0.00
18		0.00	0.00		0.00	0.00	0.00
19		0.00	0.00		0.00	0.00	0.00
20		0.00	0.00		0.00	0.00	0.00
21		0.00	0.00		0.00	0.00	0.00
	FL 47					FL 48	FL 49

TOTAL CALCULATED PAYMENT (Line 54A)	0.00
TOTAL ANTICIPATED MEDICAID PAYMENT	0.00

A. IS **MEDICAID-ALLOWED** MORE THAN **CONTRACT-ALLOWED**?

NO TREAT AS NORMAL TPL AND ENTER **TPL-PAID** IN **CALCULATED-PAYMENT** FIELD

YES DEDUCT **PATIENT-RESPONSIBILITY** FROM THE **MEDICAID-ALLOWED** AND ENTER THE RESULT IN THE **CALCULATED-PAYMENT** FIELD

Figure C

TOTAL TPL PAYMENT (TTP) =	1,920.01
TOTAL PROVIDER CHARGE (TPC) =	2,970.15
PATIENT RESPONSIBILITY (PR) = Deductible + Co-Insurance =	307.60
PRORATED PERCENTAGE COMPUTATION	
CONTRACTS ALLOWABLE (CA%) = (TTP + PR) / TPC =	0.75
TPL (TP%) = TTP / TPC =	0.65
PATIENTS RESPONSIBILITY (PR%) = PR / TPC =	0.1

	from claim	CHG X CA%	CHG X TP%	from FMMIS/Fee Schedules	CHG X PR%	see A	
LINE	(CHG) CHARGE	CONTRACT ALLOWED	TPL PAID	MEDICAID ALLOWED	PATIENT RESPONSIBILITY	CALCULATED PAYMENT	MEDICAID PAYS
1	6.25	4.69	4.06	0.00	0.63	4.06	0.00
2	52.00	39.00	33.80	2.00	5.20	33.80	0.00
3	91.25	68.44	59.31	5.00	9.13	59.31	0.00
4	74.00	55.50	48.10	6.00	7.40	48.10	0.00
5	27.00	20.25	17.55	3.00	2.70	17.55	0.00
6	63.00	47.25	40.95	4.50	6.30	40.95	0.00
7	289.90	217.43	188.44	7.67	28.99	188.44	0.00
8	19.75	14.81	12.84	1.50	1.98	12.84	0.00
9	25.25	18.94	16.41	3.00	2.53	16.41	0.00
10	155.75	116.81	101.24	87.05	15.58	101.24	0.00
11	8.00	6.00	5.20	87.05	0.80	86.25	0.80
12	26.00	19.50	16.90	87.05	2.60	84.45	2.60
13	5.00	3.75	3.25	87.05	0.50	86.55	0.50
14	246.25	184.69	160.06	87.05	24.63	160.06	0.00
15	573.00	429.75	372.45	87.05	57.30	372.45	0.00
16	26.00	19.50	16.90	48.81	2.60	46.21	2.60
17	660.00	495.00	429.00	87.05	66.00	429.00	0.00
18	153.25	114.94	99.61	87.05	15.33	99.61	0.00
19	383.50	287.63	249.28	87.05	38.35	249.28	0.00
20	85.00	63.75	55.25	87.05	8.50	78.55	8.50
21		0.00	0.00		0.00	0.00	0.00
	FL 47					FL 48	FL 49

TOTAL CALCULATED PAYMENT (Line 54A)	2215.11
TOTAL ANTICIPATED MEDICAID PAYMENT	15.00

A. IS **MEDICAID-ALLOWED** MORE THAN **CONTRACT-ALLOWED**?

NO TREAT AS NORMAL TPL AND ENTER **TPL-PAID** IN **CALCULATED-PAYMENT** FIELD

YES DEDUCT **PATIENT-RESPONSIBILITY** FROM THE **MEDICAID-ALLOWED** AND ENTER THE RESULT IN THE **CALCULATED-PAYMENT** FIELD

Once the worksheet is completed, list the figures from the column labeled "CALCULATED PAYMENT" in Form Locator 48 of the UB-92. List the figures from the column labeled "MEDICAID PAYS" in Form Locator 49 of the UB-92. Enter the TOTAL CALCULATED PAYMENT in Form Locator 54A of the UB-92. The TOTAL ANTICIPATED MEDICAID PAYMENT is calculated on the worksheet for your information only. This amount does not need to be entered on the UB-92.

The result is the UB-92 claim form represented by Figure D (next page).

If you have questions about third party billing, you may contact the Medicaid third party contractor by phone, toll free, at 1-877-446-7868, by fax at (850) 656-9271, or by mail at this address:

Health Management Systems, Inc.
2002 Old St. Augustine Road, Suite E-42
Tallahassee, FL 32301

Note: The sample in the Provider Reimbursement Handbook, UB-92, will be updated to match the one in this article.

HOSPITAL OUTPATIENT BILLING WITH THIRD PARTY CONTRACTED RATE

(continued from previous page)

FIGURE D: Example of a Prorated Outpatient Claim with Contractual Third Party Payment when the Contracted Payment Rate Is Less than the Medicaid Maximum

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

ABC Hospital
123 Palm Street
Anywhere, FL 33333

2 FC210

3 PATIENT CONTROL NO.

4 TYPE OF BILL: 131

5 FED. TAX NO.: 581234567

6 STATEMENT COVERS PERIOD FROM: 033106 THROUGH: 033106

7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: Resident, Florida A.

13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	17 DATE (ADMISSION)	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24–30	31
02041962	F	S	033106	05	3	3	14	01			

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
11	031506	A1	020462	B1	020462						

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	30	804.15				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0300	Laboratory	G0001		1	6.25	4.06	0
2	0300	Laboratory	81003		1	52.00	33.80	0
3	0300	Laboratory	81025		1	91.25	59.31	0
4	0300	Laboratory	85025		1	74.00	48.10	0
5	0300	Laboratory	85610		1	27.00	17.55	0
6	0300	Laboratory	85730		1	63.00	40.95	0
7	0301	Lab/Chemistry	88147		1	289.90	188.44	0
8	0301	Lab/Chemistry	81015		1	19.75	12.84	0
9	0301	Lab/Chemistry	85007		1	25.25	16.41	0
10	0324	DX X-Ray Chest	71020		1	155.75	101.24	0
11	0251	Drugs/Generic			1	8.00	86.25	.80
12	0258	IV Solutions			1	26.00	84.45	2.60
13	0259	Pharmacy Other			1	5.00	86.55	.50
14	0270	Medical Sur. Supplies			5	246.25	160.06	0
15	0272	Sterial Supplies			25	573.00	372.45	0
16	0310	Path Lab	88307		1	26.00	46.21	2.60
17	0360	OR Services	57520		3	660.00	429.00	0
18	0370	Anesthesia Supplies			1	153.25	99.61	0
19	0710	Recovery Room			3	383.50	249.28	0
20	0760	Treatment Room				85.00	78.55	8.50
21								
22								
23	0001	TOTAL CHARGES				2970.15		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Florida Health Network	24680	Y	Y	2215.11		
B	Medicaid	0199999999	Y	Y			
C							

57 DUE FROM PATIENT ▶

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Resident, Florida A.	01	A1593237		
B	Resident, Florida A.	01	0987654321		
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A	12345			
B	123456789			
C				

67 PRIN. DIAG. CD.: 233.1 | 68 CODE | 69 CODE | 70 CODE | 71 CODE | 72 CODE | 73 CODE | 74 CODE | 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C.: 9 | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE CODE / DATE (A, B, C, D, E)

82 ATTENDING PHYS. ID: ME 7777777

83 OTHER PHYS. ID: A ME 8888888; B

84 REMARKS

85 PROVIDER REPRESENTATIVE: X Sue Smith

86 DATE: 05/06/06

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SCORING THE INITIAL ASSESSMENT FORM FOR ORTHODONTIC COVERAGE/SERVICES

The Initial Assessment Form (IAF) is a tool for orthodontic providers to use as a guide to determine whether a recipient is eligible for Medicaid coverage of orthodontic services. The IAF assists the provider in determining whether a prior authorization (PA) request should be sent to Medicaid for review and approval of orthodontic services. The form provides a means by which the orthodontist communicates to Medicaid all the distinctive details pertaining to an individual case.

The conditions listed in the IAF should be considered in the context of whether they contribute to a disabling malocclusion. The provider must circle the applicable conditions and total the recipient's index score. A score of less than 26 but greater than 12 indicates that treatment of the recipient's condition may not qualify for Medicaid reimbursement, and the request for prior authorization may be denied. A score of less than 12 indicates that orthodontic treatment will most likely be denied.

The following clarifies the scoring for mandibular protrusion and the labio-lingual spread:

- Mandibular Protrusion in Millimeters: Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. The measurement is entered on the scoresheet and multiplied by five (5). A reverse overbite, if present, should be shown under "overbite."

- Labio-Lingual Spread: Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labio-lingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the index.

Special or mitigating circumstances, such as deep bites with palatal trauma or occlusion-related temporomandibular joint dysfunction (TMD) should be described in detail.

Please refer to the Florida Medicaid Dental Services Coverage and Limitations Handbook, January 2005 edition, pages 2-15 and 2-16 for more information on the Initial Assessment Form.

BEHAVIOR MANAGEMENT IN PEDIATRIC DENTISTRY

The American Academy of Pediatric Dentistry defines behavior management as "…a continuum of interaction with a child or parent directed toward communication and education." Florida Medicaid covers behavior management when provided to recipients under age 21, who present a management problem that must be controlled by extraordinary means. Reimbursement for behavior management is limited to recipients who are developmentally disabled or recipients who are uncooperative and difficult to manage.

When billing Medicaid for behavior management, the specific nature of the recipient management problem and the technique utilized must be documented in a written report attached to the paper claim billed with procedure code D9920. Behavior management must be billed in conjunction with diagnostic, preventive or treatment codes on the same date of service. The report must be submitted on the Medicaid Behavior Management Report Form.

Medicaid does not reimburse for behavior management when:

- Billed routinely every time the recipient visits the office; or
- Billed with either sedation or analgesia on the same date of service.

Please refer to the Florida Medicaid Dental Services Coverage and Limitations Handbook, January 2005 edition, page 2-5, for more information on behavior management, and Appendix F for the Medicaid Behavior Management Report Form.

REMINDER TO CHILD HEALTH CHECK-UP (CHCUP) PROVIDERS:

- Federal regulation requires that all Medicaid children receive a screening blood lead test at 12 months and 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. The procedure code for blood lead testing is 83655. This is explained in the Medicaid CHCUP Coverage and Limitations Handbook, October 2003, page 2-13; 2-14; and page 3-6. There is the potential for recoupment if medical record audits indicate that a screening blood lead test has not been done.

- CHCUP providers may only bill for one visit, a CHCUP or a sick visit per day, per Medicaid child, per provider. Provider discretion in evaluating the degree of illness should determine if a Child Health Check-Up should be performed. This is explained in the Medicaid CHCUP Coverage and Limitations Handbook, October 2003, page 2-3. There is the potential for recoupment if medical record audits indicate that a provider has been reimbursed for a CHCUP and a sick visit on the same day, for the same child.

- A CHCUP referral code is required on the claim form in order to be reimbursed for a CHCUP. This is explained on page 16 of this Bulletin per claim format.

- It is critical that the federally required Referral Code be appropriate for the Diagnosis Code on Child Health Check-Ups. For example, a diagnosis code of V20.2 (routine infant or child health check) would be appropriate with a referral code “U” or “NU” (complete normal/no referral). A diagnosis code of V20.2 (routine infant or child health check) is not appropriate with a referral code of “T” or “ST” (abnormal, patient referred). For the required referral codes see page 16 of this Bulletin per claim format.

- CHCUP providers are responsible for referrals and follow-up on a Medicaid child as a result of a CHCUP. This is referenced in the Medicaid CHCUP Coverage and Limitations Handbook, October 2003, page 2-2.

CHILD HEALTH CHECK-UP (CHCUP)

The Child Health Check-Up (CHCUP) claim is now billed on a physician claim form. CHCUP is referred to as EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) in national publications. The CHCUP procedure code is entered on one line and any other services provided can be entered on subsequent lines. CHCUP claims can only be billed in the following formats: CMS-1500, NSF, X12N 837P, or WINASAP 2003, Professional.

	CHCUP Indicator	CHCUP Referral Code	Special Program Indicator
CMS-1500 Claim Form	**Box 24H** (EPSDT/Family Planning) – Enter "E" if service is a result of a CHCUP referral. (Used when service is not a CHCUP procedure code)	**Box 24H** (EPSDT/Family Planning) – Enter "**V**", "**U**", "**2**", or "**T**" (see table) for the referral code most applicable. (Use only when service is a CHCUP procedure code)	Not applicable
NSF Format	**FB0-22.0** (EPSDT Indicator) – Enter "Y" if service is a result of a CHCUP referral, "N" or space if not. (Used when service is not a CHCUP procedure code) To bill a CHCUP screening claim as a physician claim also complete these fields: BA0-03.0 Batch Type = 100 EA0-32.0 Diagnosis Code 1 = required (at least one diagnosis is required) FA0-14.0 Diagnosis Code Pointer 1 = required (at least one is required)	**FB0-22.0** (EPSDT Indicator) – Enter "**V**", "**U**", "**2**", or "**T**" (see table) for the referral code most applicable. (Use only when service is a CHCUP procedure code)	Not applicable
X12N 837P	**Loop 2400, Segment SV1, Element 11** (EPSDT Indicator) – Enter "Y" if service is a result of a CHCUP referral. (Used when service is not a CHCUP procedure code)	**Loop 2300, Segment CRC**, (EPSDT Referral), Element 03 (Condition Code) – Enter "**AV**", "**NU**", **S2**", or "**ST**" (see table) for the referral code most applicable. If CRC02 is "**N**", this value must be "**NU**" (Use only when service is a CHCUP procedure code)	**Loop 2300, Segment CLM, Element 12** (Special Program Code) – Enter "01" if any line item in the transaction contains a service that is a CHCUP procedure code.
WINASAP 2003, Professional Claim	**Claim Line Items Tab**, Miscellaneous Indicators button, Other Indicators. Was the service a result of a screening referral? – Check "Yes" if service is a result of a CHCUP referral. (Used when service is not a CHCUP procedure code)	**Claim Information Tab**, EPSDT Info button – Check "Yes" for Certification Condition Indicator. Select from the list of conditions which appear in the drop down list: "Available-Not Used" "Under Treatment" "New Service Requested" Do not check the Certification Condition Indicator when selecting "Not Used" from the conditions drop down list. (Use only when service is a CHCUP procedure code)	**Claim Codes Tab**, Special Program Indicator Code – Select "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Child Health Assessment Program" from the drop-down list if any line item in the transaction contains a service that is a CHCUP procedure code.

CHCUP Procedure Codes (as of 10/16/03)

HCPC	Modifier	HCPC	Modifier
99381		99391	
99382		99392	
99383		99393	
99384		99394	
99385	EP	99395	EP

Referral Codes

Referral Code	Description
AV	Patient Refused Referral (Available, Not Used)
NU	Not Used (Patient Not Referred)
S2	Under Treatment (For referred diagnostic or corrective health problem)
ST	New Services Requested (Abnormal, Patient Referred to another provider for diagnostic or corrective treatments or scheduled for another appointment with check-up provider for diagnostic or corrective treatment for at least one health problem identified during a Child Health Check-Up, not including dental referrals)