



FLORIDA MEDICAID PROVIDER BULLETIN

Fall 2006

Volume VI, Issue 4

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VERIFYING ELIGIBILITY UNDER MEDICAID REFORM



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

Enrollment of beneficiaries residing in Duval and Broward County into Reform health plans began September 1, 2006. Eligible Medicaid beneficiaries will be transitioned into the Reform health plans over a seven month period. Some beneficiaries will continue their care with their current provider(s) who participate in the Reform health plan chosen by the beneficiary. In other cases, beneficiaries will receive care from new providers due to the fact that their current provider(s) does not participate in the Reform health plan network chosen by the beneficiary.

The process for filing claims for services provided to beneficiaries enrolled in Reform health plans will be different than the process currently utilized for reimbursement by Medicaid under fee for service. In order to be reimbursed for services provided to beneficiaries enrolled in Reform health plans, it is critical that all providers verify Medicaid eligibility prior to rendering services. Enrollment in a Medicaid Reform health plan will be designated by the codes "S" and "H". The managed care indicator provided via the Medicaid Eligibility Verification System (MEVS) will be an "S" if the beneficiary is enrolled in a Provider Service Network or an "H" if the beneficiary is enrolled in a Health Maintenance Organization. You will also be able to see the plan that the beneficiary is enrolled in. The names and phone numbers of the plans will also be provided via the eligibility verification system.

If as a result of the eligibility verification process, you find that you are not part of a plan's network, you will need to contact the plan to obtain provisions for transitional care, authorization, and payment for "out of network" services.

For more information about Medicaid Reform visit <http://ahca.myflorida.com>.

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

All Providers

CONSOLIDATION OF BANK ROUTING NUMBERS

SunTrust Bank is in the process of consolidating all the bank routing numbers to one number. If your bank has not already advised you of a change in your American Bankers Association (ABA) routing number, it is still possible that this initiative may affect your provider Automated Clearing House (ACH) payment from Florida Medicaid. We also suspect there is a possibility that other National and Regional Banks may follow this initiative.

What does this mean to you as a provider? In the event that your bank advises the Florida Medicaid Program of a change in ABA routing numbers for your individual banking account, Florida Medicaid will automatically make the necessary changes to your Electronic Funds Transfer (EFT) information. When this change occurs, your provider payment will automatically be defaulted to paper checks for two payment cycles. Your paper check will be mailed to the current payment address on file with ACS.

As a precautionary measure, we strongly urge providers to call the Florida Medicaid Provider Enrollment line at 1-800-377-8216 to verify your current payment address on file is in fact valid before this potential change occurs. Otherwise, your provider payment may be delayed.



GROUP AND TREATING PROVIDER ENROLLMENT

Providers with more than 15 group affiliations will no longer need to obtain additional individual provider numbers to accommodate large numbers of group affiliations. Medicaid has expanded the maximum number of affiliations from 15 to 99 groups per treating provider number.

Proper reimbursement will continue to depend on the correct reporting of group affiliations. Medicaid provider enrollment policy requires group providers to report the addition of new members by submitting a *Group Provider Application for Individual Membership in a Group* to the Medicaid fiscal agent. Treating providers may use letterhead stationary to request removal from a group. Applications for membership or letterhead requests for removal should be sent to the Medicaid fiscal agent, ACS Government Healthcare, at:

ACS – Florida Medicaid
Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070

Additional information can be obtained by contacting ACS, the Medicaid fiscal agent, at 1-800-377-8216.



NATIONAL PROVIDER IDENTIFIER (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires 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 identifiers. After May 23, 2007, the NPI must be used on all HIPAA mandated transactions.

A web registration site has been developed by Florida Medicaid and its contractor, Brandt Information Services, Inc., for providers to use when registering their NPI with Florida Medicaid. The web site is located at: <https://floridamedicaidnpi.com/>. Information regarding NPI is available to all users of the site in the form of Frequently Ask Questions (FAQs).

All active providers will receive a letter by the end of November regarding their NPI registration. The initial mailing of NPI registration letters will be completed by the middle of November and will include a username and password. Registrants must use their assigned username/password combination to enter the secure registration area of the site. Providers having multiple Medicaid provider identifiers will receive a single letter based on the first seven digits of their provider identifier.

Florida Medicaid will utilize a crosswalk solution for linking the NPI (and other components if necessary) to one or more Medicaid provider identifiers. The registration web site allows the use of three crosswalk components; NPI, provider taxonomy, and 9-digit ZIP code to associate their NPI to the Florida Medicaid provider identifier. Institutional providers and group practices may need to consider obtaining additional NPIs for assignment to multiple Medicaid identifiers if they are unable to crosswalk all their Medicaid identifiers to a single NPI. Providers must consider all payers when developing their NPI strategy.

Providers are encouraged to use both their Florida Medicaid Provider ID and their NPI solution on all electronic transactions starting immediately. Florida Medicaid will internally test claims to insure that reimbursement is processed identically with both identifiers.

Claims submitted to Florida Medicaid using a National Provider Identifier 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/NationalProviderStand/>.
- Submit your NPI application NOW - the web site is <https://nppes.cms.hhs.gov>.
- Register your NPI on the Florida Medicaid web site at: <https://floridamedicaidnpi.com>.
- When applying for your NPI, CMS urges you to include your provider identifiers for all payors.
- When reporting a Medicaid provider identifier to the CMS enumerator, 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.

FILE NAMING CONVENTION FOR PROVIDER PUBLICATIONS



Florida Medicaid has developed a file naming convention that allows providers to verify that the version of the Florida Medicaid Coverage and Limitations Handbook, Reimbursement Handbook, and fee schedule in their possession is the most current for their practice or business. The new file naming convention was implemented in March 2006 and will apply to all new documents distributed by CD or web site download from that date forward.

The file naming convention was designed to utilize the Windows search feature. Medicaid providers, such as group practices or institutional providers requiring many Medicaid publications, are now able to search their computer for specific documents. For example, a search for "CL_*" would locate all versions of coverage and limitations handbooks that are stored on the user's computer.

An example and explanation of each component of the file naming convention is listed below.

Example: **GH_06_040101_Provider_General_ver1.0.pdf**

- **GH:** This code represents the type of document. e.g., GH = General Handbook, CL = Coverage and Limitations Handbook, RH = Reimbursement Handbook, FS = Fee Schedule, PN = Provider Notice.
- **06:** For AHCA use only.
- **040101:** Represents the effective date of the document in YYMMDD format. In this example, 040101 = January 1, 2004.
- **Provider General:** This component represents a keyword to identify the name of the document.
- **ver1.0:** This component represents the version number of the document. The version number will increment as new versions are created. This component may not apply to all publications.

Visit the ACS FL Medicaid web site, <http://floridamedicaid.acs-inc.com>, to confirm that the stored version of your files or CD contains the most current publications.



MEDICAID COVERAGE FOR ALIENS

Federal regulations allow states to reimburse for emergency services provided to Medicaid recipients who are “non-citizens,” also referred to as “aliens,” on a limited basis. Aliens are not eligible for full Medicaid benefits due to their status as non-citizens.

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 any bodily organ or part. Labor and delivery services to pregnant women and dialysis services are considered emergencies, and therefore, are covered for non-citizens.

Alien claims, except those submitted for payment of labor, delivery, and dialysis services, are subject to medical review. Claims with place of service 11 (office setting) or 22 (outpatient hospital) must be submitted to Medicaid with documentation supporting the emergency situation. Inpatient alien claims are reviewed and reimbursed up to the point of patient stabilization and are limited to the inpatient 45-day hospital limit.

Alien claims may only be submitted as paper claims and must have accompanying medical documentation supporting the emergency status of the patient. Claims are denied with edit 909, Claim Requires Documentation, if submitted without documentation or documentation that does not support an emergent situation.

Paper alien claims and medical records must be sent directly to ACS, the Medicaid fiscal agent, for processing. The Florida Medicaid Management Information System (FMMIS) scans the claims for appropriateness of claim entries. Error-free alien claims are suspended for edit 279, Alien Claim Requires Medicaid Review, and then forwarded to the Bureau of Medicaid Services for review of the emergency. If the hospitalization, emergency room visit, or other service is determined to be an emergency, the claim is approved and then paid by the fiscal agent. If the service or hospitalization is determined not to be an emergency, the claim is denied with edit 912, Denied after Medical Review, or other applicable medical review edit.

It is important that providers submit error-free alien claims in order to reduce claim processing time. Documentation must describe the medical condition that constituted the emergency and the treatment provided to alleviate or resolve the emergency. For laboratory and radiology reimbursement, a report must be submitted representing each CPT code billed, and the report must have the corresponding date and time. For reimbursement of physician hospital visits, physician progress notes must be submitted with the corresponding date of service. For anesthesia reimbursement, an anesthesia record must be submitted with the start and stop time of the anesthesia clearly indicated. Reimbursement for any service rendered is limited to emergencies only.

Inquiries regarding the status of submitted alien claims must be directed to the fiscal agent or to the local area Medicaid office.





NEW FMMIS AND FISCAL AGENT

In May 2006, the Agency for Health Care Administration (AHCA) signed a contract with Electronic Data Systems (EDS) to develop a new Medicaid computer system and serve as the State's fiscal agent for a five year span beginning March 1, 2008.

The new Medicaid system, referred to as the Florida Medicaid Management Information System/ Decision Support System (FMMIS/DSS), will replace the current system and bring a range of new capabilities to providers and recipients. A few highlights include:

- New Web portal functionality for recipients allowing online selection of health plans, increased access to information on benefit utilization and service records;
- Providers will also reap new benefits with online, real-time claims processing and resubmission for most claims, online provider enrollment and status, web submission of service authorizations and status, and eligibility inquiry;
- Computer Based Training (CBT) courses for topic specific training, available when it is needed and conveniently located on the web; and
- A new Pharmacy claims processing system provided by First Health Services.

Current information regarding the new FMMIS/DSS system can be found on AHCA's web site at: <http://ahca.myflorida.com/Medicaid/Procurement/index.shtml>.



FREE E-MAIL ALERT SERVICE FOR MEDICAID PROVIDERS



The Florida Medicaid program maintains an e-mail alert system to supplement the present method of receiving remittance banner messages. A subscription to the E-mail Alerts will allow subscribers to receive information regarding Florida Medicaid policy changes or billing clarifications through the convenience of e-mail.

Subscriptions are not limited to Florida Medicaid providers, but available to anyone with an interest in Florida Medicaid business activities. Providers or other members of their workgroup may subscribe by entering their information in the data entry boxes of the subscription web page at: <http://ahca.myflorida.com/Medicaid/hipaa/Lyris/lyrissubscribe.shtml>.

A confirmation e-mail will be sent to new subscribers to avoid fraudulent subscription requests and must be returned to complete the subscription process. List members may unsubscribe at any time by following the instructions in the footer of each e-mail.

FLORIDA KIDCARE MEDIKIDS PROGRAM OFFERS FULL PAY OPTION



During the 2006 Legislative Session, the Florida Legislature authorized the Agency for Health Care Administration (AHCA) to implement a full pay option for the Florida KidCare MediKIDS Program. Before the enactment of the law, the MediKIDS program only offered subsidized health insurance coverage to children ages one through four if their family income was within 134% to 200% of the federal poverty guidelines. As of July 1, 2006, families with incomes exceeding 200% federal poverty level guidelines can also participate in the program by paying a monthly premium of \$159 for each child enrolled in the program. There are no co-payments. This expansion of the MediKIDS Program will permit a family of four with an annual income over \$40,000 to participate in the program.

MediKIDS is a "Medicaid look-alike" program which offers the same comprehensive benefits package as Medicaid. Families must complete a Florida KidCare application and select a managed care plan before receiving MediKIDS coverage. Children are enrolled with either a MediPass provider or a Medicaid managed care plan. Children enrolled in the full pay option plan can be identified by the MediKIDS program code "MK C" on FMMIS. Children enrolled in the subsidized plan are identified by the MediKIDS program code "MK A" for families with income up to 150% of the federal poverty level. The MediKIDS program code "MK B" identifies enrollees receiving subsidized coverage with family income from 151% to 200% of the federal poverty level.

AHCA encourages health care providers to share information about this new feature of the MediKIDS program with working families who once thought they made too much money to have their uninsured toddlers and pre-school children participate in the Florida KidCare Program.

For more information on the Florida KidCare Program, visit <http://www.floridakidcare.org> or call toll-free at 888-540-5437.

REGIONAL PERINATAL INTENSIVE CARE CENTER ANTEPARTUM HOSPITALIZATIONS



Articles carrying this graphic contain important Medicaid Provider Handbook Information.



All claims for multiple antepartum hospitalizations must include a modifier -22 on the CMS-1500 claim form for each claim line. Without this modifier, overpayments occur as each claim line is reimbursed at 100% instead of the prorated amount. The modifier -22 must follow the -TG modifier and be placed in block 24-D on the CMS-1500 claim form. Please refer to the Physician Coverage and Limitations Handbook for RPICC policy and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for completing the CMS-1500 claim form. These handbooks are available on the Medicaid fiscal agent web site at <http://floridamedicaid.acs-inc.com>. Your local Medicaid area office may be contacted for additional assistance.

UNCLASSIFIED DRUGS BILLING REQUIREMENTS FOR J3490, J3590, AND J9999

All claims for J3490, J3590 and J9999 must include the descriptor identifying the drug for reimbursement. Documentation must include the CMS-1500 claim form, medical documentation that includes a diagnosis, and a physician or nurse signature documenting the drug, dosage, and route of administration for the date of service. Medicare crossover claims also must include the Medicare EOMB. The CMS-1500 claim form must identify the National Drug Code (NDC) for the product for which reimbursement is requested.

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%. Claims involving only Medicaid must be sent to the Medicaid fiscal agent.

Medicare crossover claims must be mailed to:

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

CLAIMS FOR MEDICAL REVIEW



Claims that are submitted directly to Medicaid headquarters must be clean, error-free claims for processing. These claims include reimbursement for services of private stock flu vaccine, unclassified drugs and the Regional Perinatal Intensive Care Centers (RPICC) Program. Common errors seen by the Medicaid medical review team include missing provider numbers, missing treating provider numbers, invalid recipient identification numbers and incomplete medical documentation. Please refer to the Physician Coverage and Limitations Handbook for specific program policies and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for completing the CMS-1500 claim form. These handbooks are available on the Medicaid fiscal agent web site at <http://floridamedicaid.acs-inc.com>. Your local Medicaid area office may be contacted for additional assistance and training opportunities.

COVERAGE FOR J7317, SODIUM HYALURONATE

The maximum units for J7317, Sodium Hyaluronate, per 20 to 25 mg dose, is two. Therefore, when administered bilaterally to the knees, the drug may be billed electronically without medical documentation, regardless of the date of service.



UPDATE FOR BILLING MENACTRA

As a result of supply limitations by Sanofi-Pasteur for the tetravalent meningococcal polysaccharide-protein conjugate vaccine (MCV4), brand name Menactra™, the Center for Disease Control, in consultation with the Advisory Committee for Immunization Practices, the American Academy of Pediatrics, American Academy of Family Physicians, American College Health Association, and Society for Adolescent Medicine, is recommending that providers continue to vaccinate adolescents at high school entry and college freshmen living in dormitories who have not previously received the vaccine. Until further notice, administration of the vaccine to 11-12 year olds should be deferred. Refer to MMWR dated May 19, 2006. Therefore, the Vaccine for Children (VFC) Program is targeting adolescents at 15 and 18 years of age for coverage. Florida Medicaid will reimburse CPT code 90734 for the administration fee for Medicaid-eligible recipients, ages 11-18 when the VFC-provided vaccine is administered. CPT code 90734-SC will be reimbursed for the administration fee and non-VFC provided vaccine. Documentation of the use of private stock vaccine must be attached to the claim when requesting reimbursement of CPT code 90734-SC. CPT code 90734-HA should be used for 19-20 year olds. All claims received after June 1, 2006, regardless of the date of service, must follow this procedure for reimbursement.



HPV VACCINE

Effective 7/1/06, Medicaid began coverage for CPT code 90649 , Human Papilloma Virus (HPV) Vaccine, for 9-18 year olds, and 90649-HA (HPV) for 19-20 year olds, when the vaccine is purchased and administered in the office. Reimbursement for 90649 is \$136.90 for physicians. ARNP and PA reimbursement is \$134.90. Reimbursement for 90649-HA is \$136.90 for physicians and \$134.90 for ARNPs and PAs. This includes the cost of the vaccine and the administration fee. Medicaid will reimburse the cost of the vaccine until coverage is provided through the Vaccine for Children Program. Please follow the recommendations of the Advisory Committee on Immunization Practices for use of this vaccine.

HOSPITALIST PROGRAM

During the 2004 session, the legislature authorized the Agency for Health Care Administration (AHCA) to implement a Hospitalist program to manage Medicaid beneficiary's hospital admissions in Miami-Dade and Palm Beach Counties, in certain hospitals that serve Medicaid beneficiaries. The Medicaid hospitalist will assume responsibility for treatment of Medicaid beneficiaries upon admission to the hospital and coordinate with beneficiary's primary care physicians (PCP) to ensure continuity of care. The Hospitalist program will cover all admissions, including emergent and urgent, necessary to provide medical services for Medicaid fee-for-service, MediPass, and Minority Physician Network beneficiaries for either inpatient or observation services. The Hospitalist program will exclude certain eligibility and service categories from coverage such as Medicare dually eligible beneficiaries and Medicaid Medically Needy beneficiaries. AHCA is anticipating this program will be operational sometime in the first quarter of 2007. Additional information on the Hospitalist program will be provided in the Winter 2007 Medicaid Provider Bulletin.



AUTHORIZATION OF DME HOSPITAL BED REQUESTS



Requests for authorization of hospital beds by DME providers may be prior or post authorized using form PA01, Florida Medicaid Authorization Request. Mark the box labeled, "Other (excludes dental)," and include the post authorization date of service if applicable.

Bear in mind you must provide information with your request that supports the medical necessity for the bed you are requesting. Such information includes the diagnosis, symptoms, and physical limitations which make a hospital bed medically-necessary for your patient. It is not necessary to rewrite information already provided in supporting documentation accompanying the authorization request in the "Explanation of Necessity for Procedures" section.

Diagnoses must be provided using the ICD-9-CM format. If you provide non-specific diagnoses that do not describe the clinical condition or physical limitations that make a hospital bed necessary, then you must provide other supporting documentation, such as the Certificate of Medical Necessity for hospital beds (CMN), Form CMS-841, and the patient's most recent hospital discharge summary. The CMN allows DME and physician providers to document, on a single page, most of the information needed to qualify the request for a hospital bed. The hospital discharge summary provides documentation concerning the patient's clinical symptoms and physical limitations at the time of discharge.

The CMN can be downloaded over the internet at www.cms.hhs.gov/cmsforms/downloads/CMS841.pdf. The download includes instructions for completing the form.

(continued on next page)

AUTHORIZATION OF DME HOSPITAL BED REQUESTS

(continued from previous page)

The following are common issues which may result in authorization requests being returned to the provider for additional information if not included with the request:

- The procedure code on the authorization request must match the procedure code on the Certificate of Medical Necessity (CMN);
- You must include the physician's Unique Physician Identification Number (UPIN) on the CMN;
- Requests for variable-height beds, E0255, must include documentation that the patient requires a bed height different than a fixed-height bed, E0250, to assist in transfers to a chair, wheelchair, or standing position;
- Requests for a heavy duty bed, E0303, must include documentation that the patient weighs more than 350 pounds;
- Hospital bed codes E0260 (fixed-height) and E0265 (variable-height) may only be used if your patient is less than twenty-one years of age. These codes do not require prior authorization.

The optimal DME hospital bed authorization request will include the following items:

- Completed Florida Medicaid Authorization Request, Form PA01;
- Completed Certificate of Medical Necessity, Form CMS-841; and
- Most recent Hospital Discharge Summary.

For more information on hospital bed authorization requests consult the Florida Medicaid Durable Medical Equipment/Medical Supply Services Coverage and Limitations Handbook. This and other Florida Medicaid Coverage and Limitations Handbooks are available on the Medicaid fiscal agent web site, <http://floridamedicaid.acs-inc.com>.



“BY-REPORT” PROCEDURE CODES

The following information concerns submitting claims for review that have “By-Report” procedure codes. The Durable Medical Equipment fee schedule contains certain procedure codes that have a BR or By-Report requirement. By-Report claims are submitted directly to Medicaid’s fiscal agent and must include all the necessary documentation for the Medicaid staff or professional medical consultants to complete a medical review and price the procedure.

The following written documentation must be submitted with the claim:

- Documentation of medical necessity;
- Description of the items or services provided;
- Name of the manufacturer’s model, serial number, style, features, attachments, modifications, and accessories;
- Description of the time, skill, and equipment used;
- Documentation of any cost incurred, including the provider’s billing invoices from the manufacturer;
- Manufacturer catalog information, which lists manufacturer’s suggested retail price;
- The provider’s invoice;
- If for a non-routine service, a description of the item before and after repair;
- If for a repair for service, the manufacturer, duration of the warranty, model, and serial number;
- Date the item was made available to the beneficiary.

Durable Medical Equipment (DME) providers can submit a CMS-1500 claim to the Medicaid fiscal agent, Affiliated Computer Services (ACS), at:

ACS Government Healthcare
CMS-1500 Claims
P.O. Box 7072
Tallahassee, Florida 32314-7072

HCPCS procedure code A9900, defined as a miscellaneous DME supply, accessory, and/or service component of another HCPCS code, is one example of a By-Report code. For example, if a DME provider wanted to bill Medicaid for a Mic-Key Button, they would submit a claim to our fiscal agent using the A9900 procedure code. Please check our fee schedule for other procedure codes that utilize the By-Report process.



RESTORATION OF ADULT HEARING, VISION, AND PARTIAL DENTURE SERVICES



Effective for dates of service on or after July 1, 2006, Medicaid covers hearing, vision and partial dentures for all eligible Medicaid recipients regardless of age. Medicaid continues current coverage of complete dentures and emergency dental procedures for eligible recipients age 21 and over. Medicaid also continues current coverage to eligible recipients age 21 and over for eye exams for medically-necessary purposes, such as a reported vision problem, illness, disease, or injury. These new services are reimbursed by Medicaid when provided for medically-necessary reasons.

Vision Services:

- Eyeglasses for all recipients are limited to two pairs, per recipient, per 365 days. If a recipient requires a second pair of eyeglasses to replace the first pair within a 365-day period, a replacement pair may be provided without prior authorization, if the second pair is being provided for any of the medically-necessary reasons listed in the Visual Services Coverage and Limitations Handbook, Appendix A. If the recipient requires a third pair of eyeglasses for any reason within the 365 day period, the provider must obtain prior authorization.
- Eyeglass repairs and adjustments are covered.
- Contacts are limited by prior authorization on the basis of medical necessity.

Hearing Services:

- Hearing aid evaluations: One every three years; if more than one is needed within a three-year period, it must be prior authorized.
- Diagnostic testing: covered for the purposes of hearing aid candidacy in addition to the hearing evaluation. Diagnostic services for medically necessary purposes are covered.
- Hearing aids: Limited to one per ear every three years; if another is needed within three years, it must be prior authorized.
- Hearing aid fitting and dispensing: One per ear every three years; if another is needed within three years, it must be prior authorized.
- Hearing aid repairs: Three repairs per year outside the warranty period, starting after one full year from the date the aid was dispensed.
- Cochlear implant: Limit of one, by prior authorization only.
- Cochlear implant repairs outside the warranty period: May be post authorized.
- Cochlear implant accessories: Must be prior authorized.

Partial Denture Services:

- Removable partial dentures: One upper partial, one lower partial, or one set of partials per recipient per lifetime. Reimbursement includes the fabrication of removable partial dentures. Repairs, relines, and adjustments are reimbursable procedures. Prior authorization is required for reimbursement of partial dentures.
- Medicaid will not reimburse for:
 - Partial dentures where there are at least eight posterior teeth in occlusion; or
 - Partial dentures for single tooth replacement unless it is a missing anterior tooth.

UPDATED BEHAVIOR MANAGEMENT IN PEDIATRIC DENTISTRY



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 if:

- 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 2006 edition, page 2-5, for more information on behavior management. Please use the Medicaid Behavior Management Report Form located in Appendix F.



PRESCRIBED PEDIATRIC EXTENDED CARE SERVICES (PPEC)

The Florida Legislature authorized a ten percent Medicaid rate increase for PPEC providers effective for dates of service rendered on and after July 1, 2006. The new PPEC reimbursement rates are:

Procedure codes effective for dates of service on or after July 1, 2006		
CODE	DESCRIPTION OF SERVICE	MAXIMUM FEE
T1025	Full-Day PPEC Services (over four hours up to twelve hours per day)	\$176.05 per day
T1026	Partial-Day PPEC Services (four hours or less per day billed in units of one hour each unit with any fraction of an hour rounded up to full hour)	\$22.67 per hour



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, pages 2-13 and 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	
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	Patient Not Referred (Not Used)
S2	Under Treatment (For referred diagnostic or corrective health problem)
ST	New Services Requested (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)