



FLORIDA MEDICAID PROVIDER BULLETIN

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



Articles carrying this graphic contain important Medicaid Provider Handbook Information.

MEDICAID REFORM EXPANSION



During the 2005 Special Session, the Legislature authorized the expansion of Medicaid Reform to Baker, Clay, and Nassau Counties. The expansion of Medicaid Reform will occur in these counties July 2007.

The Agency has received applications from Provider Service Networks and Health Maintenance Organizations requesting approval to extend their services to the expansion counties. Each plan will be required to develop a provider network that will provide comprehensive health care services to Medicaid enrolled beneficiaries. The Agency encourages you to explore opportunities within the plan networks.

To obtain more information about Medicaid Reform, you may visit the Medicaid Reform website at <http://ahca.myflorida.com/Medicaid/> or contact your local Medicaid office. You may also request Medicaid Reform training by contacting your local Medicaid area office at (904) 353-2100.

All Providers

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





NATIONAL DRUG CODE (NDC) REQUIREMENT

Florida Medicaid requires the reporting of the National Drug Code (NDC) on all claims with J, Q, or S drug codes received on and after January 7, 2007, regardless of the date of service. Please enter this information in Block 24 on the revised CMS-1500 claim form. Enter the identifier N4 immediately followed by the NDC code in the shaded area above 24-A. DO NOT leave a space or place a hyphen or other separator between the N4 identifier and the NDC code. For claims submitted in the 837 professional or institution, electronic claim format, loop 2410 LIN segment must contain the NDC number.

Example of entering the identifier N4 and the NDC code:

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
From				To			CPT/HCPCS	MODIFIER	
MM	DD	YY	MM	DD	YY				
N400026064871									
10	01	05	10	01	05	11	J1563		

Florida Medicaid will only rebate products from manufacturers that have a rebate agreement. The “Current List of Drug Rebate Manufacturers” is available on the agency website at <http://ahca.myflorida.com>. Click on “Medicaid,” scroll down to “What is New in Medicaid?” then click on “Current List of Drug Rebate Manufacturers.”

Edit 241, NDC missing, will deny for Medicaid fee-for-service claims processed on and after April 1, 2007. For dually eligible Medicare/Medicaid recipients, claims will not deny for the NDC missing until June 1, 2007. Please contact your Medicaid area office if you need assistance.



NATIONAL PROVIDER IDENTIFIER (NPI)

Florida Medicaid encourages National Provider Identifier (NPI) eligible providers to register their NPI using the quick and easy Florida Medicaid NPI registration website at <https://floridamedicaidnpi.com>. Providers may re-enter the Florida Medicaid registration website to edit previously submitted information. Please call (866) 496-6493 for assistance with the website registration process. Prior to registration, providers should apply to the National Plan and Provider Enumeration System (NPPES) to receive an assigned NPI number. The federal enumeration site is located at <https://nppes.cms.hhs.gov/NPPES/>.

Note: Failure of NPI eligible providers to register an NPI with Florida Medicaid may result in future denial of claims. Please do not delay attending to this registration requirement.

PRE-ADMISSION SCREENING AND RESIDENT REVIEWS (PASRR)



Purpose, Regulations and Recent Audit of PASRR in Florida

The Code of Federal Regulation (42 CFR 483.100 – 483.138) requires Pre-Admission Screenings and Resident Reviews (PASRR) for all residents in Medicaid certified nursing facilities. The purpose of PASRR is to ensure that nursing facility applicants and residents with mental illness or mental retardation are identified prior to admission, placed in the least restrictive environment, admitted or allowed to remain in a nursing facility only if they are appropriately served, and provided with the mental health or mental retardation services they need, including specialized services.

The Centers for Medicare and Medicaid Services is charged with the federal oversight of PASRR. The Florida Agency for Health Care Administration (AHCA) is responsible to the Centers for Medicare and Medicaid Services (CMS) for the administration of PASRR at the state level through the Medicaid program. The Comprehensive Assessment and Review for Long-Term Care Services (CARES) staff from the Department of Elder Affairs is responsible for the implementation of PASRR.

Results of the last CMS audit of Florida's compliance with the federal requirements of PASRR revealed many nursing home residents were admitted to facilities without having a PASRR completed until after admission. This is not in compliance with federal PASRR regulations.

CARES Training on Revisions to the PASRR Forms and PASRR Process

To bring Florida in to compliance with federal PASRR regulations, AHCA and CARES recently revised the PASRR forms and the PASRR process. CARES is conducting statewide training for all individuals who might be responsible for completing the PASRR forms. The revised PASRR training will now include CARES staff and the following interagency partners: Agency for Health Care Administration (Medicaid and Health Quality Assurance), Department of Health (Children's Multidisciplinary Assessment Team and Early Steps), Department of Children and Families (Substance Abuse and Mental Health), and the Agency for Persons with Disabilities.

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PURPOSE, REGULATIONS AND RECENT AUDIT OF PASRR IN FLORIDA

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Medicaid letters were mailed to hospital and nursing facilities in April informing them that there were changes in the PASRR Level I and Level II forms, that the PASRR process was also revised, that CARES would provide PASRR training, as well as an attachment with an interagency contact sheet and copies of the new forms. This letter is posted on the Medicaid fiscal agent website: <http://floridamedicaid.acs-inc.com/index.jsp>. From the menu on the left, first click on 'Provider Support' and then click on 'Provider Notices'.

Statewide PASRR training sessions will be held in two phases: Phase I sessions will be training for interagency staff and Phase II sessions will be training for providers. Phase I interagency training began on March 29, 2007 in Medicaid Area 9 (West Palm Beach), and the last interagency training was held the first part of May 2007.

Phase II PASRR training for providers will begin as each area concludes Phase I training. Providers will be mailed invitations to let them know the dates and times of their training session. Phase II training will be held for hospital staff, particularly hospital discharge planners and any other hospital staff who might be responsible for completing the PASRR forms, as well as nursing home staff.

The revised PASRR forms and revised PASRR process will not be enforced until the Medicaid Nursing Facility Handbook rule is final (some time in July). Either form is acceptable until the rule is final.

The following information will be available on the Department of Elder Affairs, Comprehensive Assessment and Review for Long-Term Care Services (CARES) website in the near future: <http://elderaffairs.state.fl.us/english/cares.html>.

1. A 45 to 50 minute PASRR training video;
2. The PASRR Level I and Level II forms; and
3. Instructions on how to order PASRR forms.

Questions

If you have any questions regarding the PASRR training schedule or the PASRR process, please contact you local CARES staff. For contact information, you may access the CARES Field Staff Directory on the internet at <http://elderaffairs.state.fl.us/english/cares.html>.



HUMAN PAPILLOMA VIRUS (HPV) VACCINE

Effective on and after 4/1/07, Medicaid will reimburse the administration fee only for CPT code 90649, human papilloma virus vaccine, for 9-18 year-olds. The vaccine is available through the Vaccine for Children Program (VFC) for 9-18 year-olds. Reimbursement for CPT code 90649 is \$10 for physicians, \$8 for ARNP and PA, and \$5 for county health departments and federally qualified health centers. Reimbursement for the vaccine and the administration fee will continue for 19-20 year-olds with CPT 90649-HA. Please follow the recommendations of the Advisory Committee on Immunization Practices for use of this vaccine for Medicaid recipients 9-20 year-olds. Reimbursement is not currently available for Medicaid recipients 21 years of age and older.



IMMUNIZATION BILLING



Florida Medicaid is revising its billing procedures for reimbursement of immunization services. Changes will be effective with dates of service on and after September 1, 2007. For compliance with Current Procedural Terminology (CPT) coding guidelines, providers will be required to bill both the CPT code for the administration of the vaccine (90465-90474) AND the CPT code for the vaccine product (90476-90748).

Medicaid will continue to reimburse the administration service only for vaccines available from the Vaccine for Children (VFC) Program. For vaccines not available through the VFC program, Medicaid will continue to reimburse both the vaccine and the administration of the vaccine. The cost of the vaccine will be reimbursed for those administered to 19-20 year-olds.

All providers will bill the administration fee codes (90465-90474). Reimbursement will be \$10 for physicians, \$8 for advanced registered nurse practitioners and physician assistants, and \$5 for county health departments and federally qualified health centers.

Please contact your Medicaid area office if you need assistance. Medicaid area office phone numbers are available at the Agency for Health Care Administration website at <http://ahca.myflorida.com>.



PERIODONTAL SERVICES



Periodontal scaling and root planing (D4341 and D4342) for therapeutic treatment may be reimbursed for recipients who exhibit generalized periodontal pocket depth in the 4-5 mm range. This is a definitive, meticulous treatment procedure designed to remove cementum or dentin that is rough, and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planing is not covered by Medicaid for prophylactic purposes. The nature of any condition must be documented on the periodontal chart of the dental record.

Medicaid covers procedure code D4355 (full mouth debridement) when provided for comprehensive evaluation and diagnosis. Procedure code D4355 may not be billed with D1110, D1120, D4341 or D4342, same date of service, same recipient, or the same provider. Periodontal scaling and root planing is limited to four quadrants or four units in a 366 day period per recipient. General debridement is limited to one time per 366 day period per recipient.

Periodontal procedures are limited to Medicaid eligible recipients 20 years of age or younger. Please refer to the Dental Services Coverage and Limitations Handbook for more information pertaining to periodontal services.



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 Child Health Check-Up (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, per Medicaid child, per provider, per day. The visit may be a CHCUP visit or a sick visit. 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. Medicaid may recoup overpayments 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 8 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 8 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)