



FLORIDA MEDICAID PROVIDER BULLETIN

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All Providers

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IMPORTANT INFORMATION REGARDING CHANGES TO FLORIDA MEDICAID



The current Medicaid fiscal agent contract with ACS will end February 29, 2008. Florida Medicaid has contracted with EDS to develop a new claims processing and eligibility verification computer system and to serve as fiscal agent beginning March 1, 2008. Beginning this Fall (2007), Florida Medicaid and EDS will hold a series of training sessions to introduce EDS and the new system.

Provider community training sessions will be held in fifteen locations throughout the state. The training sessions will provide instructions on claim submission, new website features, and other changes that are associated with the new system. Some of these changes include:

- Interactive websites for Medicaid providers. Providers will be able to use the website to submit and reconcile claims, verify recipient eligibility, access information on the care given to Medicaid recipients, submit prior authorization requests (PAs), manage some aspects of your provider file, and automate other administrative functions;
- Replacement software Provider Electronic Solutions (PES) for providers who bill using WINASAP 2003. WINASAP 2003 will no longer be supported effective February 29, 2008. Providers impacted by this change will receive a separate mailing with PES training information and the training schedule. Another option for current users of WINASAP 2003 will be a new secure website. Providers will be able to bill claims online and receive a rapid status response, plus the ability to correct errors and resubmit claims; and
- New Pharmacy Benefit Manager, supporting pharmacy processing activities. Those activities include claims processing, call center support, prior authorization and more.



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



Articles carrying this graphic contain important Medicaid Provider Handbook Information.

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

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IMPORTANT INFORMATION REGARDING CHANGES TO FLORIDA MEDICAID

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There will be a variety of dates available for training. Attendees will be asked to choose a session that is best for them.

The following outlines the general timing of the training sessions and locations:

Ft. Walton Beach - Emerald Coast Convention Center	November 13 - 14, 2007
Panama City - Marina Civic Center	November 15, 2007
Tallahassee - Tallahassee Community College	November 28 - 29, 2007
Ocala - Ramada Inn & Conference Center	December 3 - 4, 2007
Gainesville - Best Western	December 5 - 6, 2007
Jacksonville - Holiday Inn – Baymeadows	December 11 - 14, 2007
Clearwater - Holiday Inn Select	January 8 - 10, 2008
Tampa - Holiday Inn Express Hotel & Suites	January 15 - 18, 2008
Orlando - Holiday Inn Hotel & Resorts	January 21 - 24, 2008
Sarasota - Sarasota Cay Club	January 28 - 29, 2008
Ft. Myers - Ambassador Riverfront Hotel	January 31 - February 1, 2008
West Palm Beach - Crowne Plaza	February 4 - 6, 2008
Marathon Key – Fischer Hospital	February 4, 5, and 7, 2008
Miami - James L. Knight International Center	February 11 - 14, 2008
Ft. Lauderdale – LaQuinta Inn	February 19 - 21, 2008

**Please note, dates and locations may change. Please monitor the EDS website below for training updates.*

Detailed training information, including dates, times and locations will be mailed to providers and posted on the following website: <http://mymedicaid-florida.com/providerreadiness>. Florida Medicaid and EDS look forward to presenting these exciting changes in the Florida Medicaid program.

MEDICAID PROVIDER SATISFACTION SURVEY

In early 2008, we will survey Medicaid providers to measure your satisfaction with the Florida Medicaid program and identify opportunities for improvement. We hope you will invest a small amount of your valuable time to respond to the survey. When it is released it will be posted on the Agency's website. More information will be provided in future bulletins and other forms of communication. We look forward to working with you to improve the Medicaid program for providers and to an improved working relationship.



PAYMENT ERROR RATE MEASUREMENT PROJECT (2008) - UPDATE

This article is the third in a series of updates on the Payment Error Rate Measurement (PERM). The Improper Payments Information Act of 2002 (HR 4878) requires federal government agencies to estimate their improper payments annually. The Agency for Health Care Administration (Agency) is Florida's single state agency that administers the state's Medicaid program; this includes the administration and management of funding for the State Children's Health Insurance Program (SCHIP), also known as Florida KidCare. The Agency is cooperating with the Centers for Medicare and Medicaid Services (CMS) in this effort.

In our Spring 2007 Provider Bulletin, the Agency stated that CMS will be measuring the accuracy of payments in the Medicaid and SCHIP (KidCare) programs. CMS will use national contractors to review claims related medical records and to measure improper payments made in this context. Livanta is the federally contracted entity that will develop the documentation and database support for PERM by collecting medical records from providers. If you have submitted a claim for services given to a Medicaid or SCHIP beneficiary, it may be one of a sample of claims selected for review. Livanta (LLC) will contact you for a copy of your medical records to support the medical review of the claim. The contractor will conduct medical reviews on all sampled Medicaid and SCHIP fee-for-service claims to determine if the claims were correctly paid and medical records are needed for this purpose.

Please note that it is of utmost importance for you, the provider, and for the State of Florida, that all requests for medical records related to the selected claims sample made by the Federal data documentation contractor, Livanta, be submitted within a ninety-day (90) period. It is also of the utmost importance that the submitted medical records be complete so that the review contractor may be able to substantiate the claims. Incomplete records, or records insufficient to substantiate the claim will be counted as errors, and the State will be required to initiate payment recovery efforts in order to reimburse the Federal share of the payments determined to be improperly paid.

Livanta is a federally contracted agent of the Centers for Medicare and Medicaid and is authorized to request and receive medical records under the Payment Error Rate Measurement program.

Livanta will attempt to contact you at the location/telephone number you have on record with the Agency. If you have changed your address or telephone number, you are required to report the change of address to the Agency (General Provider Handbook, page 2-35).

If Livanta is either unable to contact you, or if it does not get a response from you within 90 days of making a request for medical records for a sampled claim, Livanta may determine that the claim was paid incorrectly, and as stated previously, the State will initiate recovery efforts.

Medical Records Requests

Please note that providers are required by **Section 1902(a)(27) of the Social Security Act** to retain records necessary to disclose the extent of services provided to individuals receiving assistance, and furnish CMS with information regarding any payments claimed by the provider for medical services, including medical records.

In addition, the collection and review of protected health information contained in individual level medical records, for payment review purposes, is permissible by the Health Information Portability and Accountability Act of 1996 (HIPAA) and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164:

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PAYMENT ERROR RATE MEASUREMENT PROJECT (2008) - UPDATE

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“...a covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits...or other activities necessary for the appropriate oversight of (1) the health care system; (2) government benefit programs for which health information is relevant to beneficiary eligibility; (3) entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or (4) entities subject to civil rights laws for which health information is necessary for determining compliance.”

Medicaid provider agreement responsibilities require Florida Medicaid providers to:

- Keep, maintain, and make available in a systematic and orderly manner, all medical and Medicaid-related records as the Agency requires for a period of at least five (5) years; and
- Send, upon request, or as required by applicable handbooks, and at the provider's expense, legible copies of all Medicaid-related information to authorized state and federal employees, including their agents. The provider shall give state and federal employees, including their agents, access to all Medicaid patient records and to other information that is inseparable from Medicaid-related records.

Please review subsequent bulletins for additional details regarding Payment Error Rate Measurement, or for any federal changes to timeframes for submission of medical records.

We appreciate your continued cooperation with Florida Medicaid. If you have any questions, please contact Karen Chang, Administrator, Office of Medicaid Program Oversight, by telephone at (850) 414-2513, or via email at changk@ahca.myflorida.com.

If you have any questions regarding the identity of the contractors, you may contact either the contractors directly, or verify the identity with CMS directly using the contact information below:

Statistical Contractor

The Lewin Group
3130 Fairview Park Drive
Suite 800
Falls Church VA 22042
Fax: (703) 269-5705
Email us at cms.perm@lewin.com or call Moira Forbes at (703) 269-5631

Documentation/Database Contractor

For questions relating to submission of medical policies, medical record requests and tracking

Livanta LLC
9090 Junction Dr., Suite 9
Annapolis Junction, MD 20701
Fax: (240) 568-6063
Email Stephen Buckingham at sbuckingham@livanta.com or call (301) 957-2329

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Review Contractor

For questions relating to medical and processing review protocols

HealthDataInsights, Inc
2620 Regatta Blvd., Suite 208
Las Vegas, NV 89128
(702) 243-8730
(702) 233-2167 fax
Email Linda Clark Helms at linda.clarkhelms@emailhdi.com or call (410) 221-9990

Centers for Medicare and Medicaid Services

For questions relating to the federal PERM regulation, contractor oversight

Centers for Medicare and Medicaid Services
Office of Financial Management, Program Integrity Group
7500 Security Blvd., Mail Stop C3-02-16
Baltimore MD 21244-1850
Email Janet Reichert, CMS PERM Project Officer at JReichert@cms.hhs.gov.

VERIFYING ELIGIBILITY UNDER MEDICAID REFORM



Beginning September 1, 2007, beneficiaries in Baker, Clay, and Nassau counties will transition into Reform health plans over a three 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 from the process currently used 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 "P" and "H". The managed care indicator provided through the Medicaid eligibility verification systems will be a "P" if the beneficiary is enrolled in a Provider Service Network with the letter "R" preceding the plan name, or an "H" if the beneficiary is enrolled in a Health Maintenance Organization with the letter "R" preceding the plan name. The phone numbers of the organizations will also be provided via the eligibility verification system.

If as a result of the eligibility verification process, you find that you are a provider who is not part of the health plan's network, you will need to contact the health 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>.

NATIONAL DRUG CODE REQUIREMENT



Based on the Federal Deficit Reduction Act of 2006, Florida Medicaid requires the reporting of the 11-digit 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. 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, electronic claim format, loop 2410 LIN segment must contain the NDC number. The first five digits of the NDC is the manufacturer's labeler code. If the manufacturer omitted one or more leading zero from the labeler code on the package, be sure to add the leading zeros on the claim. (The first five digits should match the labeler code on the rebate list. See article regarding NDC format on the next page.)

Example of entering the identifier N4 and the NDC code:

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

Florida Medicaid will reimburse only those products from manufacturers who have a rebate agreement with the Secretary of Health and Human Services, as required by federal statute. 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."

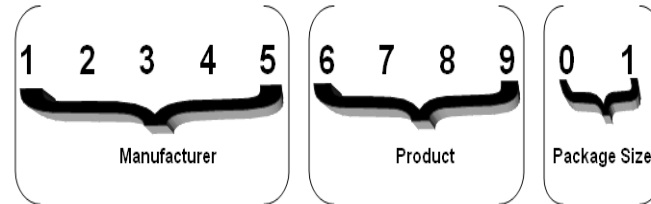
Claims for compounded medications utilizing J3490 must have the NDC for the primary product listed on the claim form and a copy of the invoice attached to the claim for reimbursement.

Medicaid CMS-1500 or 837 professional claims billed without the NDC or a non-rebate agreement NDC, processed on and after April 1, 2007, will be denied with edit 241. Claims for dually eligible Medicare/Medicaid recipients do not require the NDC and will not be denied with edit 241, NDC missing.

Please contact your Medicaid area office if you need assistance.



NATIONAL DRUG CODE 5-4-2 FORMAT



The National Drug Code (NDC) must be entered with 11 digits when completing the CMS-1500 claim form. The NDC should have 5-4-2 format. The first 5 digits are the manufacturer, the middle 4 digits are the product and the last 2 digits are the package size.

If you have been given a NDC that is less than 11 digits you will have to add the missing digits as follows:

- 1.) If you have been given a number in a 4-4-2 format – add a 0 to the beginning.
Example: 2345 6789 01 becomes 02345 6789 01
- 2.) If you have been given a number in a 5-3-2 format – add a 0 as the 6th digit.
Example: 12345 678 01 becomes 12345 0678 01
- 3.) If you have been given a number in a 5-4-1 format – add a 0 as the 10th digit.
Example: 12345 6789 1 becomes 12345 6789 01
- 4.) If you have been given a number in a 4-3-2 format – add a 0 to the beginning and a 0 as the 6th digit.
Example: 2345 678 01 becomes 02345 0678 01



MEDICAID ENCOUNTER DATA SYSTEM (MEDS)



The Agency for Health Care Administration (Agency) has recently implemented the Medicaid Encounter Data System (MEDS). Beginning with State Fiscal Year 2006-07, all Medicaid managed care plans, including Health Maintenance Organizations, Provider Service Networks that capitate their provider transportation services in the Medicaid Reform counties, and Prepaid Dental Health Plans are required to report Medicaid service utilization data, or encounter data, to the Agency in the standard HIPAA X12 formats. Other managed care organization types, including Prepaid Mental Health Plans and Nursing Home Diversion Plans will also be required to submit encounter data at a later phase in the implementation. Several state and federal laws (Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, Florida Statutes) require the Agency to collect encounter data.

The Agency will use encounter data to set risk adjusted capitation rates (409.91211, F.S.) and to analyze access to care and quality of care measures for health plans. The current risk-adjustment model is a statistical model known as Medicaid Rx which uses prescription medication usage to identify chronic conditions and derive risk scores as indicators of future health care costs. Once accurate and complete encounter data is available through MEDS, the Agency will transition to a diagnostic based model known as the Chronic Illness and Disability Payment System (CDPS).

Managed care plans are required to report encounter data from all their network providers, including encounter data from providers operating under a subcapitated payment structure, as well as encounter data from those network providers permitted to submit paper claims. Plans are readily able to produce complete, accurate encounter data from network providers submitting electronic claims. However, for managed care plans that contract with network providers through a subcapitated payment structure, or that permit network providers to submit claims in a paper format, additional effort may be required to obtain and send these encounter data to the Agency. Not sending in these additional encounter data will result in the provided services being underrepresented in MEDS, and will have an impact on the calculation of capitation rates and analyses of managed care plan performance. Therefore it is important for all providers participating in a managed care plan, regardless of the payment structure, to provide their plan with complete and accurate encounter data.

Providers should contact each managed care plan in which he or she participates to determine specific procedures for submitting data. Managed care plans have been directed to submit encounter data to the Agency following HIPAA-compliant encounter claim formats (X12 837 I, P, D, and the National Council for Prescription Drug Programs (NCPDP) Batch Transmission Standard Version 1.1 and Telecommunications Standard Version 5.1) using Florida specific transaction content as documented in the MEDS Companion Guide, posted on the MEDS website at <http://ahca.myflorida.com/Medicaid/meds/index.shtml>.

If you have any questions, please do not hesitate to contact the Agency MEDS Team via email at medsteam@ahca.myflorida.com.



WHAT IS VALIDATION OF PERFORMANCE MEASURES?



One task under Florida Medicaid's Managed Care External Quality Review (EQR) scope of work is the validation of performance measures, as required by the Balanced Budget Act of 1997. The validation of performance measures ensures that the validation activities are conducted as outlined in the Centers for Medicare and Medicaid Services (CMS) publication, *Validating Performance Measures, A Protocol for Use in Conducting External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol). The objectives of the performance measure validation process are to:

- Evaluate the accuracy of the performance measure data collected by managed care organizations and prepaid inpatient health plans; and
- Determine the extent to which the specific performance measures calculated by the managed care plans followed the specifications established for each performance measure.

Florida Health Maintenance Organizations (HMOs) have been reviewed for validation by Health Services Advisory Group, Inc. (HSAG), Florida's external quality review organization. For the HMOs, the Agency for Health Care Administration (AHCA) opted to use National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) measures to satisfy the performance measure requirement. Because the HMOs were required to calculate and submit HEDIS performance measures and undergo an NCQA HEDIS Compliance Audit, results from these audits were used to ensure that BBA requirements were met. Developed and maintained by NCQA, HEDIS is a set of performance data broadly accepted in the managed care environment as an industry standard. The NCQA HEDIS Compliance Audit is consistent with CMS protocols for validation of performance measures. The purpose of conducting a HEDIS audit is to ensure that rates submitted by the HMOs are reliable, valid, accurate, and comparable to one another.

All of Florida's Medicaid HMOs undergoing this review this year were assigned an audit designation of "Report" for all of the calendar year 2005 (reporting year 2006) performance measures required by AHCA. This means that the measures were either fully or substantially compliant with HEDIS specifications or had only minor deviations that did not significantly bias the reported rate. For each performance measure, the audit designation of "Report" translates directly to the finding of "Valid" within the CMS protocols. For more information on external quality review activities in Florida, go to HSAG's website: <http://www.myfloridaequro.com>.



081 NON-INSTITUTIONAL CLAIM FORM REPLACED BY THE CMS-1500 CLAIM FORM

The 081 Non-Institutional Claim Form Will Be Replaced by the CMS-1500 Claim Form on March 1, 2008.

Electronic Data Systems Corporation (EDS) will become Medicaid's fiscal agent on March 1, 2008. With the implementation of the new EDS Medicaid Management Information System taking effect at that time, home and community based services, mental health and children's medical services targeted case management providers will now need to submit paper claims on the CMS-1500 claim form instead of the 081 Non-Institutional claim form. The 081 Non-Institutional claim form will be discontinued after the implementation of the new EDS system. If you currently submit claims electronically on an 837 transaction, there will be no substantive change in how to submit claims.

In October 2007, home and community based services waiver providers and targeted case management providers will receive invitations to EDS training sessions on the new system; they will be held in November 2007. The training will cover how to submit claims on the CMS-1500 claim form instead of the 081 Non-Institutional claim form. If you do not receive an invitation to training by the end of October, please contact your local Medicaid area office.



ANALGESIA AND SEDATION IN THE DENTAL OFFICE



Analgesia is the administration of a drug or agent, primarily nitrous oxide (D9230), to temporarily arrest the feeling of pain in a conscious individual.

Intravenous conscious sedation (Procedure codes D9241 and D9242) is the intravenous administration of a drug or agent to produce a controlled state of consciousness. This type of sedation may reduce stress and or excitement levels. It may be accompanied by partial loss of protective reflexes, including inability to continually maintain an airway independently and or to respond appropriately to physical stimulation or verbal command.

Non-intravenous conscious sedation (Procedure code D9248) is a depressed level of consciousness produced by the administration of pharmacologic substances. This type of sedation retains an individual's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command. It includes administration of a medication via intramuscular, subcutaneous, submucosal, inhalation, oral, rectal, or transmucosal and appropriate monitoring. Non-intravenous conscious sedation does not include nitrous oxide administration. The writing of a prescription for a non-intravenous conscious sedative is excluded as a claim.

Reimbursement for procedure codes D9230, D9241, D9242, and D9248 is limited to three times per 366 day period, per beneficiary. Analgesia and sedation procedures may be reimbursed only when the beneficiary has a severe physical or mental disability, or is difficult to manage. These services may not be billed on the same date of service as behavior management.

Please refer to the January 2007, Dental Services and Limitations Handbook for additional information on analgesia and sedation procedures. The dental handbook may be accessed at <http://floridamedicaid.acs-inc.com>. Click on the "Provider Support" link. Scroll down to "Handbooks." Click on the handbook titled "Dental" under the "Medicaid Coverage and Limitations Handbook" section.

INSTITUTIONAL PROVIDERS WILL SUBMIT ALL CLAIMS ON THE UB-04 CLAIM FORM BEGINNING MARCH 1, 2008

With the implementation of the new EDS system on March 1, 2008, nursing facilities, intermediate care facilities for the developmentally disabled (ICF/DD), and state mental hospital providers must submit claims on the UB-04 claim forms instead of the 021 Institutional claim forms. Claims submitted on the 021 claim form after March 1, 2008 will be returned to the provider for resubmission on the UB-04. If you currently submit claims electronically on the 837I, there will be no substantive change in how you submit your claims.

Nursing facility, ICF/DD, and state mental hospital providers will begin receiving invitations to EDS training sessions on the new EDS FMMIS system during the month of October 2007, for training sessions that will begin in November 2007. This training will include how to submit claims on the UB-04 claim form instead of the 021 Institutional claim form. If you are a nursing facility, ICF/DD or state mental hospital provider and have not received an invitation to training by the end of October, please contact your local Medicaid area office.

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 12 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 12 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.

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

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)