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Florida Medicaid Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION



New Contact Information For Florida Medicaid



With the implementation of the new Florida Medicaid system (Medicaid Management Information System/Decision Support System – FMMIS/DSS), most contact information for providers and beneficiaries with the fiscal agent will remain the same. EDS will assume responsibility for many P.O. Boxes and telephone numbers previously associated with ACS.

Please continue to mail claims, adjustments, enrollment forms, and other paper correspondence to the P.O. Boxes you currently use for Florida Medicaid.

The Medicaid Provider Inquiry line will also be transitioning to EDS on June 26 and will, therefore, remain the same. For questions regarding current Medicaid issues, such as pending claims and enrollment, please continue to call 1-800-289-7799.

For electronic file transactions and EDI related matters associated with the transition, there will be a phone number change. Prior to June 26, 2008 you can reach EDS EDI Services at 1-850-523-5220. Beginning June 26, 2008, you can reach EDS EDI Services at 1-800-289-7799, Option 3. This is a new number to reach EDI Services. The number currently used (1-800-829-0218) will no longer support Florida Medicaid related matters after the transition.

Providers are encouraged to review information posted on many of the topics associated with the transition at the EDS Florida Medicaid Provider Readiness site at <http://mymedicaid-florida.com/ProviderReadiness/>.



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



Articles carrying this graphic contain important Medicaid Provider Handbook Information.



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A Message from Secretary Holly Benson

Dear Medicaid partner:

We are always looking for ways to work with you better. Over the last year we have been asking providers across the state how we can improve our practices, and we have been working to implement your recommendations.

As always, one of the most important things we do for you is ensure prompt payment for your services. In order to help us in that effort, on July 1st we will be switching to our new Fiscal Agent, and we hope that that will allow for even faster claims payment. We have done considerable outreach to make sure the transition is a smooth one, but just in case you have questions once we go live, we will have teams standing by at 800-289-7799, Option 7. Your service matters to us, and we hope that we will continue to serve you well.

I hope you will continue to let us know ways that we can enhance our partnership with you. Thank you for all that you do to serve the patients of Florida, and thank you for your help with our mission to help more Floridians find access to affordable, quality health care.

Sincerely,



Secretary

Agency for Health Care Administration

Medicaid Starts Comprehensive Hemophilia Disease Management Program

Florida Medicaid started the Comprehensive Hemophilia Disease Management program on April 1, 2008. Two specialty pharmacy companies—Caremark and Hemophilia of the Sunshine State (owned by Curascript)—are providing program services, which include: care management; physician and beneficiary education; 24/7 access to a toll-free nurse helpline; and dispensing of factor products, assay, and other hemophilia-related pharmaceuticals. This program is operating statewide and covers all Medicaid beneficiaries who are not enrolled in a Medicaid HMO and are prescribed drugs from the MOF and MOE therapeutic class codes.

Medicaid beneficiaries may choose which of the two companies they

would like to work with and from whom they will receive their factor products. Enrollment in this program does not replace or change a beneficiary's primary care provider or other Medicaid benefits. The two companies—Caremark and Hemophilia of the Sunshine State—will work with beneficiaries and their current doctors and nurses to coordinate their health care.

If you have any questions regarding this program, please contact your local Medicaid office or the specialty pharmacy companies at the following toll-free numbers:

Caremark: 1-888-826-5621

Curascript (Hemophilia of the Sunshine State): 1-866-804-7693

investigation, and referral of suspected fraud and abuse cases.

MPI is responsible for overseeing the activities of Medicaid beneficiaries, and Medicaid providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of beneficiaries occur to the minimum extent possible, and for recovering overpayments and imposing sanctions as appropriate. This is done by conducting audits and investigations using MPI staff as well as outside contractors. Investigations may employ statistical sampling, computer-based analyses or focused audits using selective samples of areas deemed to be of higher risk.

Providers are encouraged to be compliant with Medicaid policy. At the time of enrollment, an applicant completes a provider agreement, which states in part, that the provider agrees to comply with laws, rules and Medicaid handbooks. As a provider, you should be familiar with your Medicaid provider agreement, Section 409.913, F. S., the applicable Medicaid handbook(s) and any applicable licensure laws.

Florida Statutes and Florida Administrative Code are available on the Internet. Medicaid handbooks are located on the fiscal agent website. Additional information about the Florida Medicaid program is on the AHCA website. We encourage you to follow Medicaid policies and procedures. If you suspect any type of fraud or abuse within Medicaid, please call 1-888-419-3456 or go to http://ahcaxnet.fdhc.state.fl.us/InspectorGeneral/fraud_complaintform.aspx.

A Note from the Inspector General

— Linda Keen, R.N., J.D., M.S.W., Inspector General, AHCA

Section 20.055 (2), F.S., establishes the Office of the Inspector General (OIG) in each state agency to promote accountability, integrity and efficiency in government. Each IG is appointed, supervised and removed by their respective agency head. The major responsibilities of the OIG include investigations, audits and reviews of state agency programs and activities.

The OIG at the Agency for Health Care Administration (AHCA) has oversight of the Bureau of Medicaid Program Integrity (MPI). Title 42 CFR, Part 455, establishes the requirements for a state fraud detection and investigation

program, and for disclosure of information on ownership and control. Under the authority of sections 1902(a)(4), 1903(i)(2) and 1909 of the Social Security Act, Subpart A provides state plan requirements for the identification,

Medicaid Coverage Available for Non-Citizens



Federal regulations allow states to reimburse for emergency services provided to Medicaid beneficiaries 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.

Medically necessary services that are not also emergency services are not covered by Medicaid for alien beneficiaries. Medically necessary services are defined as services necessary to palliate or make more bearable the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration

of a condition that threatens life, causes pain or suffering, or results in illness or infirmity.

Alien claims, except those submitted for payment of labor, delivery, and dialysis services, are subject to medical review. CMS-1500 alien claims with place of service 11 (office setting) or 22 (outpatient hospital) must be submitted to Medicaid with documentation supporting the emergency situation. UB-04 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. If the service was an emergency, enter a “Y” for “Yes” in field 24C (EMG) of the CMS-1500 claim form and attach medical documentation that describes 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. Lack of appropriate documentation will result in a claim denial. Edit 909, Claim Requires Documentation, will post to the denied claim.

All paper alien claims with their medical records must be sent directly to the Medicaid fiscal agent for processing. To reduce claim processing time, submitted claims should be as error-free as possible. Inquiries regarding the status of submitted alien claims must be directed to the fiscal agent or to your local Area Medicaid Office.



Update on Medicaid's Payment Error Rate Measurement Program

This article is fifth in a series on the Payment Error Rate Measurement (PERM) program. 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 (the 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. These updates provide additional information on PERM as the program evolves, and program requirements are refined by CMS.

The implementation of PERM is now underway in Florida. CMS national contractors have begun collecting data on claims payments for services provided to Florida Medicaid beneficiaries during the period October 2007 through September 2008. CMS contractors will select a sample of claims from the universe of all paid claims during the period indicated above and conduct a thorough review of each selected claim for medical necessity and accuracy in both processing and payment, etc. The process requires reviewing supporting documentation, including medical records. If you are contacted by Livanta requesting medical records or supporting documentation, **these records should be provided to Livanta within 60 days of first receiving the request, with the following requirements:**

- Supporting medical records and documentation, and must be for the specific claim and service identified;
- Supporting medical records and documentation must be complete;
- Supporting medical records and documentation should be for services provided between October 1, 2007 and September 30, 2008 only;
- If your records and documentation are at another location, please inform Livanta immediately of this fact and provide them with correct contact

information; and

- If you are contacted by Livanta, and you are not the billing provider or record keeper for the claim, please immediately inform Livanta of this fact, and provide them with the correct name and contact information.

Past PERM results show that, on average, almost 82% of a state's errors are due to insufficient documentation or no response/no documentation being provided to the contractors; 77% of these errors are due to insufficient documentation. The following steps, if taken now, will help ensure that Florida's PERM results are not affected by errors, and that Florida Medicaid continues to enjoy a productive relationship with you, its Medicaid healthcare providers:

- Begin identifying your records and ensuring that supporting documentation is complete for each claim;
- Begin ensuring that your records and supporting documentation are readily accessible;
- Ensure that your address and contact information is on file and current with Florida Medicaid; and
- If you are intending to close up your practice or business before September 30, 2008, please ensure that the custodian for your medical records and supporting documentation is on file with Florida Medicaid.

Please note that claims for which supporting documentation is requested and not provided within the 60-day period will be determined to be improper payments. The federal share of these payments must be returned to CMS, and are recoverable by Florida Medicaid in accordance with federal law.

It is therefore important that providers



cooperate by submitting all requested documentation in a timely manner since no response or insufficient documentation will count against the state as an error. If Livanta requests medical records from you and you have any questions regarding their request, please contact Robin Reed, Livanta's Medical Record Manager, at (301) 957-2380.

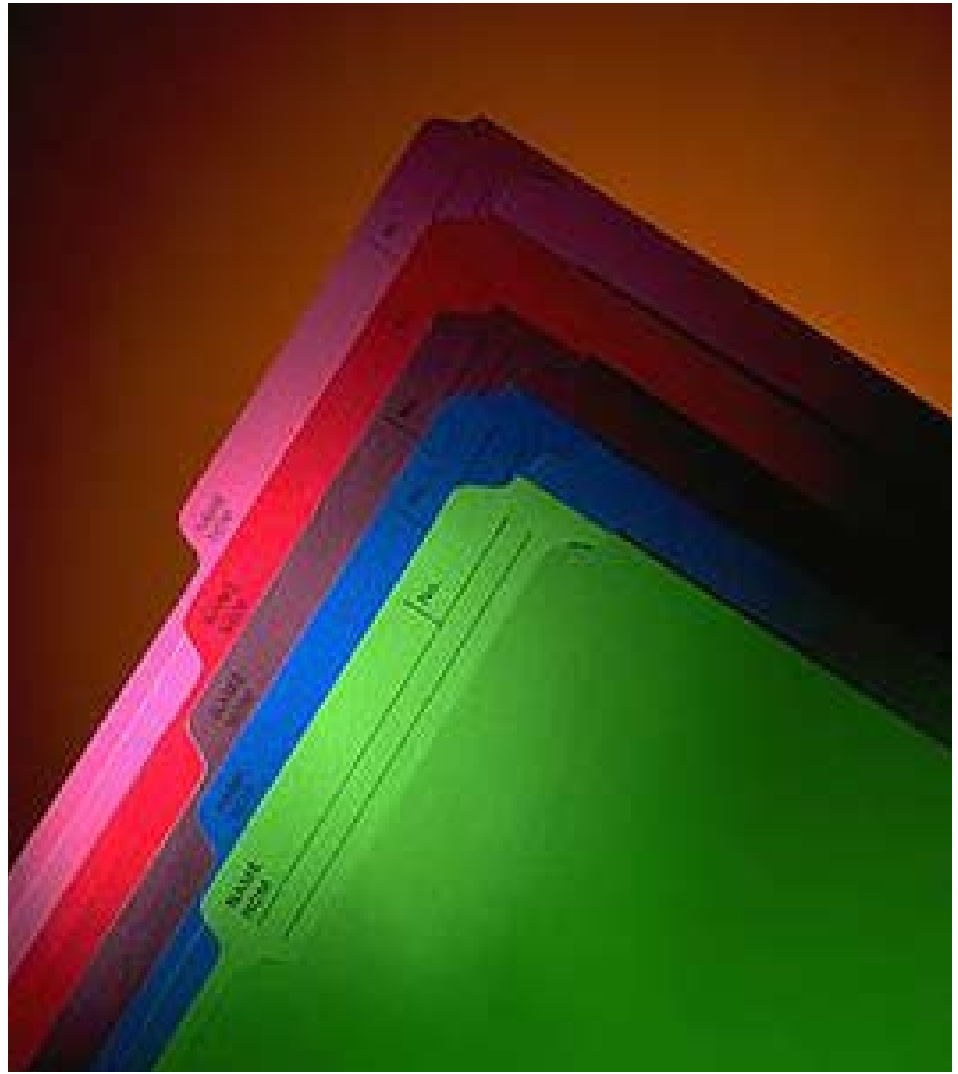
HIPAA and Medical Records Requests

Section 1902(a)(27) of the Social Security Act requires providers 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.**

Please review subsequent bulletins or the Florida Medicaid PERM website: <http://ahca.myflorida.com/Medicaid/perm/> for additional information on PERM.

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



National Provider Identifier (NPI) Issues

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the adoption and use of an NPI for all health care providers. The NPI replaces all identifiers, including Medicaid provider numbers, on HIPAA standard electronic transactions. As a Florida Medicaid provider, you must register your NPI with Florida Medicaid in order to establish a crosswalk between your NPI and your Medicaid Provider ID. If you have not registered your NPI with Florida Medicaid, you must do so in order to avoid any future disruption of payments.

If you have registered your NPI with Florida Medicaid, but have not yet submitted claims using your NPI or have been notified by us that you are using your NPI incorrectly on your claims submissions, please take a moment now to review your crosswalk information and how it is submitted to Florida Medicaid. Once you have verified and/or corrected your crosswalk and submission method, please submit some test transactions using both the NPI and the Medicaid ID. The Agency will monitor the success or failure of these transactions and report back if successful or not.

Medicaid Requires Use of 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 for HCPCS 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.)

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 new link for the "Current List of Drug Rebate Manufacturers" is available on the agency website at www.ahca.myflorida.com. Click on "Pharmacy Services," then click on "Current Information," 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 are denied with edits 4888, NDC missing or 4889, NDC invalid. Claims for dually eligible Medicare/Medicaid beneficiaries will not be denied with edit 4888, NDC missing, until further notice.

Please contact your local Medicaid Area Office if you need assistance.

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			

Submitting Medicare Crossover Claims for J3490 and J9999

All claims for J3490 and J9999 should be on a CMS-1500 claim form as follows:

- the recipient's Medicare number in Field 1a;
- the recipient's Medicaid number in field 10d;
- the NDC number in field 19;
- the NPI in field 33A; and
- the provider number in field 33B preceded by the acronym ID.

The Medicare EOMB and medical documentation that includes a diagnosis, drug, dosage, and route of administration for the date of service with the physician/nurse signature must be attached to the CMS-1500.

Medicare crossover claims are to be mailed to:

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

This is only applicable for Medicare crossover claims with a J-code of J3490 or J9999. Once a drug is assigned a J-code, the correct J-code for that drug must be used and the claim sent to the Medicaid fiscal agent.

Claims involving only Medicaid are sent to the Medicaid fiscal agent.

Commas Required as Diagnosis Pointers

The CMS-1500 billing guidelines for Field 24E require the entry of diagnosis code reference numbers, also referred to as a "pointer" from Field 21. Always place a comma between the diagnosis pointers in section 24E. If there are three diagnoses that relate to a procedure, a comma should be placed between the pointer numbers 1 and 2 and 3, such as this: 1,2,3. Medicaid claims are currently denying because of the missing commas between the pointer numbers in 24E. When the commas are missing, the digits 123 are viewed and treated by the Medicaid computer system as a real diagnosis code, rather than pointer numbers. The claim is denied as only pointers must be entered in Field 24E, not diagnosis codes. To prevent this unnecessary claim denial, please remember to enter the comma between the pointer numbers.

Transplant Global Billing Procedures Provides Higher Reimbursement

Global reimbursement for transplants allows Medicaid to reimburse providers at a different or higher rate than fee-for-service reimbursement. Global reimbursements are paid to Medicaid-designated transplant facilities for adult heart, liver, lung, and pediatric lung transplants.

It is important that providers submit error-free claims and attach necessary documentation in order to reduce claim processing time. To assist providers with this process, the following items must be checked before the submission of a global reimbursement package to Medicaid:

- Verify dates of service for evaluation and transplantation with the clinical coordinator;
- Check Medicaid recipient's eligibility status for dates of service; and
- Submit appropriate and necessary documentation and reports.

Documentation required with global reimbursement package is as follows:



- A copy of the comprehensive evaluation report stating whether the beneficiary was approved or denied for a transplant. If the beneficiary is approved, the evaluation report is submitted to Medicaid with the transplant authorization request; and
- A copy of the transplantation operative report and the hospital discharge summary.

Additional Global Billing Instructions:

- Claims must be totaled and amount must be indicated on the reimbursement form. The reimbursed amount will be the actual charges up to the global maximum amount allowed. Providers are not entitled to the maximum amount when billed charges are less;
- Beneficiary's Medicaid ID must be indicated on the CMS-1500 and UB-04, rather than the Social Security Number;
- Inpatient and Outpatient UB-04 forms must contain the 4 digit "Type of Bill," block number 4;
- UB-04 and CMS-1500 must be the original red and white claims forms;
- Medicaid must have a prior authorization dated and signed by the medical consultant prior to the service being rendered; and
- Global billing packages are subject to Medicaid billing limits of 12 months from date of service.

Submit global packages to:

Agency for Health Care Administration
ATTN: Transplant Coordinator
2727 Mahan Drive Mail Stop #20
Tallahassee, FL 32308

Global packages received with errors or without necessary and appropriate documentation will be returned to the facility for corrections.

Inquiries regarding the status of submitted global reimbursement packages may be directed to the transplant coordinator, Theresa Kumar at (850) 922-7322.



Labor and Delivery Services Undergo Expanded Review

During the 2007 Special Legislative Session C, the Legislature passed Senate Bill 2-C, which required the Agency for Health Care Administration (Agency) to expand the prior authorization requirements of labor and delivery services.

Effective February 1, 2008, all labor and delivery services which have been exempt from review by the Agency's contracted peer review organization (KePRO) will now require an authorization number for reimbursement purposes. All claims which have been coded with Obstetric Diagnostic Codes 630.0 – 677, and ICD-9 Procedure Codes 72.0 – 74.0 and/or 75.5 – 75.69 will deny if not submitted with an authorization number assigned by KePRO.

In order to comply with Florida Statute and the Newborns and Mothers Health Protection Act of 1996, the Agency is not requiring a medical necessity review of the actual delivery. KePRO will automatically assign an authorization number to inpatient days for normal deliveries (two approved days for vaginal deliveries and four approved days for Cesarean deliveries). KePRO will review any non-delivery inpatient days for medical necessity (i.e., pre-term labor or additional post partum days).

Admissions for Medicaid Beneficiaries enrolled in a Health Maintenance Organization (HMO) or a Provider Service Network (PSN) will remain exempt from KePRO review.



The Florida Discount Drug Card Offers Cost Savings

The State of Florida now offers the Florida Discount Drug Card that offers eligible Floridians savings on drugs at over 4,000 participating pharmacies. An easy-to-use website, www.FloridaDiscountDrugCard.com, is available to help consumers learn which drugs are discounted and find participating pharmacies. Participants can also choose a mail order option by calling the Florida Discount Drug Card help line.

Currently, 4,128 retail pharmacies have agreed to accept the Florida Discount Drug Card; to date, members have save more than half a million dollars on their prescription drug costs.

“The Florida Discount Drug Card is a tremendous resource for Floridians,” said Holly Benson, Secretary of the Agency for Health Care Administration. “Many families have trouble affording the prescriptions

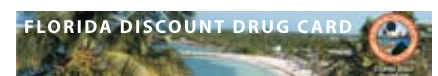
they need, and this program has made a difference for thousands of people.”

Individuals qualify for the card if they are age 60 and older and do not have prescription drug coverage or if they are in the Medicare Prescription Drug Coverage gap. Individuals, families and seniors under age 60 may be eligible if they have an annual income of less than 300 percent of the federal poverty level and do not have prescription drug coverage. Qualifying annual incomes for individuals under age 60 are up to \$30,636 for an individual, \$41,076 for a family of two and \$61,956 for a family of four. Income limits for other family sizes are also available on the website.

To enroll in the program, applicants who do not have prescription drug coverage provide their name and contact information as well as information about family members.

Individuals under age 60 also provide qualifying income information. The applicant affirms that the information provided on the application is true, complete, and accurate; no additional documentation of income, age, or residency is required.

To apply for the Florida Discount Drug Card, visit www.FloridaDiscountDrugCard and complete an online application or enroll over the phone by calling 1-866-341-8894 or TTY 1-866-763-9630. There is no application fee for the Florida Discount Drug Card; however, there is a one time \$1.50 activation fee added onto the posted cost of the first prescription filled only.



Reimbursing Procedure Codes D0145 and D1206

Dental procedure code D0145 is an oral evaluation for a patient under three years of age and includes counseling with the primary caregiver. Oral evaluation is a diagnostic and preventive service which should be provided preferably within the first six months of the eruption of the first primary tooth. The evaluation should include recording the child's oral health history, caries susceptibility, development of an appropriate preventive oral health regimen, and communication with and counseling of the child's parent, legal guardian or caregiver. Medicaid reimburses \$16.00 for procedure code D0145.

Procedure code D1206 is for the application of topical fluoride varnish and is a therapeutic application for moderate to high caries risk patients. Application of topical fluoride varnish should be delivered in a single dose involving the entire oral cavity. Fluoride varnish is not to be used for desensitization. Medicaid reimburses \$11.00 for procedure code D1206.

For children under three years of age, procedure codes D0145 and D1206 must be billed together. D0145 and D1206 may not be billed with any other type of evaluation or fluoride treatment on the same date of service.

Fluoride varnish may be applied to any child age 0 to 20. The oral evaluation (D0145) may be provided to children 0 to three years of age.

Reminder to Dental Providers

The Medicaid Child Health Check-Up Program (EPSDT) recommends that children under the age of 21 have a dental check-up beginning at age 3 or earlier, if medically necessary. Subsequent dental visits should be provided every 6 months or earlier, if medically indicated.

Prior Authorization for Private Duty Nursing and Personal Care Changes

Recently, there have been changes to the prior authorization process for private duty nursing and personal care services through the Agency's peer review organization, KePRO.

Effective March 1, 2008, certification periods can now be up to 180 days. However, home health agencies are still required to have an updated and physician approved plan of care maintained in the beneficiary's record every 60 days.

Effective April 1, 2008, KePRO modified the prior authorization submission process to include a mandatory plan of care questionnaire. Each field in the questionnaire requires a response prior to submission. To view the new mandatory plan of care questionnaire please go to the KePRO website at www.keprohomehealth.com, click on the "Providers" link located on the left side of the webpage, then select 2008-03 PDN Questionnaire2.pdf from the document directory.

Please contact the KePRO Provider Service Representatives at 1-800-922-3506 with any questions on this transition.



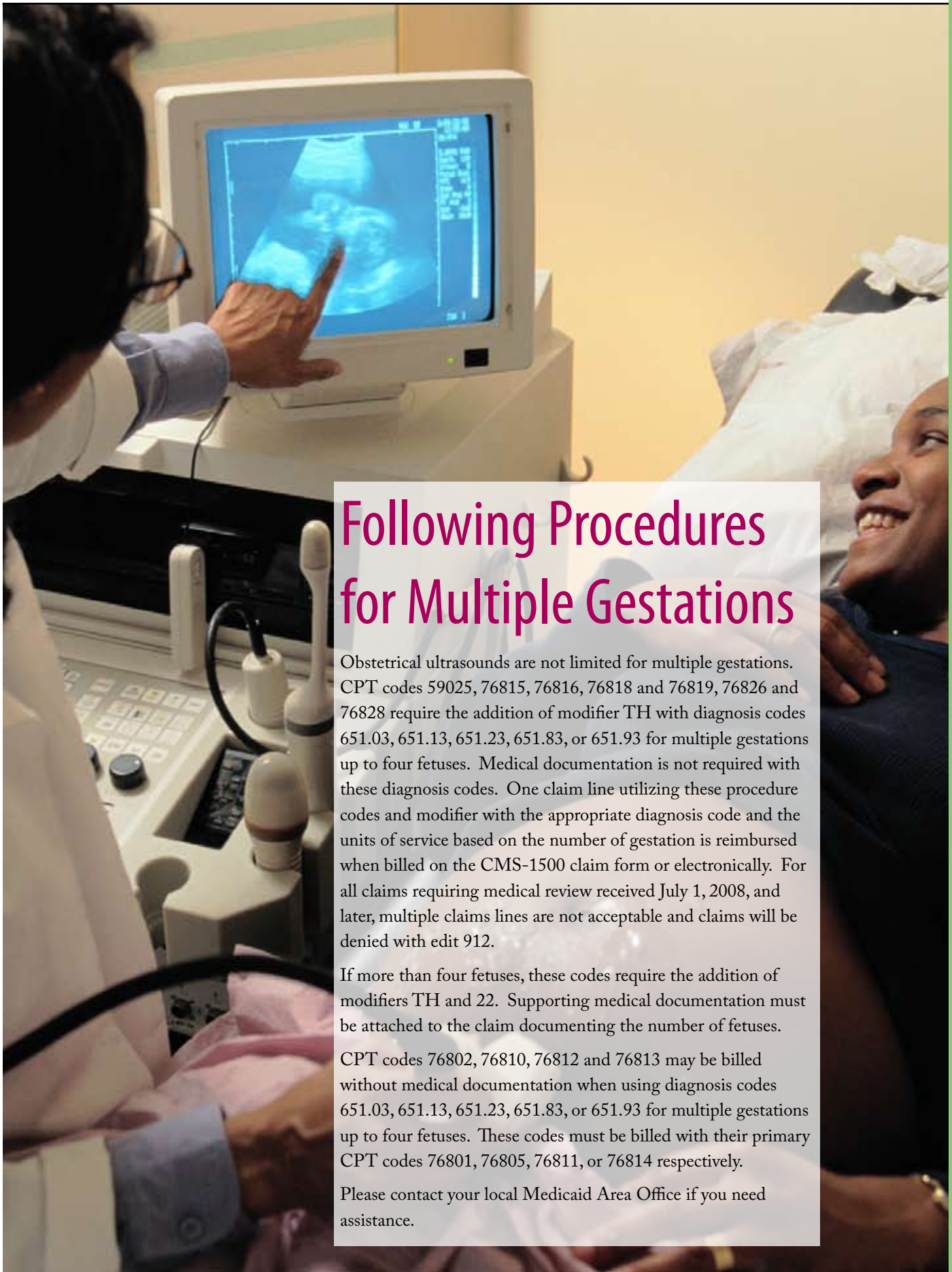
New Study of 2007-2008 Behavioral Health Prior Authorization Process

The Florida Managed Care External Quality Review (EQR) contract for Fiscal Year 2007-2008 includes a focused study on "Behavioral Health Prior Authorization Processes." This study focuses on behavioral health outpatient services across Health Maintenance Organizations, Provider Service Networks, and Prepaid Mental Health Plans, collectively referred to as Managed Care Organizations (MCOs).

The focused study consists of a desk review aimed at determining how prior authorization processes for outpatient behavioral health services vary across the MCOs. The purpose of the focused study is three-fold:

- To gather preliminary information regarding potential barriers to the prior authorization processes across MCOs;
- To determine to what extent variation exists across the MCOs between prior authorization processes and medical necessity criteria used in prior authorizations; and
- To evaluate how the timeliness of behavioral health prior authorizations varies across MCOs.

The results of this study will provide the Agency for Health Care Administration with information on which to focus quality improvement efforts. These efforts will enhance behavioral health prior authorization processes and foster collaborative efforts between the Agency, managed care organizations, and behavioral health care providers. For more information about this focused study and Florida's managed care external quality review initiative, please visit <http://www.MyFloridaEORO.com>.



Following Procedures for Multiple Gestations

Obstetrical ultrasounds are not limited for multiple gestations. CPT codes 59025, 76815, 76816, 76818 and 76819, 76826 and 76828 require the addition of modifier TH with diagnosis codes 651.03, 651.13, 651.23, 651.83, or 651.93 for multiple gestations up to four fetuses. Medical documentation is not required with these diagnosis codes. One claim line utilizing these procedure codes and modifier with the appropriate diagnosis code and the units of service based on the number of gestation is reimbursed when billed on the CMS-1500 claim form or electronically. For all claims requiring medical review received July 1, 2008, and later, multiple claims lines are not acceptable and claims will be denied with edit 912.

If more than four fetuses, these codes require the addition of modifiers TH and 22. Supporting medical documentation must be attached to the claim documenting the number of fetuses.

CPT codes 76802, 76810, 76812 and 76813 may be billed without medical documentation when using diagnosis codes 651.03, 651.13, 651.23, 651.83, or 651.93 for multiple gestations up to four fetuses. These codes must be billed with their primary CPT codes 76801, 76805, 76811, or 76814 respectively.

Please contact your local Medicaid Area Office if you need assistance.

New Claims System for Multiple Surgery Billing

Multiple surgeries are separate procedures performed by a physician on the same patient during the same operative session or on the same day. Medicaid is programming the new claims processing system to price multiple surgery claims. This will reduce the requirements for paper processing in the future. Providers should bill surgical claims in the following manner to ensure correct reimbursement:

- Bill all surgical procedures performed during the same operative session on the same claim;
- Put the primary procedure with the highest Medicaid reimbursement on the first line.;
- Bill the secondary procedure with the second highest Medicaid reimbursement on the claim line directly under the primary procedure;
- If the secondary surgical procedures are subject to Medicaid/Medicare multiple surgery pricing rules, use modifier 51;
- If the procedure is an add-on code, or not subject to multiple surgery pricing, use modifier 59, or no modifier. Do not use modifier 51;
- Use modifier 62 in the first modifier field when billing co-surgeon claims; and

- Use modifier 80 in the first modifier field when billing assistant surgeon claims.

Reimbursement for multiple surgery procedures for the same beneficiary, on the same day by the same treating provider, are priced using the following methodology:

- 100% of the Medicaid fee for the procedure with the highest fee;
- 50% of the Medicaid fee for the procedure with the second highest fee; and
- 25% of the Medicaid fee for all remaining procedures that are subject to multiple surgery pricing rules.

For example: If you are billing for a repair of a rotator cuff (Code 23412), a ligament release (Code 23415), and a claviclectomy (Code 23120), report the codes as follows:

- 23412;
- 23415-51; and
- 23120-51.

For questions regarding this information, contact your local Medicaid Area Office.

Biophysical Profiles Required or Claim is Denied

The Florida Medicaid Physician Coverage and Limitations Handbook requires all components of a biophysical profile documented in the report. All claims with reports without the detailed components will be denied with edit 909. Refer to page 2-75 of the handbook. This handbook is available on the fiscal agent website at <http://floridamedicaid.acs-inc.com>, click on "Provider Support" then "Handbooks".

CPT code 76819 requires a maximum score of 8 with four listed components. These components include fetal breathing, fetal movements, fetal muscle tone, fetal heart rate and amniotic fluid. CPT code 76818 requires a maximum score of 10 with five listed components. These components include fetal breathing, fetal movements, fetal muscle tone, fetal heart rate, amniotic fluid, and a non-stress test.

Reimbursing Fluoride Varnish Application

Effective April 15, 2008, Medicaid will cover the application of fluoride varnish when provided to beneficiaries in a physician's office. Physicians, physician assistants, and advanced registered nurse practitioners may provide this service and bill Medicaid using CPT procedure code 99499 SC (medically necessary service). Procedure code 99499 SC must be submitted once per claim on the same date of service. Medicaid payment for 99499 SC will be \$27.00 and is a combined payment amount for both the application of fluoride varnish and the oral evaluation for a child from birth to three years of age. Fluoride varnish may be billed once every three months up to age three.

The oral evaluation and fluoride varnish application are preventive services which should be provided to high risks patients, preferably within the first six months of the eruption of the first primary tooth. The fluoride varnish application should include communication with and counseling of the child's caregiver. The caregiver should be informed that the child needs to be seen by a dentist. If a dental provider is not available in an area, physicians should notify the area Medicaid office that the child needs a dental visit.

When provided in a county health department (CHD) or federally qualified health center (FQHC), fluoride varnish must be billed using the CHD or FQHC fee-for-service group provider number. The treating provider number must be entered in item 24J on the CMS-1500 claim form.

Managed care plans will cover the service and it will be included in their capitation rate.

Note: Fluoride varnish maybe applied to a child's teeth at the time of immunizations or a Child Health Check-Up visit. Procedure code 99499 SC can be billed in addition to immunizations and Child Health Check-Up visit code(s).

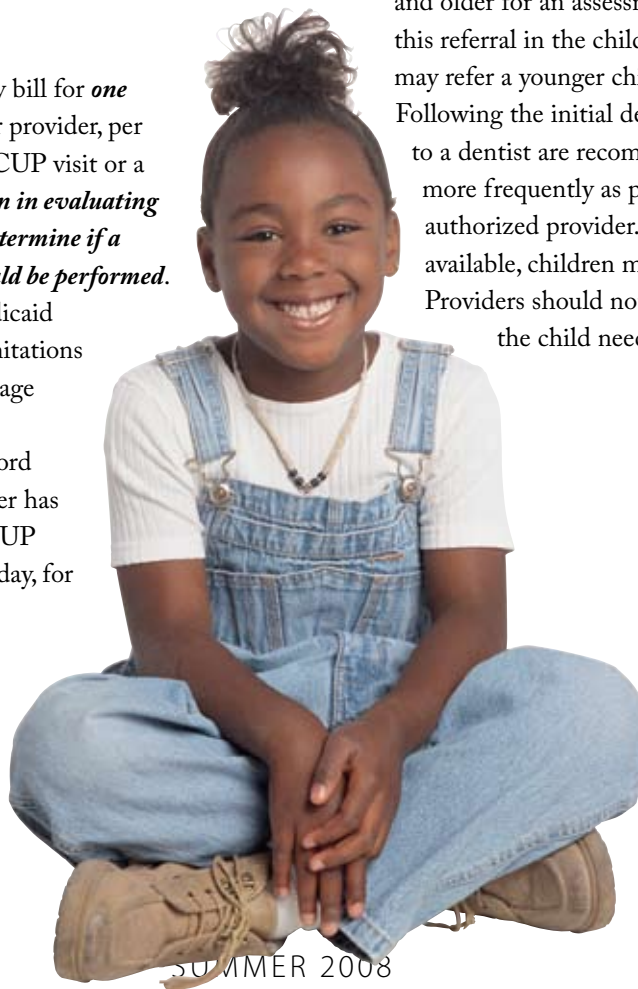
Critical Reminder to Child Health Check-Up (CHCUP) Providers



- As licensed health care professionals you are aware that performing a blood test for lead is a federal requirement at specific intervals during the “Child Health Check-Up.” This note is to remind you how important it is to document the blood tests you are performing in compliance with this federal mandate. Failure to provide documentation can lead to a federal audit and the requirement to repay Medicaid for fees received. The **federal regulation** as referenced in the Child Health Check-Up Coverage and Limitations Handbook, October 2003, pages 2-13 and 2-14; and page 3-6, **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.
- 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 19 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.
- **Dental referrals are required beginning at three years of age; earlier as medically indicated.** CHCUP providers must refer Medicaid children who are three years old and older for an assessment by a dentist and document this referral in the child’s medical record. The provider may refer a younger child if it is medically necessary. Following the initial dental referral, subsequent visits to a dentist are recommended every six months, or more frequently as prescribed by a dentist or other authorized provider. If a dental provider is not available, children must still be referred to a dentist. Providers should notify the area Medicaid office that the child needs a dental visit.

Please also note:

- 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 19 of this Bulletin per claim format.



CHILD HEALTH CHECK-UP

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 (Use 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 (Use 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 (Use 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)





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