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# Florida Medicaid Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION



## UNDERSTANDING COMPLAINTS/ GRIEVANCES AND WAYS TO IMPROVE ENROLLEE SATISFACTION

Federal and state regulations for Medicaid managed care contracts differ from the regulations for commercial health plans. One major difference involves the handling of complaints/grievances. The Code of Federal Regulations (CFR) governing the complaint/grievance process is described in 42 CFR 438.400. States also have the option of applying additional state-specific requirements.

Specific to Florida Medicaid, complaints and grievances are defined as follows:

- Complaint: "any expression of dissatisfaction by a subscriber, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care." [s. 641.47, F.S.]
- Grievance: "an expression of dissatisfaction about any matter other than an action (e.g., action is defined as failure to provide services or the denial/reduction of payment of services)." [42 CFR 438.400(b)(6)]
- Possible subjects for grievances: "the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights." [42 CFR 438.400]

Medicaid enrollees may file a complaint for any level of dissatisfaction concerning the quality of care or services provided. Most of the complaints made to health plans and Medicaid agencies involve:

- Delays in or limited access to referrals or specialists.
- Access to or denial of services (including pharmaceuticals).
- Dissatisfaction with quality of care.
- Billing procedures or co-pay disputes.
- Waiting times for appointments.
- Administrative issues.

The state of Florida regularly reviews Medicaid managed care organizations (MCOs) to ensure that MCOs have an appropriate structure in place for enrollees to file complaints/grievances. The state also continuously monitors the types of complaints/grievances filed by enrollees and conducts investigations on particular complaints/grievances. Health Services Advisory Group (HSAG), Florida's external quality review organization (EQRO), verifies that the Agency for Health Care Administration monitors Medicaid member

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



Articles with this graphic contain important Medicaid provider handbook information.



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# A MESSAGE FROM SECRETARY HOLLY BENSON

Dear Medicaid Partner:

Last year Governor Charlie Crist launched Accelerate Florida to speed up the expenditure of billions of dollars in approved construction and capital outlay projects and to identify ways to grow Florida's businesses. In response, we launched our own AHCA-celerate Florida initiative which was designed to streamline the ways we do business with our licensees and providers and to reduce the regulatory costs to them.

This year our AHCA-celerate team has been evaluating our business processes and finding ways to use Web and portal technologies to make it easier for our providers to work with us. A key element in this effort is the elimination of duplication of effort in the Agency's work processes and data management.

Our team is working on over 40 initiatives throughout the Agency to increase efficiency, eliminate duplication, and improve the way we work with you. At the same time, we are looking at statutory changes needed to reduce and streamline regulations. Better health care for all Floridians includes helping providers spend less time on paperwork and more time on patient care. We appreciate that you are committed to providing the best possible care to our neediest Floridians. While we may not be able to pay you more during these tight budget times, we will continue to work to cost you less.

We are also challenging our staff to find new ways to save on operational costs. We launched the AHCA Challenge in August with a goal of reducing energy and supply costs across the Agency. Among other things, we will be measuring the impact of team efforts to reduce the use of paper by consolidating the use of printers and setting printer defaults to always use double-sided printing. Our buildings will compete to find new ways to reduce energy costs. In addition, we are looking for ways to allow you to submit documents to us electronically, and if you have suggestions I hope you will e-mail them to [ahcasecretary@ahca.myflorida.com](mailto:ahcasecretary@ahca.myflorida.com).

And speaking of technology, we are home to the Florida Center for Health Information and Policy Analysis (Florida Center). The Governor has designated the Florida Center as the coordinating body for the health information technology stimulus dollars under the American Recovery and Reinvestment Act (ARRA). The Florida Center is responsible for promoting the adoption of health information technology, including the electronic exchange of health information among providers, adoption of electronic health records, personal health records and e-prescribing among Florida's provider community and consumers. Our team is working with stakeholders statewide to implement health information technology programs funded through ARRA. You can learn more about these resources by visiting the Agency's Web site, [www.FHIN.net](http://www.FHIN.net).

We are always looking for innovative ways to drive change in Florida's health care system and looking for tools to make it easier to do business with us. We appreciate your suggestions, and as always, we are grateful for your commitment to providing quality health care to your patients who are on Medicaid.

Sincerely,



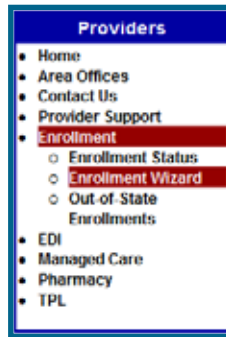
Holly Benson



# WEB PORTAL ONLINE PROVIDER ENROLLMENT

Did you know that you can enroll in the Florida Medicaid program on the Web Portal?

*Enrollment is easy!* The online Enrollment Wizard is a quick and efficient way for you to complete your application and track your application status. The wizard is available 24 hours per day, so you choose the time that is convenient for you. Once you complete and submit the application, delivery to Florida Medicaid is instantaneous. No waiting for mail delivery to confirm receipt. Since the enrollment effective date for most providers is the date their application was received, this instant delivery guarantees the earliest possible receipt date.



*No hold time!* In the Web Portal, you can obtain real time status updates anytime without calling the Provider Enrollment call center. An Application Tracking Number (ATN) is assigned to your application by the wizard. You can track the status of your application from the Enrollment Status page by simply providing the ATN and the business or last name that was submitted on the application.



The Enrollment Wizard is available in the public Web Portal. From the Florida Medicaid home page, <http://mymedicaid-florida.com>, click on Public Information for Providers, Enrollment, and then Enrollment Wizard. Click the "Enroll Now" link at the bottom of the page to access the wizard. Follow the on-screen instructions to complete the application.

After the application is submitted, you will be able to print or save a copy of your application for your records. You will also receive instructions regarding any supporting documentation, such as proof of licensure or specialty certification, which must be submitted to the Florida Medicaid fiscal agent in order to complete your enrollment. Remember to include the ATN with any correspondence related to your online application.

If you have questions about completing the online provider enrollment application, please review the *Guide for Completing a Medicaid Provider Enrollment Application*, which is available for download from the Enrollment page in the Web Portal, or call the Florida Medicaid fiscal agent's Provider Enrollment Unit at 1-800-289-7799, Option 4.

All providers may use the Web Portal; however, if your provider type requires a prior approval from another agency or organization, contact that agency or organization for enrollment instructions prior to submitting the online application.



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complaint/grievance information and reports the monitoring activities to the federal government annually.

Medicaid providers can reduce Medicaid enrollee complaints by:

- Maintaining a courteous and professional office environment, including a timely schedule.
- Providing timely, medically necessary referrals to specialists.
- Surveying enrollees to determine types of enrollee dissatisfaction and instituting improvement interventions to avoid future enrollee complaints.
- Ensuring enrollees receive education about medical office practices (office hours, what to expect during visits, diagnoses and treatment follow-up, etc.).

For additional information on Florida's external quality review initiatives for managed health care, which include health maintenance organizations, provider service networks, prepaid mental health plans and nursing home diversion plans, visit HSAG's Web site at: [www.MyFloridaEQRO.com](http://www.MyFloridaEQRO.com).



## CONSENT FOR STERILIZATION FORMS

Federal regulations require both male and female recipients to give written consent prior to sterilization procedures being performed. To meet this requirement, the provider must submit with the claim a Consent for Sterilization form, HHS-687 (11/06), that has been signed by the Medicaid recipient. In the past, medical reviewers have noted that many consent forms are either filled out incompletely or incorrectly, resulting in denial of the claim.

To access the Consent for Sterilization form, get step-by-step instructions, and to view a completed sample form, please go to <http://mymedicaid-florida.com>; click on Public Information for Providers, Provider Support, then Provider Handbooks. Near the bottom of the page, click on Provider Reimbursement, CMS-1500 Claim Form. Go to pages 3-36 through 3-44 for detailed instructions and a copy of the Consent for Sterilization form.

Please contact your local Medicaid area office if you have questions or need additional information.

Thank you for complying with this federal requirement.



## FLORIDA NEWBORN SCREENING RESULTS (FNSR) WEB SITE



Florida Newborn Screening Program is proud to announce the Florida Newborn Screening Results (FNSR) Web site available to primary care physicians to access newborn screening results online.

It's as easy as one, two, three:

1. Register at <https://www.fnsr.net>.
2. Click the *Request* link and complete the online form.
3. An automated password will be faxed prompting the user to create a new password within 24 hours.

FNSR maintains specimen results for the previous six months only. For specimens older than six months, a written request must be made to Florida Newborn Screening Program. Forms are available at the Florida Newborn Screening Web site listed below.

If you experience technical difficulties or have questions, please contact Drew Richardson at 850-245-4200 ext. 2261 or Kristin Jenkins at 850-245-4674 at the Florida Department of Health.

For more information about Florida Newborn Screening, visit the Web site at:

<http://doh.state.fl.us/cms/nbscreen.html>.



# NURSING HOME TRANSITION INITIATIVE

The Agency for Health Care Administration (Agency), the Department of Elder Affairs, the Department of Children and Family Services, and the Department of Health are working to identify Medicaid eligible nursing home residents 18 years of age or older who may be able to move to more independent community living settings.

If you are aware of nursing home residents who are interested in moving back into the community, please contact:

## **Clearinghouse on Disability Information**

**1-877-ADA-4YOU (1-877-232-4968)**

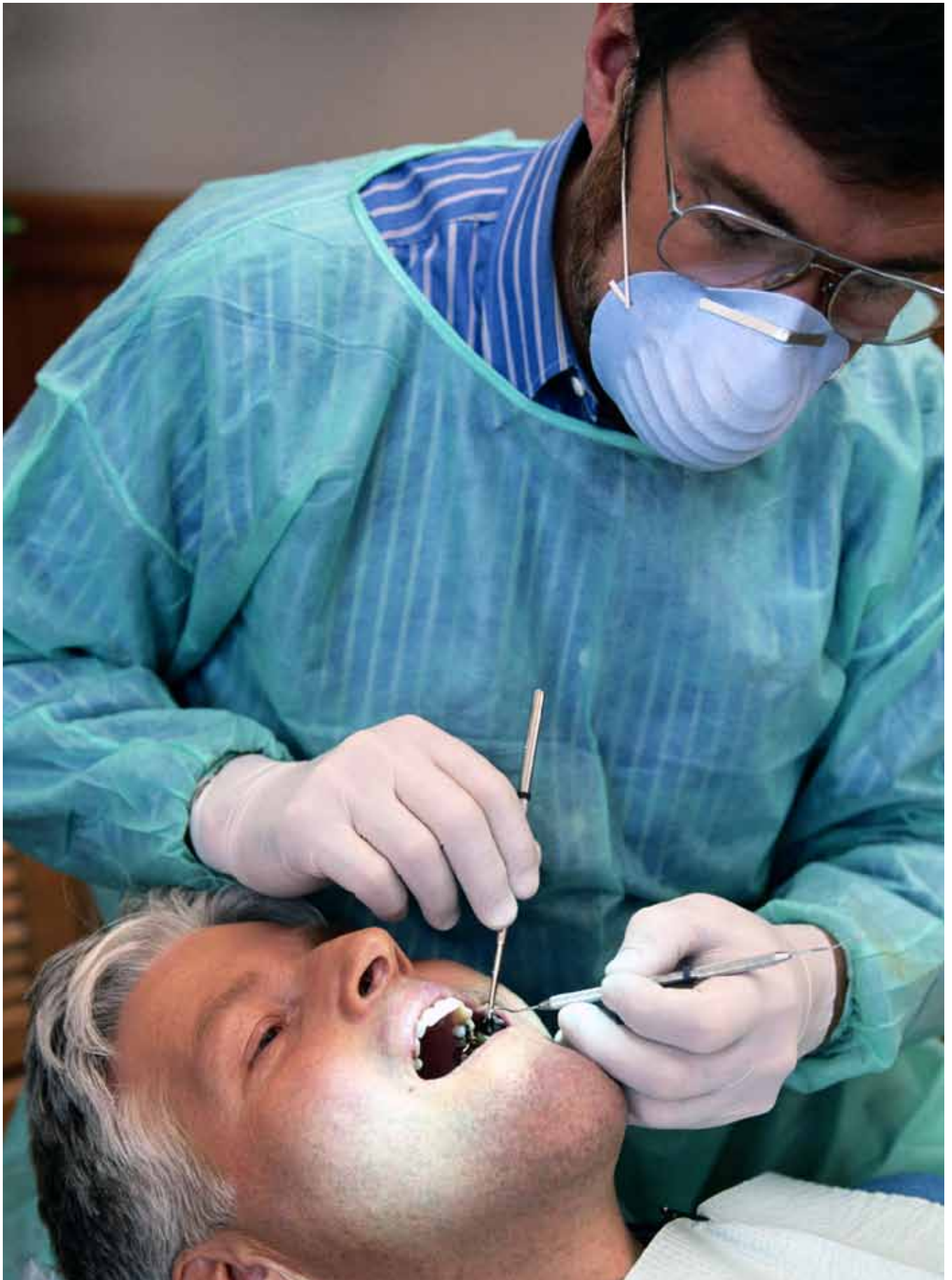
**Toll Free – Voice – TTY**

[clearinghouse@dms.myflorida.com](mailto:clearinghouse@dms.myflorida.com)

A specialist at this number will refer callers to the appropriate agency for assistance. Transition candidates will be interviewed and screened by the appropriate agency and, based on program availability, may be offered priority placement and services in home and community-based care programs.

The Agency will be sending out additional information concerning this initiative in the near future.





# A D U L T D E N T A L S E R V I C E S

The Medicaid adult dental services program provides medically-necessary, emergency dental procedures to alleviate pain or infection to eligible Medicaid recipients 21 years of age and older. Emergency dental care is limited to a problem focused evaluation, necessary radiographs to make a diagnosis, extraction, and drainage of an abscess. Removable partials, full dentures, and denture-related services such as adjustments, relines, and repairs are also covered services of the Medicaid adult dental services program. Surgical extractions and procedures are covered if the recipient is to receive a denture. Removable partials or full dentures are covered once in the lifetime of the recipient 21 years of age and older. Medicaid does not pay for lost partials or full dentures.

It is important that dental providers are aware of what dental services are covered for adults 21 years of age and older. Medicaid cannot pay for cleanings, periodontal procedures, fillings, or crowns. A provider cannot bill Medicaid for any services that are not covered under the Medicaid adult dental services program. Federally qualified health centers and county health departments cannot bill Medicaid the all inclusive encounter rate for a service that is not covered under the Medicaid adult dental services program. If these services are billed for adults 21 years of age and older, the claim will deny.

Please refer to the Dental Services Coverage and Limitations Handbook for information about the Medicaid adult dental services program. The handbook may be accessed at <http://mymedicaid-florida.com>; click on Public Information for Providers, Provider Support, then Provider Handbooks, and select the Dental Services Coverage and Limitations Handbook.



# 12 TIPS FOR SUCCESSFULLY SUBMITTING (PA 01) PRIOR AUTHORIZATION REQUESTS

*The Summer 2009 Provider Bulletin included this article with an inaccurate list of provider types displayed across the top portion of page 8. To avoid inappropriate submissions of prior authorization requests, we are re-running the article. We apologize for any confusion or inconvenience the previous publication may have caused.*

Here are 12 tips for in-state physicians and providers who are required to submit prior/post authorization requests for the following types of Medicaid services: Medical/Surgical (including Ophthalmologic surgeries, and excluding requests for transplants), Chiropractic, Podiatric, Hearing (including cochlear implantation surgery), Optometric, and Visual.

1. Florida Medicaid's Authorization Request form is also referred to as a PA request or the PA 01 form. A current PA 01 form can be downloaded at the following address: <http://mymedicaid-florida.com>. Select Public Information for Providers, Provider Support, and Forms, and under the "General Information" section of the "Category" column, select "Prior Authorization Request."
2. An Authorization Request (PA 01) form is only required for select procedures and services. To determine which procedures require the submission of a PA 01, review the Fee Schedule and Chapter 2 of the Coverage and Limitations Handbook specific to the procedure or service being requested.
3. Indicate the "type" of authorization requested, at the top of the PA 01 form:
  - Prior Authorization = Requesting Medicaid's determination of medical necessity for a specific service, before the service is provided to the recipient.
  - Post Authorization = Not appropriate for all codes requiring prior authorization. Only used to request Medicaid's determination of medical necessity for a specific service after the recipient has received the service (i.e., medical/surgical procedures that had to be performed as an emergency procedure, and hearing aid replacement parts/repairs).
4. Verify recipient's eligibility for Medicaid services and his/her 10-digit Medicaid ID #. Please note that the number on the recipient's gold card is NOT their Medicaid ID #. If needed, please review the Florida Medicaid Provider General Handbook, Chapter 3, "Ways to Access Recipient Information".
5. Include the diagnosis code(s) for the disease or condition which the code(s) will address. Do NOT write out the name of the diagnosis or condition in the diagnosis code box. Providers must use the current issue of the International Classification of Diseases (ICD-9-CM) guidebook, to identify the appropriate diagnosis code.

6. "Bilateral" surgical procedures require that a modifier "50" be added immediately after the procedure code being requested, and the modified procedure code must be requested as a quantity of one (1).
7. Attach documentation to support each request (i.e., clinical records, test results, and operative reports). Photos are also required for all surgical procedures that will alter the recipient's physical appearance (color is preferred). Audiogram results and a Medical Release are required for all hearing aid requests. Total dollar amounts requested must exclude shipping, handling, and tax.
8. Requests for contact lens must include specific information that will answer the medical reviewer's questions: Type of fitting = New or refit, one eye or both eyes; Lens type = Spherical or Toric; Lens material = PMMA, RGP, or Hydrophilic; Intended wear = Daily or continuous; Spectacle Rx: for both the right & left eye; Aphakia treatment = Yes or No; Price = List total fees in dollars (excluding initial exam); V codes = List all V codes required for service requested. "Special" contact lens fitting requests (i.e., Keratoconus, Corneal transplant, trauma, nystagmus, anisometropia, or other) must include diagnostic data, signs and symptoms.
9. Provider ID # entered in section II of the PA 01 must match name and address of requesting provider affixing his/her dated signature in this section. Contact name = first and last name of individual preparing/submitting the PA 01 form (may be different from the provider). Contact Phone Number = Daytime (work) phone number of identified contact person.
10. "Agency Use Only" section of the PA 01 form is reserved for use by Medicaid staff.
11. If an authorization request is returned to the provider for additional documentation:
  - Do NOT submit a new PA 01 form (make requested edits on the original PA 01 form).
  - Attach requested documentation and/or photos to original PA 01 form and supporting documentation.
  - Promptly return entire packet to address located at the top left portion of PA 01 form.
  - Retain a copy of PA 01 form and documentation for your file.
12. If the authorization period of approved Authorization Request expires before the services can be delivered to recipient:
  - Do NOT submit another (new) PA 01 form requesting an extension.
  - Promptly contact your local Medicaid area office to request the additional time required.





# 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" (CHCUP). 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 the ages of 12 months and 24 months, and between the ages of 36 months and 72 months if they have not been previously screened for lead poisoning.\* The procedure code for blood lead testing is 83655. The Child Health Check-Up Coverage and Limitations Handbook can be accessed by visiting <http://mymedicaid-florida.com>. Click on Public Information for Providers, Provider Support, then Provider Handbooks, and select the Child Health Check-Up Handbook.

\*The Florida Department of Health has announced the publication of the Childhood Lead Poisoning Screening and Case Management Guide. The guide provides valuable updated information for health care providers about childhood blood lead screening and case management requirements. The guide is available by calling 850-245-4444 ext. 2694 or by visiting the Florida Department of Health's [Florida Childhood Lead Poisoning Prevention Program](#) Web site.

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 CHCUP should be performed. This policy is explained in the Child Health Check-Up 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.
- It is critical that the federally required referral code be appropriate for the diagnosis code on CHCUPs. For example, a diagnosis code of V20.2 (routine infant or child health check) would be appropriate with a referral code of "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 3-4 of the Child Health Check-Up Coverage and Limitations Handbook, October 2003.
- CHCUP providers are responsible for referrals and follow-up on a Medicaid child as a result of a CHCUP. This is referenced in the Child Health Check-Up Coverage and Limitations Handbook, October 2003, page 2-2.
- Dental referrals are required beginning at 3 years of age; earlier as medically indicated. CHCUP providers must refer Medicaid children who are 3 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 6 months, or more frequently as prescribed by a dentist or other authorized provider. If a dental provider is not available, providers should notify the local Medicaid area office that the child needs a dental visit and still complete the referral.



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Connecting Florida to health care information  
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