



The Medicaid Bulletin

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*A Publication of the Agency for Health Care Administration
and UNISYS, the fiscal agent*

From the Medicaid Director

“As we work together to achieve these goals, we will continue to make a difference in the health care of our most vulnerable citizens and we will make Florida’s Medicaid program even more efficient and valuable to all of our citizens.”

As the Medicaid program begins a new fiscal year I wanted to take this opportunity to share with all of you, Florida’s Medicaid providers and your staff, our accomplishments of the past year and also inform you of our goals for the upcoming year.

Medicaid has accomplished a great deal over the last year. We have fully enrolled the Medicaid population required to participate in either the MediPass program or an HMO; reduced Medicaid inflation from 20+ percent annually down to 3.5 percent for the ten-year period ending in fiscal year 1995-96 (which represents the lowest growth rate in the history of the program); implemented reforms in several key programs, including community mental health, home health, and transportation; and staffed a Medicaid Reform Task Force, which laid the foundation for a number of additional Medicaid reforms.

Medicaid will save nearly \$200 million during FY 1996-97 and FY 1997-98 by:

- ⇒ Implementing fraud and abuse measures including provider re-enrollment and criminal background checks;
- ⇒ Expanding the Florida Medicaid Management Information System (FMMIS) edits;
- ⇒ Implementing provider bonding requirements;
- ⇒ Implementing site visits for high risk providers; and
- ⇒ Implementing new utilization review standards in several high growth service areas.

I also want to share with each of you our current goals and how we are making the Medicaid program even stronger and more efficient this year.

Data Warehousing - establish a data warehouse with five years of claims history, which provides easy and quick retrieval and analysis of data.

Performance Based Budgeting - develop outcome measures for the Medicaid program that will allow us to more effectively gauge the program’s performance.

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Contain the Growth in Medicaid Expenditures - maintain the low growth rates in Medicaid expenditures for the base program, allowing us to advocate for any new funds to improve services and access.

Medicaid Service Monitoring - analyze each Medicaid service, assessing service limits, system edits, provider performance, and other factors, to ensure we are operating as efficiently as we can.

Report on Medicaid in Florida - prepare a comprehensive report on why the Medicaid program is vital to Florida's communities and citizens including information on expenditures, recipients and providers.

Fiscal Agent Procurement - conduct a fiscal agent re-procurement, which will provide for better data reporting capabilities, enhanced fraud and abuse initiatives, and stronger prior authorization processing capabilities.

Third Party Liability - enhance our third party recovery efforts to provide for even greater cost avoidance and increased recoveries.

Expanded Area office Operations - conduct credentialing site visits to MediPass providers along with medical records reviews, and conduct provider and recipient satisfaction surveys.

Fraud and Abuse - continue our aggressive efforts to curtail fraud and abuse in the Medicaid program, which has made us the leader nationally in this area.

You, the Medicaid providers, are the core of the health care system for Florida's most vulnerable citizens -- low income families, children, the elderly, and the disabled. As we work together to achieve these goals, we will continue to make a difference in the health care of our most vulnerable citizens and we will make Florida's Medicaid program even more efficient and valuable to all of our citizens.

Gary Crayton

Director of Medicaid

Medicaid extends its thanks to Gary Crayton for a "job well done in Medicaid." Gary is now with the Florida Health Care Association as the Director of Reimbursement.

Richard T. Lutz, Director, Division of State Health Purchasing, has assumed the direction of Medicaid.

Guidelines for Submitting Paper Claims, Prior Authorizations, and Crossover Claims

In order to help keep the claims and prior authorization process flowing smoothly, Medicaid and Unisys strongly encourage providers to follow the instructions listed below. When these instructions are not followed, in most cases, claims will be returned unprocessed. **Help us help you!**

Please ...

When submitting claims or prior authorizations:

- ◆ Put one staple (or paper clip) at the top when there are attachments.
- ◆ Do not hole-punch the papers.
- ◆ Tear apart perforated forms.
- ◆ Do not use fax copies of claims or attachments (they can't be imaged).
- ◆ Do not use highlighter; circle names on EOMBs in red ink only.
- ◆ Do not use peel-off labels on the claim form.
- ◆ Use only one EOMB per claim total on crossover claims (no split balances).
- ◆ Put the provider's name and address and recipient's name on all photos. (Staple photos to the claim; photos that are not stapled to a claim can become separated from the form they belong to, and cannot be identified or used in processing the claim.)

Please...

When submitting crossover claims, **DO NOT**:

- ◆ Submit crossover claims when there are zero ("0") dollar amounts in EOMB fields 5, 9, or 11 for physician providers.
- ◆ Submit crossover claims when there are zero ("0") dollar amounts in the Medicare allowed, deductible, and Medicare paid fields of any EOMBs.

When zero dollar amounts appear in the above fields of crossover claims, either the claim is not covered by Medicare, or Medicare has paid the claim in an amount that equals or exceeds Medicaid's rate.

Area Medicaid Offices Offer Provider Training

If you want to learn about Medicaid, the basics of MediPass, get an explanation of current changes, or share your questions, problems and solutions with area Medicaid staff and other Medicaid or MediPass program providers, see the training schedules listed below for opportunities in your area:



Area 1: Serving Escambia, Santa Rosa, Okaloosa and Walton counties, conducts a claims workshop for physician HCFA-1500 billers on the second and fourth Wednesday of each month. Call Becky Thomas at (850) 494-5840, ext. 125, to sign up and obtain training times and location. MediPass training is held the second Thursday of each month from 10:00 AM until 12 noon. Call Linda Bane at (850) 494-5840, ext. 150, for reservations and additional information. Space is limited and reservations are required.



Area 4: Serving Baker, Clay, Duval, St. John's, Nassau, Flagler and Volusia counties, conducts claims workshops, MediPass provider training, and other specialty training each month. Space is limited and reservations are required. Call Kateria Jenkins at (904) 353-2100, ext. 129, for more information, to sign up for training, and to obtain specific dates, times, and locations of training.



Area 10: Serving Broward county, offers HCFA-1500 training at the area office. Information concerning dates and times is available when you call for reservations at (954) 202-3200, ext. 120.



Area 11: Serving Dade and Monroe counties offers regular individual claims assistance for physician and hospital billers. Providers may come to the area office in Miami, at 8355 N.W. 53rd St., from 10:00 am to 12:00 noon, on the first and third Tuesday of every month. Reservations are no longer necessary. Please arrive early to assure a seat.

Have You Stopped Providing Medicaid Services?

If you plan to, or have already stopped providing Medicaid services for any reason (e.g., retirement), you or your authorized representative (in the event of your incapacity or death), must notify Unisys, Medicaid's fiscal agent, and request that your Medicaid provider number be terminated.

To request termination of your provider number, you or your authorized representative must send on letterhead stationery, the following information:

- ⇒ Provider name
- ⇒ Provider address
- ⇒ Provider Medicaid number
- ⇒ Reason for cancellation
- ⇒ Effective date of termination

The letter must have an original signature from the provider or the authorized representative.

Send the letter to:

UNISYS Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070



Receiving Multiple Copies Of Medicaid Publications

Occasionally, a provider will inform the Agency for Health Care Administration (AHCA) or Unisys that he or she receives multiple copies of a handbook, update, notice or Medicaid Bulletin, needs more than received, or wants a reduction in the number to be mailed in the future.

Unisys must mail the appropriate Medicaid provider handbooks, updates, notices, and a quarterly Medicaid Bulletin to every active individual provider and provider group.

If a practice has one group provider number and three individual provider numbers, all with the same "mail to" address, the group and all the individual providers within the group will receive an appropriate handbook, update, notice, or Medicaid Bulletin. This furnishes each Medicaid provider and group with an official notice of all information they are required to know and apply when furnishing services to Medicaid recipients and billing for those services.

Medicaid appreciates efforts by providers to report multiple copies of publications; however, Medicaid and its fiscal agent, Unisys, must send notification to every active provider listed on the Florida Medicaid Management Information System whenever there is a change in information affecting each of those providers and the services they render. If your group receives multiple copies, please make sure they are distributed to each appropriate provider.

If you are a group whose providers use a common copy of Medicaid information and you would like to return any unused copies, please return them to your local area Medicaid office or give them to your local Unisys field representative.

Area 10 Medicaid Has Moved

The Area 10 Medicaid Office that serves Broward County has moved to:

**1400 West Commerical Blvd., Suite 100
Ft. Lauderdale, Florida 33309**

New phone number: (954) 202-3200

Fax number: (954) 202-3220

TDD number: (954) 202-3222



NOTICE OF CHANGE

Vendors for Medicaid Eligibility Verification Services (MEVS)

Authorized Vendors as of 9/1/97

*Please update your records
and other materials now!*

Consultec, Inc.

1-800-987-6718

ENVOY Corporation

1-800-366-5716

Healthcare Data Exchange Corporation

1-610-219-1784

HealthNet Data Link, Inc.

1-800-486-7352

Insurance Benefit Spot Check, Inc.

1-800-233-7768

MedE America (was Gen. Cmputr. Corp.)

1-800-521-4548

MedE America (was Time-Share Cmputr. Sys.)

1-800-521-4548

MediFAX / The Potomac Group, Inc.

1-800-444-4336

NDC "Healthcare EDI Services" (was Equifax)

1-800-882-0802

National Data Corporation

1-800-994-9100

Omega Systems, Inc.

1-800-260-3316

1998 Diagnosis Codes for Physicians and Hospitals

Effective October 1, 1997, Medicaid will cover the new diagnosis codes listed on this page and on page six.

| Code | Diagnosis | Code | Diagnosis |
|--------|--|--------|--|
| 007.4 | Other protozoal intestinal diseases, cryptosporidiosis | 438.42 | Late effect of cerebrovascular disease, monoplegia of lower limb affecting non-dominant side |
| 031.2 | Disease due to disseminated mycobacterium, avium-intracellular complex (DMAC) | 438.50 | Late effect of cerebrovascular disease, other paralytic syndrome affecting unspecified side |
| 038.10 | Staphylococcal septicemia, unspecified | 438.51 | Late effect of cerebrovascular disease, other paralytic syndrome affecting dominant side |
| 038.11 | Staphylococcal aureus septicemia | 438.52 | Late effect of cerebrovascular disease, other paralytic syndrome affecting non-dominant side |
| 038.19 | Other staphylococcal septicemia | 438.81 | Other late effect of cerebrovascular disease, apraxia |
| 275.40 | Unspecified disorder of calcium metabolism | 438.82 | Other late effect of cerebrovascular disease, dysphasia |
| 275.41 | Hypocalcemia | 438.89 | Other late effect of cerebrovascular disease |
| 275.42 | Hypercalcemia | 438.9 | Unspecified late effects of cerebrovascular disease |
| 275.49 | Other disorder of calcium metabolism | 458.8 | Other specified hypotension |
| 438.0 | Late effect of cerebrovascular disease, cognitive deficits | 474.00 | Chronic tonsillitis |
| 438.10 | Late effect of cerebrovascular disease, speech and language deficits, unspecified | 474.01 | Chronic adenoiditis |
| 438.11 | Late effect of cerebrovascular disease, speech and language deficit, aphasia | 474.02 | Chronic tonsillitis and adenoiditis |
| 438.12 | Late effect of cerebrovascular disease, speech and language deficit, dysphasia | 482.84 | Legionnaire's disease |
| 438.19 | Late effect of cerebrovascular disease, other speech and language deficits | 518.6 | Allergic bronchopulmonary aspergillosis |
| 438.20 | Late effect of cerebrovascular disease, hemiplegia affecting unspecified side | 655.70 | Decreased fetal movements unspecified as to the episode of care or not applicable |
| 438.21 | Late effect of cerebrovascular disease, hemiplegia affecting dominant side | 655.71 | Decreased fetal movements delivered, with or without mention of antepartum condition |
| 438.22 | Late effect of cerebrovascular disease, hemiplegia affecting non-dominant side | 655.73 | Decreased fetal movements antepartum condition or complication |
| 438.30 | Late effect of cerebrovascular disease, monoplegia of upper limb affecting unspecified side | 686.00 | Other skin and subcutaneous tissue infection, pyoderma, unspecified |
| 438.31 | Late effect of cerebrovascular disease, monoplegia of upper limb affecting dominant side | 686.01 | Other local infection of skin and subcutaneous tissue, pyoderma gangrenosum |
| 438.32 | Late effect of cerebrovascular disease, monoplegia of upper limb affecting non-dominant side | 686.09 | Other local infection of skin and subcutaneous tissue, other pyoderma |
| 438.40 | Late effect of cerebrovascular disease, monoplegia of lower limb affecting unspecified side | 756.70 | Congenital anomaly of abdominal wall, unspecified |
| 438.41 | Late effect of cerebrovascular disease, monoplegia of lower limb affecting dominant side | 756.71 | Congenital anomaly of abdominal wall, prune belly syndrome |

1998 Diagnosis Codes for Physicians and Hospitals

| Code | Diagnosis |
|-------------|--|
| 756.79 | Other congenital anomalies of abdominal wall |
| 780.31 | Febrile convulsions |
| 780.39 | Other convulsions |
| 790.94 | Other nonspecific findings on examination of blood, euthyroid sick syndrome |
| 796.5 | Abnormal findings on antenatal screening |
| 959.01 | Head injury, unspecified |
| 959.09 | Injury of face and neck |
| V02.60 | Viral hepatitis carrier, unspecified |
| V02.61 | Hepatitis B carrier |
| V02.62 | Hepatitis C carrier |
| V02.69 | Other viral hepatitis carrier |
| V12.40 | Personal history of unspecified disorder of nervous system and sense organs |
| V12.41 | Personal history of benign neoplasm of the brain |
| V12.49 | Personal history of other disorder of nervous system and sense organs |
| V16.40 | Family history of malignant neoplasm of genital organ, unspecified |
| V16.41 | Family history of malignant neoplasm of ovary |
| V16.42 | Family history of malignant neoplasm of prostate |
| V16.43 | Family history of malignant neoplasm testis |
| V16.49 | Family history of other malignant neoplasm |
| V28.6 | Antenatal screening for streptococcus B |
| V42.81 | Organ or tissue replaced by transplant, bone marrow |
| V42.82 | Organ or tissue replaced by transplant, peripheral stem cells |
| V42.83 | Organ or tissue replaced by transplant, pancreas |
| V42.89 | Other organ or tissue replaced by transplant |
| V45.61 | Cataract extraction status |
| V45.69 | Other states following surgery of eye and adnexa |
| V45.71 | Acquired absence of breast |
| V45.72 | Acquired absence of intestines, large/small |
| V45.73 | Acquired absence of kidney |
| V53.01 | Fitting/adjustment of cerebral ventricular (communicating) shunt |
| V53.02 | Fitting/adjustment of neuropacemaker, brain, peripheral nerve, spinal cord |
| V53.09 | Fitting/adjustment of other devices related to the nervous system and special senses |
| V64.4 | Laparoscopic surgical procedure converted to open procedure |
| V76.10 | Screening for malignant neoplasm, breast screening, unspecified |
| V76.11 | Screening mammography for high risk patient, malignant neoplasm of breast |
| V76.12 | Other screening mammography for malignant neoplasm of breast |
| V76.19 | Other screening breast examination for malignant neoplasm |

Physicians, Hospitals

Invalid Diagnosis Codes

Effective October 1, 1997, the diagnosis codes listed below will be invalid. They have been replaced by new codes with 4th or 5th digit positions.

| Code | Description |
|-------|--|
| 038.1 | Staphylococcal septicemia |
| 275.4 | Disorders of calcium metabolism |
| 438 | Late effects of cerebrovascular disease |
| 474.0 | Chronic tonsillitis and adenoiditis |
| 686.0 | Other local infections of skin and subcutaneous tissue, pyoderma |
| 756.7 | Other congenital anomalies of abdominal wall |
| 780.3 | Convulsions |
| 959.0 | Injury, other and unspecified of head, face, and neck |
| V02.6 | Carrier or suspected carrier of viral hepatitis |
| V12.4 | Personal history of disorders of nervous system and sense organs |
| V16.4 | Family history of malignant neoplasm of genital organs |
| V42.8 | Unspecified organ or tissue replaced by transplant |
| V45.6 | Other postsurgical state following surgery of eye and adnexa |
| V53.0 | Fitting and adjustment of devices related to nervous system and special senses |
| V76.1 | Special screening for malignant neoplasm of the breast |

Hospitals

New ICD-9 CM Procedure Codes

Effective October 1, 1997, the new ICD-9 CM procedure codes listed below will be covered by Medicaid for hospitals:

| Code | Description |
|-------|---|
| 37.35 | Partial ventriculectomy |
| 41.05 | Allogeneic hematopoietic stem cell transplant |
| 41.06 | Cord blood stem cell transplant |

Physicians, Hospitals



Reimbursement for Registered Nurse First Assistants

Effective July 1, 1997, Medicaid received legislative approval to directly reimburse registered nurse first assistants (RNFA) for their services. RNFAs must be enrolled as Medicaid providers to receive reimbursement. RNFAs who are employed directly by the facility may not receive additional reimbursement for their services when their costs are incorporated into the facility per diem rate. Medicaid provider enrollment packages may be obtained by calling Unisys at 1-800-289-7799.

Medicaid is currently developing RNFA policies and procedures. Only those surgical procedures that allow an assistant at surgery may be reimbursed to a RNFA based on 12.8 percent of the maximum fee on file.

If you want additional information about this program, please call your area Medicaid office. Also, look for more information on this new program in future Medicaid Bulletins.

Hospitals



Repayment Of PRO Denied Days

Hospitals may repay Medicaid for PRO denied days prior to receiving a recoupment letter by using the Medicaid claim adjustment or reimbursement void process. Specific procedures for completing these processes are outlined in the *Medicaid Provider Reimbursement Handbook, UB-92*, under “Resolving an Incorrect Payment” (pages 8-13, 14, & 15) and “How To File A Void Request” (pages 8-15 through 8-24).

If the claim was paid more than one year from the time of the PRO denial, you must submit the adjusted claim to your area Medicaid office for the override of edit 846 (adjustment exceeds 12 months from date).

Physicians, Independent Labs

Medicaid Does Not Cover New Temporary Codes

The Health Care Financing Administration (HCFA) allows billing for four new laboratory panels through the use of the temporary codes, G0095-G0098. Permanent Physicians' Current Procedural Terminology (CPT) codes for these new laboratory panels will be available for use effective January 1, 1998.

Until CPT codes are available for use, Medicaid providers should continue to bill the following components:

... for Hepatic Function Panel

- Albumin; serum (82040)
- Bilirubin, total AND direct (82251)
- Phosphatase, alkaline (84075)
- Transferase, aspartate amino (AST)(SGOT)(84450)
- Transferase, alanine amino (ALT)(SGOT)(84460)

... for Basic Metabolic Panel

- Carbon dioxide (bicarbonate) (82374)
- Chloride; blood (82435)
- Creatinine; blood (82565)
- Glucose; quantitative (82947)
- Potassium; serum (84132)
- Sodium; serum (84295)
- Urea nitrogen; quantitative (84520)

... for Electrolytes Panel

- Carbon dioxide (bicarbonate, 82374)
- Chloride; blood (82435)
- Potassium; serum (84132)
- Sodium; serum (84295)

... for Comprehensive Metabolic Panel

- Albumin; serum (82040)
- Bilirubin; total (82250)
- Calcium; total (82310)
- Chloride; blood (82435)
- Creatinine; blood (82565)
- Glucose; quantitative (82947)
- Phosphatase, alkaline (84075)
- Potassium; serum (84132)
- Protein; total, except refractometry (84155)
- Sodium; serum (84295)
- Transferase, aspartate amino (AST, SGOT, 84450)
- Urea nitrogen; quantitative (84520)

How To Handle EOB 163 Denials of W1875

It was announced in the February 1997 Medicaid Bulletin that independent laboratory providers could begin billing for the viral load HIV+ test using the temporary code W1875.

Regrettably, those providers who have submitted claims for W1875 without a diagnosis code have had their claims denied with EOB 163 (missing or invalid procedure code).

Since Medicaid does not require that a specific diagnosis code be included on the claim for reimbursement of this test, we are working with Unisys on a system change to remedy this incorrect denial. Subsequently, Unisys will reprocess any claims for W1875 that denied with EOB 163 up to the effective date of the system change.

To avoid the EOB 163 denial for W1875 prior to completion of the system change, you must:

- obtain a medically appropriate diagnosis code, and
- include it beside the procedure code in claim item 24E of the HCFA-1500 or electronic equivalent.

HCFA's G0100 Not Covered

HCFA has established the temporary code G0100 for the billing of HIV-1 viral load tests. Florida Medicaid does not allow the use of this code and providers are reminded that they are already able to bill for this test using the temporary code W1875 (see related article above).

Independent Labs

Correction

The article entitled "Procedure Code 86922 Now Covered By Medicaid" on page 15 of the June 1997 *Medicaid Bulletin* incorrectly included independent laboratories as a provider type who could be reimbursed for this procedure code as well as procedure code 86920. Neither procedure code 86920 nor 86922 is covered for independent laboratory providers. We apologize for the error.

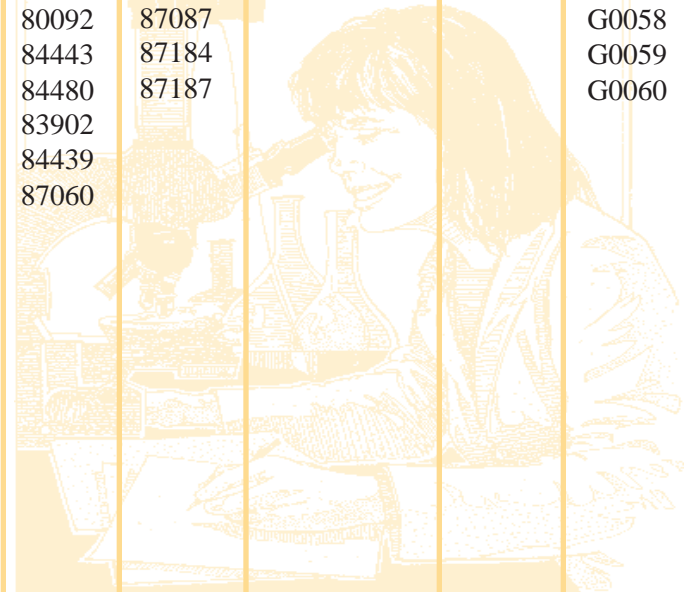
physicians/labs/podiatrists/PAs/ARNPs

Physicians, Independent Labs, Podiatrists

New Limits On Laboratory Procedure Codes

Effective September 1, 1997, the following laboratory procedure codes will be limited per recipient/per month(s) or year(s). This affects all claims being processed after September 1, 1997, regardless of the date of service.

| Per Recipient, per Year | | | | | | | | or, per Month | | |
|-------------------------------|-------|-------|-------|-------|-------|--------|-------|---------------|-------|---------|
| One | Two | Three | Four | Six | Eight | Twelve | Two | Three | | |
| 82103 | 82128 | 82307 | 86702 | 80059 | 82150 | 80091 | 87086 | 82785 | 87015 | 80002 |
| 82180 | 82380 | 84478 | 84153 | 82465 | 83010 | 84436 | 87088 | 86003 | 87045 | through |
| 82390 | 82607 | 86235 | 86225 | 83625 | 83690 | 84479 | 87186 | 86005 | 87177 | 80019 |
| 82525 | 84134 | 86290 | 86289 | 83715 | 83719 | 80092 | 87087 | | | G0058 |
| 83020 | 86038 | 86296 | 86295 | 83721 | 87040 | 84443 | 87184 | | | G0059 |
| 83825 | 86063 | 86306 | 86302 | 87070 | 87075 | 84480 | 87187 | | | G0060 |
| 84255 | 86160 | 86318 | 86317 | 87076 | 87082 | 83902 | | | | |
| 84446 | 86161 | 86644 | 86632 | 87085 | | 84439 | | | | |
| 84590 | 86162 | 86687 | 86677 | 87106 | | 87060 | | | | |
| 85660 | 86430 | 86692 | 86692 | 87181 | | | | | | |
| 82175 | 82131 | 86701 | 86703 | 80061 | | | | | | |
| 82300 | 82552 | 84066 | | 82784 | | | | | | |
| 82495 | 83930 | 86060 | | 83655 | | | | | | |
| 83015 | 84165 | 86255 | | 83718 | | | | | | |
| 83785 | 86039 | 86293 | | 85044 | | | | | | |
| 83885 | 86140 | 86299 | | 87072 | | | | | | |
| 84425 | | 86316 | | 87081 | | | | | | |
| 84252 | | 86631 | | 87101 | | | | | | |
| 84630 | | 86645 | | 87163 | | | | | | |
| 86689 | | 86688 | | 87205 | | | | | | |



If a procedure code limit needs to be exceeded due to medical necessity, the provider must attach a report to the claim, send it to the fiscal agent and bill the procedure with a -22 modifier. These claims will be reviewed by medical consultants.

If you have any questions concerning this new policy change or the specific codes affected, please call your area Medicaid office for assistance.

Physicians, Independent Labs, PAs, ARNPs

MediPass and Independent Labs



MediPass recipients may receive non-managed services such as mental health (except in Medicaid area 6) or family planning from any Medicaid provider of their choice, without authorization from their MediPass primary care provider. Lab services connected to non-managed services are also exempt from MediPass authorization. However, providers using independent labs for non-managed services must supply the lab with the appropriate related diagnosis code in order for the lab to bill and receive reimbursement from Medicaid. Lab services for any MediPass managed service requires the MediPass provider's authorization.

Licensed Midwives

Reimbursement for Licensed Midwife Services



Effective July 1, 1997, licensed midwives will be reimbursed by Medicaid for the following services:

| Code | Description | Reimbursement |
|-------|---|---------------|
| 59410 | Vaginal Delivery | \$640.00 |
| 99351 | Home Visit (limit 2) | \$ 20.76 |
| 99070 | Supplies/Materials | *By Report |
| J0290 | Ampicillin, 500 mg IV (max 14 units) | \$ 1.30/500mg |
| J1642 | Heparin Lock Flush | \$ 1.00 |
| J2790 | Rhogham (one dose pkg.) | \$ 51.22 |
| J3430 | Vitamin K Injection | \$ 2.32 |
| J7050 | Normal Saline, 250cc | \$ 2.50 |
| X5906 | Post Delivery Recovery | \$160.00 |
| X5907 | Labor Management Fee | \$200.00 |

* For "by report," you must submit a paper claim with the following statement: "standard birth kit."

Birth Centers

Reimbursement for Birth Center Services



Effective July 1, 1997, birth center providers will be reimbursed by Medicaid for the following services.

| Code | Description | Reimbursement |
|-------|--|---------------|
| J0290 | Ampicillin, 500mg IV (limit 14 units) | \$1.30/500mg |
| J1642 | Heparin Lock Flush | \$1.00 |
| J3430 | Vitamin K Injection | \$2.32 |
| J7050 | Normal Saline, 250cc | \$2.50 |

Future handbook updates to the *Birth Center and Licensed Midwife Services Coverage and Limitations Handbook* will reflect all the changes listed above.

Physicians, PAs, ARNPs



Surgical Codes* Now Reimbursable "In Addition To A Visit"

In an effort to be more consistent with Medicare reimbursement methodology, Medicaid has been reviewing its Current Procedural Terminology (CPT) code files relative to CPT guidelines.

Effective November 1, 1997, and affecting claims processed after December 1, 1997, surgical procedure codes with an asterisk (*) in the *Physicians' Current Procedural Terminology* book may be reimbursed in addition to a visit.

Physicians, Podiatrists, Chiropractors, PAs, ARNPs

MediPass and Limited Direct Access

During the 1997 legislative session, bills were passed to allow Medicaid recipients enrolled in MediPass to have direct access to chiropractors and podiatrists for the first ten visits and four visits respectively (per calendar year) without requiring authorization from their primary care providers. Although the legislation was effective July 1, 1997, the Agency did not obtain federal approval to implement this policy change until August 5, to be effective for dates of service on or after August 15, 1997.

Approval has been received from the Health Care Financing Administration to allow limited direct access to chiropractors and podiatrists. The necessary system changes will be made with Unisys, Medicaid's fiscal agent, to allow implementation of this new policy. Providers will be notified when the system changes have been completed.

Attacking Asthma: A Cost Saving Public/Private Initiative To Improve The Quality Of Children's Lives



“Attacking Asthma” is a cost saving public/private initiative designed to improve the quality of life for asthmatic children in South Florida. It is a multidisciplinary, family/culturally sensitive, research-based framework, that involves the collaboration and cooperation of the Agency for Health Care Administration (AHCA), Miami Children’s Hospital, the Health Council of South Florida and doctors in the targeted community. The Florida Legislature created a special “Innovations Investment Program” to encourage state agency initiatives that would improve the delivery of public service and/or result in cost savings. “Attacking Asthma” was one of thirteen proposals selected.

Research has shown that asthmatic children have a high rate of hospitalization and emergency room utilization and that 25 percent of absences of these children from school are related to asthma. Medicaid statistics indicate that over one thousand Medicaid children in Dade County are hospitalized each year with a diagnosis of respiratory illness. The cost to serve this population is over six million dollars.

Medical experience shows that chronic conditions like asthma can be more effectively managed through prevention, education and early intervention services. The “Attacking Asthma” program will provide a comprehensive asthma education program for both patients and their parents/families. A variety of perspectives will be utilized to address the many issues surrounding the management of this disease, including:

- ⇒ Identifying and targeting recipients from Miami Children’s Hospital Clinic of Pulmonology who are from “low compliance families” (i.e., recipients have missed two or more appointments and/or have had two or more emergency room visits/hospitalizations in the past year) for intensive services, home visits, and compliance incentives;
- ⇒ Providing seminars on the latest protocols for the treatment of asthma to Medipass physicians in Dade and Monroe counties;
- ⇒ Providing information for recipients in English, Spanish, and Creole; and
- ⇒ Selecting and training some of the parents of asthmatic children from the Miami Children’s Hospital Clinic as para-professionals who will work with other targeted children and their families.

The goals of the “Attacking Asthma” program are to:

- ⇒ Improve the quality of life for children with asthma;
- ⇒ Decrease the number of asthma-related hospitalizations ;
- ⇒ Decrease the number of emergency room visits;
- ⇒ Increase school attendance of asthmatic children;
- ⇒ Increase employability skills for parent outreach workers; and
- ⇒ Reduce Medicaid costs related to asthma.

Judy Rosenbaum, Ed. D., Area 11 Medicaid Program Administrator and Asthma Project Director says, “This is a wonderful example of a public/private initiative where everybody wins! Children and their families will have an improved quality of life. The children will have an increase in school attendance. Taxpayers will see a dramatic reduction in asthma related Medicaid costs.”

Sonya Albury, Executive Director, Health Council of South Florida says, “It is important to evaluate the program’s ability to assess behavioral change among patients and families with high noncompliance rates. If successful, the program could be widely replicated throughout the state.”



One of the many planning and development meetings between the major participants of this initiative program: (left) Sonya Albury, Executive Director of the Health Council of South Florida; (center) Judy Rosenbaum, Ed.D., Program Administrator of the Medicaid Program Area 11; (right) Dr. Moises Simpser, Director of Pulmonary Department of Miami Children’s Hospital.

Provider Spotlight

As many as 1,000 Dade County children who receive Medicaid are hospitalized every year with asthma or related respiratory illnesses, often unnecessarily, due to inadequate understanding of how to control the disease. The Agency for Health Care Administration, which administers Florida's Medicaid program, in conjunction with Miami Children's Hospital and the Health Council of South Florida, expects to significantly reduce the number of asthma-related hospitalizations and emergency room visits among Medicaid-eligible children in Dade County due to the comprehensive asthma education program that has recently been developed.

“Families will have an improved quality of life, children will be able to better manage the disease and increase school attendance, and taxpayers will see a reduction in asthma-related Medicaid costs,” said Douglas M. Cook, Director of the Agency for Health Care Administration. **“We believe we have devised a program that will help children suffering from asthma to manage the disease better and lead fuller lives.”**

The project is being funded with an \$83,000 grant from the Florida Innovation Investment Program, established in 1994 to encourage state agencies to improve costs and delivery of services. Matching funds in the form of in-kind services are being provided by Miami Children's Hospital.

Miami Children's Hospital's chief pulmonologist, Moises Simpser, M.D., is coordinating the identification of those families who are participating in the program.

Provider Spotlight

Dr. Moises Simpson, M.D., FAAP., FCCP., was one of the key developers of the “Attacking Asthma” grant which will help combat asthma and asthma-related illnesses in Dade and Monroe Counties. Dr. Simpson will both coordinate the identification of the families who will participate in the program and provide medical services to recipients. Since the Miami Children’s Hospital asthma center has been working with this grant, it has already seen between a 70 to 85 percent reduction in emergency room visits and a 95 percent reduction in the admission rate for asthma among participating recipients. The length of stay for asthma for this group has been reduced from 5.3 days to 2.7 days and is currently following an asthma pathway to 1.3 days.

Dr. Simpson was born and raised in Mexico City, Mexico, and graduated as an honor student from the Universidad Nacional Autonoma de Mexico (UNAM), Mexico City medical school. He went on to complete a three-year residency at Hospital Infantil de Mexico and then moved to Boston Children’s Hospital where he did a fellowship in Pediatric Pulmonology (Harvard Medical School). He completed an additional two years of pediatrics at Boston City Hospital (Boston University) following his pediatric pulmonology fellowship. After his training, Dr. Simpson moved from Boston to the Children’s Hospital of New Jersey (United Hospitals) affiliated with the University of Medicine and Dentistry of New Jersey (UMDN), where he was the Director of the Pediatric ICU and Pediatric Pulmonology. He was also an instructor and then Assistant Professor at UMDNJ. He moved to Miami Children’s Hospital in 1984 and is currently the Director of the Division of Pulmonology and Pulmonary Care.



Since Dr. Simpson’s arrival at Miami Children’s Hospital he has developed the largest home care ventilator program in the State of Florida. He created the first respirator camp (VACC) in the world and he initiated the first Cystic Fibrosis Center in Dade County, which is affiliated with the National Cystic Fibrosis Foundation.

When asked why he started an asthma center for underprivileged children, he says it is because he believes that everybody is entitled to a high quality of medical care regardless of ability to pay.

He is the author of two dozen medical papers and abstracts and has participated in multiple research projects as well as contributed to multiple educational programs for physicians, health care professionals, educators, parents and community agencies.

Dr. Simpson is a Trustee of Miami Children’s Hospital, has been a member of the Medical Board and participates in multiple committees of the Hospital. He is a member of the American Medical Association, the American Academy of Pediatrics, American Thoracic Society and others. He has taken leadership roles in the American Lung Association pediatric disease prevention for the last fifteen years. He has been working with Medicaid for many years trying to reduce the rate of admissions for asthma and improve the quality of life of the children with asthma and their families.

Medicaid would like to take this opportunity to thank Dr. Moises Simpson for all he has done for Medicaid recipients in South Florida and for all of his contributions as a medical humanitarian.

DR. MOISES SIMPSON, M.D., TALKS ABOUT ATTACKING ASTHMA

“My belief is that asthma can be controlled if:

- ⇒ patients have direct access to specialized care in asthma centers;
- ⇒ focus is on education and teaching self-management; and
- ⇒ there is round-the-clock availability of health care providers.”

The biggest frustration in treating asthma is the lack of compliance from families of patients with asthma; for this reason, follow-up visits to centers are necessary in order to reinforce education. Patients with chronic asthma should be seen three to four times a year to avoid exacerbations. When asthma is under control, the whole family’s quality of life improves.”



Rosa M. Garrido, A.R.N.P., M.S.M., with two “Attacking Asthma” participants.

Even in the 90’s, we cannot cure asthma; yet, we can control it.

- ☺ Asthma is one of the largest known causes of school absenteeism: with proper management it can be reduced.
- ☺ Parents are empowered through asthma education to manage their children’s asthma and reduce their children’s asthma-related medical needs.
- ☺ With proper medical management, children with asthma should and can remain in school.
- ☺ Children with asthma are normal children and should participate in playground activities.
- ☺ Asthma is an outpatient disease. When experts and education are available to recipients, emergency room visits and hospital admissions are avoided.



Discussing “Attacking Asthma” cases at Miami Children’s Hospital are: (left) Marcia Castro, Peer Volunteer; (center) Bela Florentin, Grant Coordinator; and (right) Alicia Nodarse, Peer Counselor.



Change in Ownership

A

All Florida Medicaid Home Health providers must notify the Agency for Health Care Administration's (AHCA) Division of Health Quality Assurance (HQA) 60 days

prior to any change in ownership (CHOW) and submit a Medicaid enrollment application to:

Agency for Health Care Administration
 Medicaid Program Development
 2727 Mahan Drive
 Building 3, Room 2211-D
 Tallahassee, FL 32317-2600

The CHOW is effective the date all agreements/contracts are signed between the two entities or as approved by AHCA/HQA.

Provider numbers are assigned to the person or licensed operator who signs the Medicaid agreement and cannot be transferred to any other person or licensed operator (per Chapter 59G, Florida Administrative Code). Therefore, on the effective date of the CHOW, the previous owner's provider number(s) will be terminated and the new owner's number will be activated. All new owners must obtain their own provider numbers before they can be reimbursed or provide services to any Medicaid recipients. CHOWS are treated the same as new enrollments.

In accordance with Title 42-70 of the Code of Federal Regulations, any provider using the previous provider's Medicaid number(s) for billing will be required to reimburse the Medicaid program all funds received under the old provider number.

Diagnosis Code Required On Each Claim Line



Effective August 8, 1997, home health providers are required to enter a diagnosis code on each claim line specific to the 4th or 5th digit as identified in the latest ICD-9 CM codes.

Home Health Plan Of Care



The attending physician's **signature** on a plan of care must be his/her original actual signature. A rubber stamp or initialed rubber stamp signature is not acceptable on a home health plan of care.

A written or stamped **date** next to the physician signature is acceptable on a home health plan of care.

A plan of care with no date next to the physician signature, or in box 25 on the HCFA-485 (or corresponding field on an agency specific plan of care), is not acceptable.

Home Health Visits Policy



The Medicaid home health program will not reimburse:

- home health visits, private duty nursing or personal care services furnished by the parents, stepparents or spouse of a Medicaid recipient; or
- home health visits (W9611, W9612, W9613, W9620) for normal newborn or postpartum services.

Precertification Changes



Effective for dates of service on or after July 1, 1997, home health visits (W9611, W9612, W9613, W9620) are limited to 60 visits per lifetime, per recipient without precertification.

Effective September 1, 1997, KePRO will authorize home health visits (W9611, W9612, W9613, W9620) for children who have reached the 60 visit cap. KePRO guidelines for submitting adult and child precertification requests are the same. The area Medicaid service authorization nurses will authorize **only** private duty and personal care services.

Documentation Requirements for ASCs



Effective October 1, 1997, there is a new policy regarding documentation requirements for ambulatory surgical center (ASC) providers. Prior to this date the only documentation required in ASCs has been for abortion and sterilization procedures.

ASC providers are now required to:

- ⇒ Submit operative reports with all multi-surgery claims billed to Medicaid; and
- ⇒ Attach an operative report to each claim on the first submittal.

This change in policy will eliminate the necessity of resubmitting claims denied for edit 909 (documentation required), and will allow for a more comprehensive review of the services rendered.



Use of Modifiers for ASCs



This is to remind ambulatory surgical center (ASC) providers that the only modifiers allowed on facility claims sent to Medicaid are -50 (bilateral) and -51 (multi-surgery).

- ⇒ Anything on claim line two and on all subsequent lines must always have modifier -51 following the 5-digit procedure code.
- ⇒ If modifier -51 is not present on those claim lines, the Medicaid computer system will pay each of those lines at 100 percent of the rate for the procedure payment level. This results in an overpayment and is incompatible with the Medicaid reimbursement policy for ASC facilities.
- ⇒ If you have not used modifier -51 on claim line two and all subsequent lines, you will receive an overpayment from Medicaid. Consequently, you must correct your claim lines by adding modifier -51 and resubmit to Medicaid for an adjustment.

Please follow the instructions for filing adjustments in your *Medicaid Provider Reimbursement Handbook, HCFA-1500 and EPSDT 221*.



Procedure Coverage Consideration

Medicaid covers all procedures the Health Care Financing Administration (HCFA) and Medicare allow to be performed in ambulatory surgical centers (ASCs). Additionally, there are procedures not covered by Medicare that are covered by Medicaid for ASCs. Procedures covered for ASCs are limited to the 10080 through 69970 range of surgical codes. If a procedure in that range is not currently covered, you may request coverage consideration from Medicaid. ***Coverage consideration requests must be made prior to the rendering of the service.***

No coverage consideration can be granted for procedures outside of the 10080 through 69970 range and for unlisted procedures - those whose codes ending with 99 or 999. Requests for coverage considerations must be directed to your area Medicaid office.

A Medicaid recipient must be informed of Medicaid coverage of procedures prior to receiving the services. If the recipient needs a non-covered procedure, the recipient must be told that he/she will be responsible for the payment of this service, not Medicaid. Information about procedure coverage can be found in the *Medicaid Ambulatory Surgical Center Coverage and Limitations Handbook*.

Physicians, Pharmacies, PAs, ARNPs, Nursing Facilities

OTC Products For Yeast Infections Covered By Medicaid

In the last several years, many products used to treat vaginal yeast infections have become available over-the-counter (OTC). Pharmacists and physicians may not be aware that these OTC products are still covered by Medicaid. Brand names include Monistat, Vagistat, and Gyne-Lotrimin, and many generics of clotrimazole and miconazole that are widely available and far less expensive than prescription only alternatives.

Pharmacists may prescribe these under the “Pharmacist Self-Care Act” for initial therapy, and physicians, physician assistants, and advanced registered nurse practitioners may wish to prescribe these OTC products as inexpensive treatments for this common condition.

Nursing facilities are reminded that all medically-necessary OTC products must be provided to residents as part of the per diem payment. They are not to be billed to Medicaid as a pharmacy service.

Pharmacies

Check That Claim!

The two most common invalid entries on pharmacy claims are:



- Prescriber identification number, and
- The number of days’ supply a claim represents.

A pharmacist entry of an invalid “days’ supply” interferes with claims processing for valid refills if overstated and permits excess utilization if understated. Invalid entries on claims for prescriber identification or days’ supply entries may result in claims being denied and, in addition, can result in sanctions for submitting false information.

Unisys, the Medicaid fiscal agent is working on professional license number matching and this will become a required field for claim payment when testing is completed.

Physicians

Fee Adjustment for Procedure Code W1700

Effective January 1, 1997, the fee increase for procedure code W1700 (screening, evaluation and examination in emergency room) was inadvertently omitted in the fee schedule update.

The fee schedule has been corrected to reflect the increase; reimbursement for this procedure is \$14.09. You may adjust any claims for dates of service January 1, 1997 forward that have paid the incorrect amount of \$12.00.

Physicians



Computerized Corneal Topography

Effective July 1, 1997, Medicaid will reimburse physicians for “computerized corneal topography” using procedure code W4500. Reimbursement is \$50 per procedure and will be limited to four per year per recipient.

CPT-4 code 99070 can not be utilized for computerized corneal topography after September 30, 1997. Claims for procedure code W5400 do not require documentation and should be submitted directly to the fiscal agent for processing.

CHDs/FQHCs/RHCs

CHDs, FQHCs, RHCs



New ARNP Coverage

Effective May 1, 1997, rural health clinics, federally qualified health centers, and county health departments employing advanced registered nurse practitioners (ARNPs) may be reimbursed their specific encounter rate for ARNPs performing services at the Evaluation & Management code levels of 99204 and 99214.



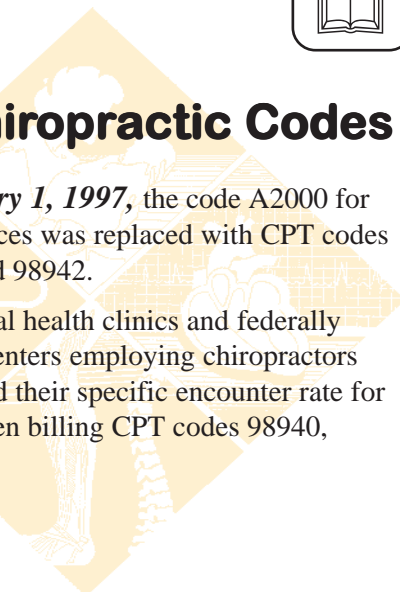
FQHCs, RHCs



New Chiropractic Codes

Effective January 1, 1997, the code A2000 for chiropractor services was replaced with CPT codes 98940, 98941, and 98942.

Subsequently, rural health clinics and federally qualified health centers employing chiropractors will be reimbursed their specific encounter rate for these services when billing CPT codes 98940, 98941, or 98942.



FQHCs, RHCs

Unbundling Of Services

Florida Medicaid continually improves claims processing to ensure that all claims are adjudicated accurately, timely, and according to program policy. Some services and supplies that are included in your inclusive encounter rate have been billed and reimbursed by using your clinic's fee schedule provider number. These practices, known as "unbundling," have been uncovered by Medicaid's Program Integrity Unit.

Changes have been implemented to the Florida Medicaid Management System to detect this practice thereby making it possible to audit claims retrospectively. All moneys obtained through "unbundling" will be subject to recoupment.

Appendix A, page A-3 of the *Federally Qualified Health Center Services and Rural Health Center Services Coverage and Limitations Handbooks* contains a table of fee-schedule services that are not covered in the inclusive encounter rate. This means when providing services and supplies as defined on page A-3, you may bill them with your "fee-for-service" provider number. All other CPT codes are included in your inclusive encounter rate.

The codes listed below have been identified as excluded codes. Rural health clinics (RHCs) and federally qualified health centers (FQHCs), may not bill the following codes, because they are components of the encounter rate.

Excluded Codes:

11200 - 01999 J0001 - J1054
80002 - 89399 J1056 - J7299
90780 - 99199 J7301 - J9999
10040 - 69979, W1922
W1991]
W9881]

FQHCs only:

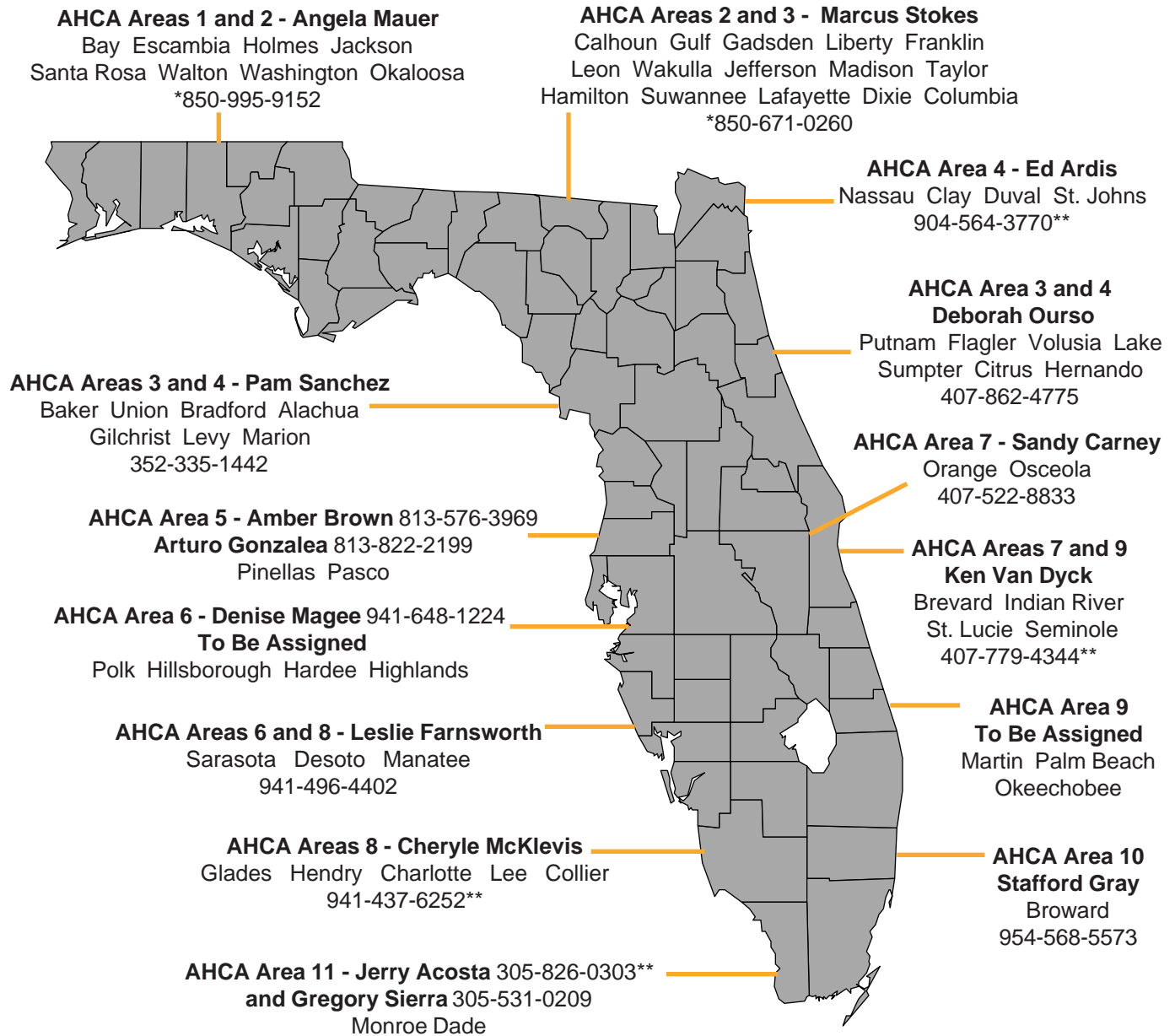
70010 - 79999 90700 - 90749



UNISYS field representative map

***Effective June 23, 1997 the area code for the Area 1, 2, and 3 Field Representatives changed from 904 to 850.**




****Please note new area code or telephone number.**




Dialing the number "1" before the area code may be necessary to complete your telephone call.

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= Articles carrying this graphic contain important Medicaid Provider Handbook information.



= Articles carrying this graphic contain information about utilization review.





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