



# FLORIDA MEDICAID PROVIDER BULLETIN

Winter 2006

Volume VI, Issue 1

All Providers

## INSIDE THIS ISSUE:

### **ALL PROVIDERS**

Free E-Mail Alert Services for Medicaid Providers .....	1
HIPAA Update .....	2
Medicaid Eligibility Access.....	3
DOEA Launches New Initiative .....	4
Sterilization Consent Form .....	5
HIPAA National Provider Identifier (NPI) .....	5
Flu Vaccine Coverage for 2005-2006 Season .....	5

### **PHYSICIANS, AUDIOLOGISTS, & HEARING AID SPECIALISTS**

Policy Clarification on the Use of 92557 vs. V5010 .....	6
--	---

### **PHYSICIANS & CMS**

Important Reminder Regarding Provider Enrollment .....	7
Vagal Nerve Stimulator .....	7
Coverage for Botulism Toxin Type B .....	7
New Infusion Codes .....	8
Claim Review for J3490 and J9999 .....	8

### **HOSPITALS**

Hospital Trauma Admissions.....	8
Hospital Inpatient Interim Billing .....	9

### **CHCUP PROVIDERS**

Reminder to CHCUP Providers .....	10
CHCUP Chart .....	11

### **DENTISTS**

Dental Policy Change .....	12
----------------------------	----

## FREE E-MAIL ALERT SERVICE FOR MEDICAID PROVIDERS



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

The Florida Medicaid Program has created an e-mail alert system to supplement the present method of receiving remittance banner messages. Currently, notices are appended to the bottom of paper remittance vouchers or available in electronic format from the fiscal agent web site.

A subscription to the E-mail Alerts will allow subscribers to receive information regarding Florida Medicaid policy changes or billing clarifications through the convenience of e-mail. Subscriptions are not limited to Florida Medicaid providers, but available to anyone with an interest in Florida Medicaid business activities.

Providers or other members of their workgroup may subscribe by entering their personal information in the data entry boxes of the subscription web page at: <http://ahca.myflorida.com/Medicaid/hipaa/Lyris/lyrissubscribe.shtml>. A confirmation e-mail will be sent to new subscribers to avoid fraudulent subscription requests, and must be returned to complete the subscription process. List members may unsubscribe at any time by following the instructions in the footer of each e-mail.

Providers can change their e-mail address (only for the E-mail Alerts) or other demographic information by using a web form located at: [http://ahca.myflorida.com/Medicaid/hipaa/Lyris/edit\\_lyris\\_profile.shtml](http://ahca.myflorida.com/Medicaid/hipaa/Lyris/edit_lyris_profile.shtml).

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





## HIPAA UPDATE

The Department of Health and Human Services (HHS) has published its semi-annual regulatory agenda that identifies regulatory actions it intends to take. Several of the upcoming actions will affect HIPAA requirements and efforts to build a national health information network. Deadlines for anticipated actions are not always accurate. The complete semi-annual regulatory agenda was published in the Oct. 31 issue of the *Federal Register*, at <http://www.gpoaccess.gov/fr/index.html>. The department anticipates taking action in the following areas:

- Safe harbor for certain electronic prescribing initiatives under the federal anti-kickback statute - final rule expected in March 2006. This will enable hospitals and others to give physicians non-monetary remuneration - such as hardware, software, and training - to assist in adopting electronic prescribing.
- Create exceptions in the physician self-referral prohibition - final rule expected in October 2008. This will enable hospitals and others to assist physicians with adopting electronic prescribing and other electronic medical records components. Federal officials recently said some rules to lift regulatory barriers would be delayed until certification programs were in place for various electronic records components.
- Electronic prescribing - final rule, anticipated in February 2008, to require Medicare Part D plans and Medicare Advantage Plans to support and adopt electronic prescribing and initial related standards.
- Standard unique national health plan identifier - proposed rule, slated for June 2006, to establish national health plan identifiers under the HIPAA administrative simplification provisions.
- NPI - A notice, for publication in February 2006, describing the data that will be available from the National Plan and Provider Enumeration System.
- HIPAA administrative simplification enforcement - final rule, anticipated in February 2006.
- HIPAA electronic transactions and code sets - proposed rule, expected in May 2006, to make annual modifications to the standard mandated by HIPAA. A proposed rule, scheduled for September 2006, would call for revisions to certain code sets.
- Claims attachments - final rule, slated for September 2008, to establish national electronic standards for claims attachments.
- Electronic submission of Medicare claims - final rule, expected in December 2006, to implement requirements for electronic submission of Medicare claims and conditions upon which a waiver could be granted. HHS in 2003 published two interim final rules.
- Release of Medicare beneficiary-specific information - proposed rule, slated for September 2006, to permit release of Medicare beneficiary-specific information - upon patient consent - from quality improvement organizations to clinicians who are in a "treatment relationship" with the beneficiary.





## MEDICAID ELIGIBILITY ACCESS



Articles carrying this graphic contain important Medicaid Provider Handbook Information.

The Department of Children and Families (DCF) is the state agency responsible for determining Medicaid eligibility for recipients. In order to increase access and efficiency, DCF recently redesigned its service delivery model for all forms of public assistance, including Medicaid. To support these changes, the Economic Self-Sufficiency website, <http://www.dcf.state.fl.us/ess/>, has been enhanced to provide customers with the ability to apply for and check the status of their application online. In addition, the ACCESS Automated Response Unit (ARU) provides callers with general information on the department's programs as well as case information. Whenever possible, customers are encouraged to utilize the website or ARU to apply for, or access, department resources.

The Florida Medicaid Management Information System (FMMIS) is the primary source of Medicaid eligibility verification for medical providers and billing agents. Refer to the *Medicaid Provider General Handbook*, pages 3-5 through 3-8, for detailed information on this process. Health care providers and billing agents should check FMMIS using one of the mechanisms explained in the handbook (e.g., Automated Voice Response, Medicaid Eligibility Verification System, etc.) prior to contacting DCF regarding a patient's Medicaid eligibility.

In the event eligibility is not reflected on FMMIS for the period in question, it is appropriate to contact DCF. The Medicaid application processing standards are 90 days for applications that require a disability determination and 45 days for all other applications. In light of these standards, DCF asks health care providers to wait at least 30 days from the date of application before contacting the department.

If it is necessary to contact DCF for an individual's eligibility status, call the ARU at **1-866-762-2237** and use the provider option.

DCF's ability to release information to providers is limited to:

- The individual's status (applicant or recipient);
- The application's status (approved, denied, or pending);
- The Share of Cost amount;
- Patient Responsibility (provided to nursing facility or hospice provider only);
- The dates of eligibility; and
- The PIN # of the individual.

Please note: Due to confidentiality regulations, DCF is unable to release information regarding why an application is pending or whether an appointment was kept.



## DEPARTMENT OF ELDER AFFAIRS LAUNCHES NEW INITIATIVE

Recently, the Department of Elder Affairs (DOEA) announced implementation of a new initiative called "Passport to Care." Passport to Care will assist hospitalized elders by providing them with information about community-based services in their area before they are discharged. Through Passport to Care, elders will have the resources they need to make decisions about their care. Additionally, the initiative will allow them to receive the services they need while remaining in their community. DOEA CARES staff provides pertinent information about community placement earlier in the discharge process, which permits elders and their families to choose the most cost-effective setting for long-term care placement.

The goal of Passport to Care is to provide elders and their families with information and access to home or community-based service programs so that they can transition from a hospital or nursing home to the community efficiently and effectively. These home and community-based service programs provide resources for elders to remain in the community when their only other alternative may be a nursing home. Research has shown that allowing elders to remain in their community longer significantly increases their quality of life.

To medically qualify for the Passport to Care program, an elder's condition or situation must require 24-hour nursing supervision.

Some of the Medicaid waiver services provided are:

- Assistance with some activities of daily living such as bathing, dressing, walking, eating, or transferring from bed to chair; and
- Assistance with some instrumental activities of daily living such as medication management, light housekeeping and using transportation.

To qualify for Passport to Care, individuals must be 60 years or older as well as eligible for Medicaid through the Economic Self-Sufficiency Office of the Department of Children and Families. Further information about this program can be obtained by calling the CARES office in the appropriate county listed below.

County	Telephone	Hamilton	(352) 955-6560	Nassau	(904) 723-5827
Alachua	(352) 955-6560	Hardee	(863) 238-4946	Okaloosa	(850) 595-8563
Baker	(904) 723-5827	Hendry	(239) 278-7210	Okeechobee	(772) 460-3692
Bay	(850) 747-5840	Hernando	(352) 620-3457	Orange	(407) 228-7700
Bradford	(352) 955-6560	Highlands	(863) 238-4946	Osceola	(407) 228-7700
Brevard	(321) 690-6445	Hillsborough	(813) 631-5300	Palm Beach	(561) 540-1181
Broward	(954) 746-1773	Holmes	(850) 747-5840	Pasco	(727) 588-6882
Calhoun	(850) 747-5840	Indian River	(772) 460-3692	Pinellas	(727) 588-6882
Charlotte	(239) 278-7210	Jackson	(850) 747-5840	Polk	(863) 238-4946
Citrus	(352) 620-3457	Jefferson	(850) 414-9803	Putnam	(352) 955-6560
Clay	(904) 723-5827	Lafayette	(352) 955-6560	Saint Johns	(904) 723-5827
Collier	(239) 278-7210	Lake	(352) 620-3457	Saint Lucie	(772) 460-3692
Columbia	(352) 955-6560	Lee	(239) 278-7210	Santa Rosa	(850) 595-8563
DeSoto	(239) 278-7210	Leon	(850) 414-9803	Sarasota	(239) 278-7210
Dixie	(352) 955-6560	Levy	(352) 955-6560	Seminole	(407) 228-7700
Duval	(904) 723-5827	Liberty	(850) 414-9803	Sumter	(352) 620-3457
Escambia	(850) 595-8563	Madison	(850) 414-9803	Suwannee	(352) 955-6560
Flagler	(386) 238-4946	Manatee	(813) 631-5300	Taylor	(850) 414-9803
Franklin	(850) 414-9803	Marion	(352) 620-3457	Union	(352) 955-6560
Gadsden	(850) 414-9803	Martin	(727) 460-3692	Volusia	(386) 238-4946
Gilchrist	(352) 955-6560	Miami-Dade N.	(786) 336-1400	Wakulla	(850) 414-9803
Glades	(239) 278-7210	Miami-Dade S.	(305) 671-7200	Walton	(850) 595-8563
Gulf	(850) 747-5840	Monroe	(305) 671-7200	Washington	(850) 747-5840



## STERILIZATION CONSENT FORM

The Sterilization Consent Form must be completed according to the instructions in the *Medicaid Provider Reimbursement Handbook, CMS-1500*, dated October 2003, pages 2-33 through 2-37 or the *Medicaid Provider Reimbursement Handbook, UB-92*, dated April 2004, pages 2-30 through 2-34. The facility name and address where the person obtaining consent is employed must be completed. Claims will be denied without all components of this form being completed appropriately. These handbooks are available at <http://floridamedicaid.acs-inc.com>.



## HIPAA NATIONAL PROVIDER IDENTIFIER (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the adoption and use of a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care providers and assigns each a unique National Provider Identifier (NPI). An application for an NPI may be submitted online at: <https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart>. The use of the NPI will be required for all health care providers submitting electronic transactions following the May 23, 2007 implementation date.

Florida Medicaid is completing its assessment of NPI replacement of Medicaid provider numbers, and will develop guidelines for Florida Medicaid providers. Look for correspondence relating to NPI and continue to check the Florida Medicaid HIPAA web site at: <http://www.fdhc.state.fl.us/Medicaid/hipaa/NPI/npi.shtml> or from the National Plan and Provider Enumeration System (NPPES) located at: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

## FLU VACCINE COVERAGE FOR 2005 - 2006 SEASON

Effective for dates of service after December 7, 2005, Florida Medicaid will reimburse physician providers when using private stock influenza vaccine (when Vaccine for Children stock is unavailable) for Medicaid eligible recipients 0-18 years of age who have an identified high-risk condition as noted on the Vaccine Information Sheet, dated October 20, 2005. CPT code 90749 with medical documentation identifying the high risk factor and the use of private stock must be submitted to the Immunization Coordinator, 2727 Mahan Drive, Mail Stop #20, Tallahassee, Florida 32308. Without adequate documentation, these claims will be denied. Reimbursement is \$24.64 for physicians, \$22.64 for ARNPs and Pas, and \$19.64 for county health departments and federally qualified health centers. Medicaid will continue coverage for Medicaid eligible recipients 19-20 years of age utilizing the –HA modifier. FluMist is not covered through the Vaccine for Children's Program. Therefore, Medicaid will provide reimbursement for the cost of the vaccine and the administration fee using CPT code 90660 for Medicaid eligible recipients 5-20 years of age. This vaccine is not recommended for ages less than 5. Reimbursement is \$28.98 for physicians, \$26.98 for ARNPs and PAs, and \$23.98 for county health departments and federally qualified health centers. The Florida Medicaid Prescribed Drug Program provides coverage for inactivated influenza vaccine for all Medicaid eligible recipients regardless of age.

## POLICY CLARIFICATION ON THE USE OF 92557 VS. V5010

This message is to clarify the proper use of CPT code 92557 versus the HCPCS code V5010. CPT code 92557 applies to a comprehensive audiological evaluation including pure tone air conduction and bone conduction thresholds, speech reception thresholds, and speech discrimination or identification measures. This code descriptor typically applies toward meeting the diagnostic evaluation needs of a patient. However, this code may also be used in preparation for a hearing aid evaluation and selection for self-pay patients or some private third party payers.

The intended use of V5010 is the performance of an audiogram solely for the purpose of hearing aid selection. It includes all of the elements of CPT code 92557 but also goes beyond the procedures of 92557 to include MCL, LDL, loudness growth measurements, or any other procedures necessary for the initial selection of hearing aids. Florida Medicaid allows the billing of V5010 only one time every three years without obtaining prior authorization. In contrast, there is no restriction on how many times code 92557 can be reported for reimbursement as long as each occasion is medically necessary. Medical necessity typically refers to the reporting of a new symptom, a change in symptoms, or a perceived change in symptoms. It is such that the referring physician cannot determine the magnitude and extent of a problem involving the auditory or vestibular system without diagnostic testing.

V5010 should not be reported for routine audiometrics where CPT code 92557 would be appropriate. V5010 should be reported for reimbursement only when the purpose of the evaluation and the extra procedures (e.g., MCL, LDL) are performed in addition to the standard audiometric evaluation.

Please note that there is no provision for post-authorization of V5010. If it has been less than three years since the last time this code was billed, then a prior authorization must be submitted *before the testing is performed* in order to qualify for reimbursement. If it has been more than three years since the last time V5010 was billed to Medicaid, then prior authorization is not necessary.



## COVERAGE FOR FETAL DOPPLERS IN MULTIPLE GESTATIONS

Effective for dates of service beginning October 1, 2005, Medicaid will not require the submission of medical documentation for reimbursement of CPT codes 76820 and 76821 for multiple gestations (up to quadruplets) with diagnosis codes 651.03, 651.13, 651.23, 651.83, and 651.93. These codes must be billed with a TH modifier and a listed diagnosis code. Electronic claims are acceptable. The maximum units must reflect the number of fetuses for correct reimbursement. If there are more than four fetuses, a modifier 22 is required with medical documentation.





## IMPORTANT REMINDER REGARDING PROVIDER ENROLLMENT

Florida Medicaid has specific requirements for healthcare practitioners who practice together in the same location. The *Physicians Coverage and Limitations Handbook* requires that if a physician provider employs or contracts with any health care practitioner who can enroll as a Medicaid provider and that health care practitioner is treating Medicaid recipients, he or she must enroll as a Medicaid provider. It also requires that two or more Medicaid providers whose practice is incorporated under the same tax identification number must enroll as a Medicaid provider group. In order to receive payment from Medicaid, each member of the group must also enroll as an individual treating provider within the group.

This means that:

- If you employ an Advanced Registered Nurse Practitioner, a Physician Assistant, or another physician in your office, those individuals must enroll as Medicaid providers. You must contact ACS and request a group enrollment provider number, listing each individual provider who is practicing as part of that group. When you bill for services, the claim must be submitted under the group number, but it must reflect the Medicaid number of the treating practitioner.
- If you share an office or clinic with another physician and you routinely cover each other's patients, you must either enroll as a group, billing under the group number, and identifying the actual treating provider on the claim form; or bill under your own number only for the services you yourself provided.

Providers who bill for services that they did not render are subject to having payments recouped and administrative sanctions applied.



### VAGAL NERVE STIMULATOR

Effective September 1, 2005, procedure codes for the vagal nerve stimulator for recipients with intractable epilepsy are covered for recipients age 3 and over. The procedures were previously covered for ages 12 and over. The CPT codes affected by this change are 61885, and 64573.



### COVERAGE FOR BOTULINUM TOXIN TYPE B

Effective for claims processed after November 1, 2005, Medicaid coverage for J0587, Botulinum Toxin Type B, per 100 units, is limited to the following ICD-9 diagnosis codes: 333.6, 333.81, 333.82, 333.83, 334.1, 341.0-341.9, 342.11-342.12, 344.31, 344.32, 344.41, 344.42, 343.0-343.9, 351.8, 478.75, 565.0, 723.5, 728.85, 780.8.

## NEW INFUSION CODES

Effective for dates of service beginning January 1, 2006, Florida Medicaid will no longer reimburse for codes G0345-G0363. They have been replaced with new CPT codes 90760-90799 and 96401-96417. The following CPT codes will replace the above mentioned G codes and are reimbursable based on three categories of codes: hydration (90760-90761); therapeutic or diagnostic intravenous infusions other than hydration (90765-90799); and chemotherapy administration (96401-96417). Chemotherapy administration codes apply to parenteral administration of radionuclide anti-neoplastic drugs and also to anti-neoplastic agents provided for the treatment of noncancer diagnoses, or to substances such as monoclonal antibody agents and other biologic response modifiers.

---



### CLAIM REVIEW FOR J3490 AND J9999

All claims for J3490 and J9999 must identify the drug for reimbursement. Documentation must include the CMS-1500 claim form; medical documentation that includes a diagnosis; and physician/nurse signature documenting the drug, dosage, and route of administration for the date of service. Medicare crossover claims also must include the Medicare EOMB.

Without adequate documentation, claims will be denied with edit 909, claim requires documentation. Reimbursement is based on the lesser of the average wholesale price less 15.4% or wholesale acquisition cost plus 5.75%. Claims involving only Medicaid must be sent to the Medicaid fiscal agent.

Medicare crossover claims must be mailed to: Agency for Health Care Administration, Medicaid Physician Services, 2727 Mahan Drive, Mail Stop #20, Tallahassee, Florida 32308 Attention: Injectable Medications Program.

---



## HOSPITAL TRAUMA ADMISSIONS

Trauma admissions now have their own admit type. Hospitals designated by the State of Florida as trauma centers should now report admit type "5" in UB-92 Form Locator 19 on claims involving a trauma activation. Such claims are exempt from the Medicaid prior authorization requirement if the claim is no more than one billable day.

In addition, outpatient emergency room claims with admit type 5 are exempt from the MediPass approval requirement.

Handbook updates are forthcoming. If you have questions, please call your local Medicaid area office or Melissa Vergeson at (850) 922-7724.

## HOSPITAL INPATIENT INTERIM BILLING

In order to bring about uniformity of hospital billing across payer types, Florida Medicaid adopted the billing standard approved by the National Uniform Billing Committee for interim billing. For billing segments of an extended hospitalization, the three new types of bill (Form Locator 4 on the UB-92 claim form) are as follows:

### **112 - Interim (First Claim)**

This code is to be used for the first of a series of bills to Medicaid for the same confinement or course of treatment.

### **113 - Interim (Continuing Claim)**

This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted.

*Note: 113 is the only bill type that can be repeated for a single confinement.*

### **114 - Interim (Last Claim)**

This code is to be used for the last of a series of bills to Medicaid for the same confinement or course of treatment.

Additionally, beginning with date of service 07/01/05, the Medicaid system has been updated to pay interim bills like other payers. If a hospital elects to submit an interim bill for a Medicaid recipient still in-house, ALL billed days will pay. Such a claim would have a Type of Bill 112 or 113 (UB-92 Form Locator 4) AND a Patient Status of 30 (UB-92 Form Locator 22). If a claim meets both criteria, all dates indicated in UB-92 Form Locator 6 will be paid, including the "Through" date. For example, such an interim claim for dates of service 07/01/05-07/31/05 will pay 31 days.

This differs from the typical inpatient claim. Because Medicaid does not pay for the day of discharge, a typical inpatient claim (Type of Bill 111) pays all but the last day listed in UB-92 Form Locator 6. For example, a typical inpatient claim for dates of service 07/01/05-07/31/05 will pay 30 days.

These program changes will enable hospitals to submit interim bills for recipients with lengthy inpatient stays. If you have questions, please call your local area office or Melissa Vergeson at (850) 922-7724.





## REMINDER TO CHILD HEALTH CHECK-UP (CHCUP) PROVIDERS:

- Federal regulation requires that all Medicaid children receive a screening blood lead test at 12 months and 24 months of age, and between the ages of 36 months and 72 months of age if they have not been previously screened for lead poisoning. The procedure code for blood lead testing is 83655. This is explained in the *Medicaid CHCUP Coverage and Limitations Handbook, October 2003*, pages 2-13 and 2-14; and page 3-6. There is the potential for recoupment if medical record audits indicate that a screening blood lead test has not been done.
- CHCUP providers may only bill for one visit, a CHCUP or a sick visit per day, per Medicaid child, per provider. 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. There is the potential for recoupment 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 11 of this Bulletin per claim format.
- It is critical that the federally required Referral Code be appropriate for the Diagnosis Code on Child Health Check-Ups. For example, a diagnosis code of V20.2 (routine infant or child health check) would be appropriate with a referral code “U” or “NU” (complete normal/no referral). A diagnosis code of V20.2 (routine infant or child health check) is not appropriate with a referral code of “T” or “ST” (abnormal, patient referred). For the required referral codes see page 11 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 explained in the *Medicaid CHCUP Coverage and Limitations Handbook, October 2003*, page 2-2.



## CHILD HEALTH CHECK-UP (CHCUP)

The Child Health Check-Up (CHCUP) claim is now billed on a physician claim form. CHCUP is referred to as EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) in national publications. The CHCUP procedure code is entered on one line and any other services provided can be entered on subsequent lines. CHCUP claims can only be billed in the following formats: CMS-1500, NSF, X12N 837P, or WINASAP 2003, Professional.



CHCUP Providers

	CHCUP Indicator	CHCUP Referral Code	Special Program Indicator
<b>CMS-1500 Claim Form</b>	<b>Box 24H</b> (EPSDT/Family Planning) – Enter “E” if service is a result of a CHCUP referral. (Used when service is not a CHCUP procedure code)	<b>Box 24H</b> (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
<b>NSF Format</b>	<b>FB0-22.0</b> (EPSDT Indicator) – Enter “Y” if service is a result of a CHCUP referral, “N” or space if not. (Used when service is not a CHCUP procedure code) To bill a CHCUP screening claim as a physician claim also complete these fields: BA0-03.0 Batch Type = 100 EA0-32.0 Diagnosis Code 1 = required (at least one diagnosis is required) FA0-14.0 Diagnosis Code Pointer 1 = required (at least one is required)	<b>FB0-22.0</b> (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
<b>X12N 837P</b>	<b>Loop 2400, Segment SV1, Element 11</b> (EPSDT Indicator) – Enter “Y” if service is a result of a CHCUP referral. (Used when service is not a CHCUP procedure code)	<b>Loop 2300, Segment CRC</b> , (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)	<b>Loop 2300, Segment CLM, Element 12</b> (Special Program Code) – Enter “01” if any line item in the transaction contains a service that is a CHCUP procedure code.
<b>WINASAP 2003, Professional Claim</b>	<b>Claim Line Items Tab</b> , Miscellaneous Indicators button, Other Indicators. Was the service a result of a screening referral? – Check “Yes” if service is a result of a CHCUP referral. (Used when service is not a CHCUP procedure code)	<b>Claim Information Tab</b> , 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)	<b>Claim Codes Tab</b> , 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	Modifier
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	Not Used (Patient Not Referred)
S2	Under Treatment (For referred diagnostic or corrective health problem)
ST	New Services Requested (Abnormal, 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)



## DENTAL POLICY CHANGE

Effective for dates of service beginning October 1, 2005, Medicaid coverage of procedure code D0330 (panoramic film) is allowed for reimbursement once in a three (3) year period instead of the current one (1) per year. For instance, if a recipient had a panoramic film exposed on 10/5/2005, another film may not be exposed until 10/5/2008.

Panographic-type radiographs are insufficient for diagnosis in periodontics, endodontics, and restorative dentistry. Medicaid will not reimburse a panoramic film on the same date of service that procedure code D0210, (intraoral-complete series) has been provided to the same recipient by the same provider.

An update to the *Florida Medicaid Dental Services Coverage and Limitations Handbook* will be included in the next publication. In the interim, please update your current handbook with this notice.

