Purpose

The Agency for Health Care Administration (Agency) and its fiscal agent, DXC Technology (DXC), have created this comprehensive reference guide for Florida Medicaid Managed Care onboarding, fee-for-service submissions, and encounter processing. This document assists health plans in onboarding and testing to become Medicaid Managed Care Providers. In addition, this guide references and ties together all of the managed care-related information publicly available through the Florida Medicaid Web Portal, and provides guidance for handling common encounter data submissions. All public Web Portal resources can be reached from http://www.mymedicaid-florida.com. Agency resources can be found on the Agency page at http://ahca.myflorida.com. Navigation and links in this document provide direct access from those pages.

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Please note: A heading followed by an asterisk (*) signifies that this does not apply to dental plans.

Communication Resources

Florida Medicaid offers a variety of helpful resources to its health plan community, including educational materials located on both the Agency’s website, http://ahca.myflorida.com, and the Florida Medicaid Public Web Portal.

Below are some of the ways the Agency, DXC, and Magellan Medicaid Administration (Magellan) communicate with the health plan provider community. Health plans can access these communication resources before becoming enrolled Medicaid Managed Care Plans.
Signing Up for Alerts

Health plans may complete an online subscription form on the Agency’s Florida Medicaid Health Care Alerts page to receive informative health plan-related alerts. Health plans may browse through past and present managed care and provider alerts in the Managed Care Alert Archive on the Managed Care Alerts page. To access or subscribe to alerts, please visit mymedicaid-florida.com. From the Florida Medicaid Web Portal homepage, hover over the Managed Care tab and click Alerts under the Alerts menu.

Providers within health plan networks are encouraged to sign up for alerts and make full use of these resources as well. Fee-for-Service alerts can be found on the public Web Portal as well by hovering over the Provider Services tab and clicking Alerts under the Support menu.

Bulletins

Medicaid Bulletins are published on a quarterly basis by Florida Medicaid. The bulletins contain new policies, training opportunities, and other pertinent Medicaid information. Bulletins can be found on the Agency’s website at http://ahca.myflorida.com/Medicaid/Program_Coordination/provider_bulletins/index.shtml or reached from the public Web Portal by hovering over the Provider Services tab and selecting Bulletins under the Support menu.

Managed Care Support Page

The Managed Care Support page found on the public Web Portal contains helpful information health plans may reference, such as the SMMC Encounter Support Contact Sheet, Capitation Payment Schedule, Tip Sheets, Web Based Training, Training Presentations, and more. The Managed Care Support page can be accessed by hovering over the Managed Care tab and clicking on the Support menu.

Tip Sheets

Tip sheets are helpful documents specifically designed for health plans. The Agency, DXC, and Magellan create these documents to assist providers with encounter-related topics, anticipated system enhancements, and agency initiatives. The following tip sheets are available and provide information on medical or pharmacy encounter submissions.

Medical

Several tip sheets are available for medical encounter-related topics, such as daily 835 files, nursing facility encounter submission, as well as how to submit encounter adjustments, voids, and resubmissions. Tip sheets may be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Tip Sheets under the Support menu.

Pharmacy*

Providers may access submission tips on how to report MCO Amount Paid, encounter attestation, instructions on how to submit paid and health plan denied encounters, and Expanded Benefits. Tip sheets for pharmacy encounter submissions may be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Pharmacy under the Encounter Transactions menu.

Implementation Guides

A key component of HIPAA is the establishment of national standards for electronic health care transactions for providers, insurers, and employers.

The standards are meant to improve the efficiency and effectiveness of the United States (U.S.) health care system by encouraging the widespread use of Electronic Data Interchange (EDI). In effect since January 1, 2012, the current HIPAA EDI transaction sets are based on the Accredited Standards Committee (ASC) X12 version 5010 and NCPDP D.0.
The Washington Publishing Company (WPC) offers accredited X12 software to submit information accurately. To access the implementation guides, visit http://wpc-edi.com/, to view the various EDI tools and resources.

For Pharmacy, health plans may access the Telecommunication Standard D.0 guides by going to the website of the National Council for Prescription Drug Plans (NCPDP) at http://ncpdp.org (membership is required.)

**Companion Guides**

Companion Guides are documents published by various entities to supplement Implementation Guides, which define the data to include in ASC X12 transaction sets for specific business purposes. Health plans must use the applicable companion guide in conjunction with the correct implementation guide to submit a valid encounter to Florida Medicaid. Florida Medicaid specific companion guides are available on the Companion Guides page of the public Web Portal.

The companion guides can be accessed by hovering over the Provider Services tab and clicking Companion Guides under the EDI menu. The list of 5010 Companion Guides can be found at the bottom of the page.

**D.0 Payer Specification***

Providers may reference the Florida D.0 Payer Specification – Encounters document for fields and segments required by Florida Medicaid on the NCPDP D.0 Telecommunication Standard. The D.0 payer sheet may be accessed from the public Web Portal homepage by hovering over the Managed Care tab and clicking Pharmacy under the Encounter Transactions menu. The Florida D.0 Payer Specification – Encounters link may be found under the section titled Encounter D.0 Specifications.

**Provider Handbooks (Promulgated Rules) and Fee Schedules**

The Agency transitioned all rule materials to the Agency’s website at http://ahca.myflorida.com. Once on the homepage, select Medicaid from the top of the web page. On the Medicaid page, click the Provider Fee Schedules and Provider Handbooks hyperlink. This will direct you to the rules page, which contains the Promulgated Rules and Fee Schedules.

**Encounter Known Issues**

The SMMC Encounter Known Issues List provides an informative, concise, up-to-date list of current issues related to the processing of encounters as well as informational items that have been identified or reported in recent months.

*Note: This is only an informational list. The resolution priority of an issue is not determined by whether or not it appears on this list. Items that have been removed may still maintain an open status.*

The SMMC Encounter Known Issues List may be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Encounter Known Issues under the Support menu. This will lead you to the Managed Care Support page. The Encounter Known Issues List link may be found under the section titled Encounter Known Issues.

**FAQs**

**Medical**

Health plans may reference the SMMC Encounter Support FAQ to view a comprehensive listing of encounter ICN region codes, duplicate denial logic, and other common questions or concerns related to the submission of medical encounters.

This FAQ may be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Contact Us under the Support menu. This will lead you to the Managed Care Support page. The SMMC Encounter Support FAQ link may be found under the section titled Contact Us.
Health Plan Support

The Agency, DXC, and Magellan offer support to health plans for onboarding, encounters, and other inquiries through multiple avenues. Below are the ways health plans can obtain assistance.

Health Plan Support Team

The Agency and DXC have established a dedicated group of Provider Field Services representatives known as the DXC Health Plan Support team. The team’s main function is to assist health plans with medical encounter submissions, understanding Medicaid processes, and staying up-to-date with the latest Medicaid updates.

On-Site Health Plan Visits

Health plans find regularly scheduled meetings with the Health Plan Support team are beneficial and informative. Regularly scheduled onsite health plan visits with a member of the Health Plan Support team representatives is recommended, since these onsite health plan visits consist of:

• An agreed upon, scheduled meeting date and time. The scheduled meetings should be held at regular intervals throughout the year. Health plans may schedule on-site visits on a monthly, bi-monthly, or quarterly basis.

• The health plan should submit any topics of discussion for the scheduled encounter health plan visit approximately two (2) weeks prior to the meeting date. This will allow DXC representatives and the Agency enough time to review and research the health plan’s discussion items prior to the meeting. This will also ensure the meetings are productive and informational.

• Health plan visits are usually two (2) hours in duration, with Health Plan Support team representatives, allowing the health plans enough time to discuss encounter submissions, encounter denials, and Medicaid-related processes.

• Representatives from the Agency attend virtually and give health plans the opportunity to ask policy, procedure, and timeliness-related questions.

• Representatives from Magellan also attend virtually and answer any pharmacy-related questions.

• Health Plan Support team representatives take detailed notes during the meetings and record action items for topics that require additional research or clarification.

• Health plans are encouraged to schedule the next encounter health plan meeting at the end of each visit.

• Approximately one (1) week after a health plan visit is conducted, DXC provides the health plan with detailed summary notes of the topics discussed during the visit, including updates on any action items.

Note: Although Provider Field Services representatives can conduct meetings virtually with the health plans, it is encouraged that encounter health plan meetings be conducted on-site whenever possible.

Health plans may schedule an onsite or virtual visit by contacting the Health Plan Support team at healthplan.support@dxc.com.

Medical Health Plan Support by Email

The Health Plan Support team also maintains and oversees the Health Plan Support mailbox, available at healthplan.support@dxc.com. Health plans can email the support mailbox with any inquiries. This is an especially good resource to use in between scheduled health plan visits. Health plans may receive immediate guidance on their encounter submissions or encounter denials, Medicaid processes, general Medicaid inquiries, and enrollment-related inquiries. If the health plans have policy-related questions or concerns, the health plans may email the Health Plan Support mailbox and a Health Plan Support team representative will escalate the inquiry to the Agency or appropriate department best suited to answer the health plan’s questions or concerns.
Pharmacy Health Plan Support by Email

Providers may contact Magellan at flmcosupport@magellanhealth.com with inquiries related to NCPDP version D.0 transactions, format-related questions, batch file submissions, corrections from response files, and questions regarding remediating rejected claims.

Continuity of Care Supporting Data

The state plans to provide to each of the continuing and new health plans open prior authorization data from the current plans and six months of health plan encounter services data for each recipient enrolled with each continuing health plan. The continuity of care supporting data will be made available to each of the health plans within the 30 days prior to recipient initial effective enrollment date, followed up with additional data of any changes that may have occurred within two weeks after the recipient’s initial effective enrollment date. File layouts, directions, and additional information will available in the near future as they are finalized.

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Health Plan Enrollment

The Agency works closely to assist health plans with enrolling. A health plan receives a provider ID number for each region in which the health plan is contracted. The health plan will be linked to a unique trading partner ID (TPID), established separately for each health plan’s contract line of business with the Agency (i.e., MMA, LTC, and Specialty). Once the health plan’s provider ID has been activated, the health plan will receive a welcome letter and a PIN letter. The PIN letter is used to create a secure Web Portal account; however, a health plan need not wait for the letters before beginning RAMP manager testing with DXC and Magellan.

Encounters

Encounters are submitted to Medicaid by Health Plans under SMMC because, unlike fee-for-service, the Medicaid program does not pay health plan providers directly for services to beneficiaries. In this type of payment system the health plan is responsible for providing encounter data—comparable to claims data—that details the specific services provided to an enrollee by a provider, and the costs associated with them. Medicaid pays health plans a monthly capitation payment for each beneficiary enrolled in each health plan. The health plans then pay providers for services delivered to Medicaid enrollees. Depending on the terms of the contract between the health plan and the provider, a health plan may pay the provider for these services through fee-for-service or through capitation.

All health plans must submit complete, accurate, and timely encounter data to DXC and Magellan, as defined in the health plan’s contract and in accordance with generally accepted industry best practices. The health plan is held responsible for errors or noncompliance resulting from the health plan’s own actions or the actions of an authorized agent acting on behalf of the health plan.
Health plans should refer to the Companion Guides on the public Web Portal for instructions regarding submission of Florida Medicaid encounters. Encounters can be reported via Secure File Transfer Protocol (SFTP) or by Batch file submission on the portal. These methods are explained below.

**Kick Payments***

A kick payment is a method of reimbursing eligible health plans in the form of a separate, one-time, fixed payment made by the Agency for a specific service. The Agency currently pays the health plan one kick payment for each obstetrical delivery service provided on or after September 1, 2016. These services will be required to be billed using the fee-for-service guidelines. The Kick Payment Tip Sheet can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Tip Sheets under the Support menu.

**Region Codes**

Kick payment claim submissions will be assigned a non-encounter Region Code.

**Sample Region Codes:**

- 20 – X12 claims with no attachments
- 21 – X12 claims with attachments
- 22 – Web Portal claim with no attachments
- 23 – Web Portal claim with attachments
- 10 – Paper claim with no attachments
- 11 – Paper claim with attachments
- 59 – Web Portal adjustment or void

**Testing**

Kick payment testing is conducted via the Dynamic Encounter Testing Environment, also known as the BETA testing application. More information about this testing environment can be found in this document in the Transaction Testing section.

**Electronic Data Interchange (EDI)**

As part of the enrollment process, health plans complete an EDI Agreement for fee-for-service claims as well as an EDI Agreement for Encounters. An EDI Agreement is a contract that defines the liability for information transferred between the provider and the vendor as reported to the state of Florida and the Medicaid fiscal agent. An EDI Agreement authorizes Florida Medicaid to allow the third-party vendor to act on behalf of the Medicaid provider.

The EDI Agreement can be accessed from the public Web Portal by hovering over Provider Services and clicking Enrollment forms under the Enrollment menu. The EDI Agreement link can be found under the section titled Additional Enrollment Forms.

The EDI Agreement for Encounters can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Encounter Transactions. An EDI Welcome letter is mailed advising of TPID for fee-for-service transactions and one advising of TPID for contract specific encounter submissions.

**TPID**

A Trading Partner ID (TPID) is required when uploading through the Trade Files menu in the secure Web Portal, uploading via Secure File Transfer Protocol (SFTP), billing via Web Portal batch, or for real-time transactions through a software vendor/clearinghouse.
Each trading partner, whether a clearinghouse, a vendor, or a billing agent, must be enrolled as a Florida Medicaid provider. Once the trading partner agreement is complete, a TPID is issued. The EDI Agreement serves as the trading partner agreement.

Note: Each health plan will be linked to a unique trading partner ID (TPID), established separately for each of the following health plan’s contract line of business:

- Managed Medical Assistance (MMA)
- Long Term Care (LTC)
- Statewide Dental (SWDEN); and
- Specialty.

For example: A Comprehensive plan would have one TPID for MMA and one for LTC, as would an LTC Plus.

Sub-Contractors

Medicaid policy requires any third-party acting on behalf of a health plan to obtain a Medicaid ID by completing the Florida Medicaid Provider Enrollment application found on the Enrollment Forms page of the public Web Portal. In order for a third-party entity to submit and/or inquire using X12 transactions, the third-party must be linked to the health plan by completing an Electronic Data Interchange Agreement form. The Florida Medicaid Provider Enrollment form can be accessed from the public Web Portal by hovering over Provider Services and clicking Enrollment forms under the Enrollment menu. The form link may be found under the section titled Clearinghouse Providers.

EDI Transactions

As discussed above, the Health Insurance Portability and Accountability Act (HIPAA), which was passed in 1996, requires all insurance carriers and payers in the United States to comply with a set of Electronic Data Interchange (EDI) standards adopted by the Secretary of Health and Human Services. These standards were created to ensure an efficient and secure exchange of electronic health information.

Health plans should refer to the EDI Companion Guides for encounter or fee-for-service submission requirements and the D.0 Payer Specification for data field requirements for pharmacy transactions.

Web Portal Batch File Upload

The Florida Medicaid Secure Web Portal provides alternative submission methods for health plans. Once logged in to the secure Web Portal, users may access the Trade Files menu to upload 5010 X12 batch files. This method does not require file encryption; therefore, encrypted 5010 X12 files should not be uploaded through the secure Web Portal. Users must access the Trade Files download menu to download response files (999, TA1, etc.).

Secure File Transfer Protocol (SFTP)

Secure File Transfer Protocol (SFTP) is a method of submission that uses encryption to transmit files to and from Florida Medicaid. SFTP is offered to all health plans for encounter transaction submissions and any high volume fee-for-service submitters. Each approved SFTP account is assigned a unique folder and credentials (user name and password) to access the site. Once credentials are assigned and testing is complete, SFTP may be used for 5010 X12 batch file submissions. SFTP is the recommended method for health plans as it is the most efficient submission method. Once files received from the user’s inbound folder are processed, response files (999, TA1, etc.) are available in the outbound folder.

Files left on the SFTP outbound directory are subject to removal and deletion. Florida Medicaid is not responsible for the storage of files on the SFTP site. SFTP users are encouraged to remove their files from the outbound directory and archive them locally, in a timely manner, to avoid removal and deletion.
EDI Sample Files

Sample 834, 820, 835, and 999 files can be found on the public Web Portal by hovering over Provider Services and clicking Submission Information under the EDI menu.

New 834 sample files are now available for each contract type. Please visit the EDI Submission Information page to view these files.

820 Outbound
The 5010 X12 820 is the Health Care Premium Payment transaction that is used for transmitting information on premium payments to the health plans. The information provided in an 820 includes payer and payee identification, bank and account IDs, invoice number(s), adjustments from an invoice, billed and paid amounts.

The Capitation Payment Schedule can be accessed by hovering over the Managed Care tab and clicking Capitation Payment Schedule under the Support menu.

834 Outbound
The 5010 X12 834 is the Benefit Enrollment and Maintenance transaction that provides enrollment information, including benefits, plan subscription, employee demographic, and dental information. FMMIS generates a daily 834 to report demographic changes to a health plan’s existing members. Daily files are produced Tuesday through Saturday, if available. The 834 Daily transactions can contain:

- Member demographics changes;
- Changes in Patient Responsibility;
- Changes in eligibility; and
- Activated newborns.

An 834 Audit file is created to provide a full list of members for health plans for the current month. FMMIS generates this file the first business day of the month. 834 Audit transactions contain a complete roster that includes new, current, terminated, retroactive, and pended members. No past changes are reported. An 834R Tip Sheet can be accessed by hovering over the Managed Care tab and clicking Tip Sheets under the Support menu.

To avoid any difficulties in reconciling 834 files to the 820 files, four additional audit files, called 834 R (Reconciliation) files, are provided during the last week of every month, as follows:

- The 834R file reflects the payments for the upcoming month’s enrollments appearing on the upcoming month’s 820 file.
- The 834 R1 file reflects the payments and adjustments for last month’s enrollments (the month before the upcoming month) appearing on the upcoming month’s 820 file.
- The 834R2 file reflects the payments and adjustments for enrollments from two months back appearing on the upcoming month’s 820 file.
- The 834R3 file reflects the payments and adjustments for enrollments from three months back appearing on the upcoming month’s 820 file.

837 Inbound
The 5010 X12 837 is the Health Care Claim transaction and is designated by the specific claim type: 837 D (Dental), 837 I (Institutional), and 837P (Professional).
The 837 transactions are the electronic correspondents to the paper claim forms; therefore, any claim types submitted on the CMS-1500, UB04 or ADA claim forms correlate to one of the following transactions:

- 837 Professional (837P),
- Institutional (837I)
- Dental (837D)

999 Outbound
The purpose of the 999 FA is to confirm that a transaction has been received by FMMIS. The 999 not only validates that a transaction was received, but also whether the received transaction has errors, and that it is in compliance with HIPAA requirements. For example, the 999 can confirm that a claim was received, but that does not mean the transaction will be processed. To verify whether the transaction was accepted or denied, look for the IK5 and AK9 segments within the file. If these two segments are followed by an A, the file was accepted. If these two segments are followed by an E, the file was accepted with errors. If the two segments are followed by an R, the file was rejected.

835 Outbound
The 5010 X12 835 is the Health Care Claim Payment and Remittance Advice transaction that shows all claims that have been adjudicated during the financial cycle. The financial cycle runs on the following schedule:

- Fee-for-service: after close of business on Friday; and
- Encounters: Sunday through Wednesday and every other Friday.

276 Inbound / 277 Outbound
The 5010 X12 276 is a Health Care Claim Status inquiry transaction sent to FMMIS by providers to request the status of claims previously sent.

The 5010 X12 277 is the Health Care Claim Status Response transaction set used by FMMIS to report on the status of claims (837 transactions) previously submitted by providers. The 277 transaction, which has been specified by HIPAA for the submission of claim status information, is sent by FMMIS in response to a 276 Claim Status Inquiry.

The 277 transaction indicates where the claim is in the process, either as Pending or Finalized. If finalized, the transaction indicates the disposition of the claim—rejected, denied, approved for payment, or paid. If the claim was approved or paid, payment information may also be provided in the 277, including such information as method, date, and amount. If the claim has been denied or rejected, the transaction may include an explanation, for example that the patient is not eligible.

277U Outbound
The 277U batch file is sent to health plans in response to an inbound 837 file that contains a Medicaid provider ID or National Provider Identifier (NPI) that is unidentifiable.

ERA277U Outbound
Unsolicited Health Care Payer Claim Status response is available on Mondays in a batch file for fee-for-service providers and health plans if they have claims and encounters identified as suspended in the most current weekly financial cycle.
NCPDP D.0*

NCPDP D.0 Telecommunication Standard is used to submit Pharmacy encounters. In addition to paid encounters for MMA and Specialty lines of business, the D.0 format is used to submit separate batch files containing encounters for pharmacy Expanded Benefits (OTC) in MMA, LTC and Specialty. If a health plan chooses to submit plan denied encounters, these are also submitted in the D.0 format. Once the inbound file is processed, an NCPDP response file is available for upload by the health plan.

Safe Harbor

ACA Section 1104 requires the Secretary of the Department of Health and Human Services (HHS) to adopt and regularly update standards, implementation specifications, and operating rules for the electronic exchange and use of health information for the purposes of financial and administrative transactions.

In compliance with this requirement, Health and Human Services (HHS) designated CAQH-CORE to be the authoring entity for the required rules. The CAQH-CORE Operating Rules defined a Connectivity/Security Rule, which is a safe harbor that requires the use of the HTTP/S transport protocol over the public Internet. Since the CORE Phase I Connectivity Rule is a safe harbor, CORE-certified entities are required to support the adopted CORE Phase I Connectivity method at a minimum.

FMMIS supports batch and real time ASC X12 transactions over the Safe Harbor connection. The following transactions are supported on the Safe Harbor connection.

- Implementation Acknowledgement For Health Care Insurance (999);
- Health Care Eligibility Benefit Inquiry and Response (270/271);
- Health Care Claim Status Request and Response (276/277); and
- Health Care Claim Payment/Advice (835).

Additional transactions will become available over the Safe Harbor connection according to the CAQH-CORE Operating Rules.

Recipient Eligibility Verification

Health plans may verify recipient eligibility using the following methods: AVRS, 270/271 files, MEVS, Safe Harbor, and Web Portal.

AVRS

DXC Technology maintains an Automated Voice Response System (AVRS) that provides recipient verification, coverage limitations, third party resource information, claims status information, and information regarding check amounts.

The AVRS system provides an automated path to information by keying the appropriate responses to prompts—such as Provider ID number (PID) or option number desired—as soon as each prompt begins. This greatly increases speed of inquiry.

The number of inquiries is limited to five (5) per call. The AVRS spells both the recipient’s name and announces the dates of service to increase accuracy of responses. Check amount data is also accessible through the AVRS voice menu. The provider file can be used to access up to the last three (3) check dates and amounts. In addition, the AVRS system provides each caller with a tracking number for the call, in case the provider wishes to follow up on any information.
270 Inbound / 271 Outbound

The 5010 X12 270 is the Health Care Eligibility Request transaction used by providers to request information from FMMIS about Medicaid recipient eligibility. The 270 transaction is used to inquire about general information on coverage and benefits, and what services are covered, including required copay or coinsurance.

The 5010 X12 271 is the Health Care Eligibility Request response transaction used to transmit the information requested in a 270.

MEVS

MEVS switch vendors or Value Added Networks (VANS) are private companies that provide current online Medicaid eligibility information, and other interactive transactions. Medicaid providers may select the switch vendor of their choice and contract with this vendor to provide the agreed upon services. The differences in switch vendors lies in that they provide a large array of products available at various price ranges. Eligibility transactions may be submitted using PC software supplied by the switch vendor, via a point of sale device similar to those used for credit card transactions, over the telephone using a voice response system, or other possibilities depending on what the switch vendor offers.

Web Portal

The Eligibility Verification Request section allows the user to search Medicaid fields for eligible recipients by using information such as the Recipient ID, Card Control Number, Social Security Number (SSN), and Recipient Name. Medicare Information and other service limit information related to the recipient will show here, if applicable.

Recipient Eligibility Verification Quick Reference Guide

The Recipient Eligibility Verification Quick Reference Guide houses detailed steps on how to access, and utilize, the resources available to health plans and providers. Health plans are encouraged to access the quick reference guide via the Quick Reference Guides page of the public Web Portal.

Transaction Testing

Testing is one of the ways in which health plans can both attain and maintain readiness for successful submission of encounter and fee-for-service transactions. Some tools are available to health plans before they become enrolled Florida Medicaid plans. Others require enrollment to be complete before they can be accessed. Below are some testing tools available to health plans.

Ramp Manager

Ramp Manager is an application that provides interactive, self-service tools for trading partners (TPs) to test X12N transactions against the Florida Medicaid Companion Guides and test National Council for Prescription Drug Programs (NCPDP) D.0 transactions against the Florida D.0 Payer Specification - Encounters document. Ramp Manager is hosted by EDIFECIS in an environment customized for Florida Medicaid transaction activities. Health plans do not need to be enrolled in Florida Medicaid to test using RAMP Manager.

Using Ramp Manager, health plans may:

- Create an account for testing purposes;
- Submit test transactions against the Florida Medicaid processing specifications consistent with the rules outlined in the companion guides;
- Review detailed information on errors for correcting files;
- Resubmit test transactions as needed; and
- Keep track of testing activity with online tracking utilities for historical submissions.
The Ramp Manager testing site can be accessed at https://sites.edifecs.com/index.jsp?flmedicaid.

**Beta Encounter and Claims Testing Tool for Health Plans**

The Agency and DXC have created a dynamic encounter claims testing environment tool for use by the health plan community. It requires an active Medicaid Provider ID for use. This tool tests readiness for various upcoming changes to Florida Medicaid medical encounter and fee-for-service data. Health plans are encouraged to participate in testing with Florida Medicaid to prepare for upcoming changes, even if they are currently submitting successful encounters and fee-for-service claims. For assistance with registration and testing, contact the Health Plan Support mailbox at healthplan.support@dxc.com.

Once registered, health plans may submit Institutional, Professional, and Dental encounters via batch submission on the secure Web Portal using the Beta Encounter and Claims Testing Tool for Health Plans or by using the Secure File Transfer Protocol (SFTP). Health plans may also submit fee-for-service claims, such as kick payments, for testing in this environment. A health plan uses its current login and password to access the BETA testing tool in the secure Web Portal to upload test encounters through the batch process. Health plans are encouraged to obtain the Encounter Testing tip sheet and Encounter Testing Scenarios document. These are available on the public web portal by hovering over the Managed Care tab, and clicking Support. The Encounter Claims Testing section can be found toward the bottom of the page.

**Pharmacy Encounter Testing***

Newly contracted health plans that have never been established with Medicaid, or are unfamiliar with the current NCPDP D.0 Telecommunication Standard, must successfully complete the D.0 testing process before submission of production encounter batch files is permitted. The testing process is outlined in the Florida Medicaid Pharmacy Encounters Testing Guide located on the public Web Portal. This process starts using RAMP Manager, as discussed above, and therefore does not require a health plan to be enrolled before it begins testing.

The Testing Guide can be reached from the public Web Portal by hovering over the Managed Care tab and clicking Pharmacy under the Encounter Transactions menu. The link for the Testing Guide is available under the section titled Encounter D.0 Payer Specifications.

The current Encounters Testing Guide is not designed for testing PBM changes or verifying format changes. This type of testing is voluntary and has no set requirements by Magellan or the Agency at this time.

*Note: The testing guide is in the process of revision to address this type of testing and provide a standard protocol for the health plans to follow if a health plan requires this specific testing.*

**Attestation**

Health plans must verify the encounter information it submits to the Agency is accurate, truthful, complete, and in accordance with 42 CFR 438.606. An Attestation file is required with every encounter submission.

**Medical**

Health plans are responsible for meeting the basic requirements that apply to all submissions. One of these requirements is submitting an Attestation of Medicaid Encounter Data file to ensure the accuracy, completeness, and timely submission of each medical encounter file submission.

Health plans are encouraged to reference the SMMC Attestation for Medical Encounter Files Tip Sheet, as this document contains information regarding successful medical Attestation file submissions. The tip sheet can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Tip Sheets under the Support menu. The Attestation for Medical Encounter Files Tip Sheet link can be found under the section titled Attestation for Medical Encounter Files.
Pharmacy*

Health plans are responsible for meeting the basic requirements that apply to all submissions. One of these requirements is submitting an Attestation of Medicaid Data which certifies the accuracy, completeness, and timely submission of each pharmacy encounter file submission.

Health plans are encouraged to reference the Pharmacy Encounter Attestation Tip Sheet as this document contains information regarding successful pharmacy Attestation file submissions. The Tip Sheet and Attestation Signature page can be reached from the public Web Portal by hovering over the Managed Care Tab and clicking Pharmacy under the Encounter Transactions menu. Both document links can be found under the section titled Pharmacy Attestations.

Secure Web Portal

How to Log In

After completing enrollment, providers receive a welcome letter and a PIN letter. The PIN letter is used to access the secure Web Portal and create a secure Web Portal account. To access the secure Web Portal user accounts (also known as MEUPS accounts), navigate to mymedicaid-florida.com, select the Secure Web Portal link at the top left of the screen, and then log on using your unique Username and Password. For more information on creating an account, see the Web Portal Handout.

Web Portal Tools

Signing in to the secure Web Portal, allows providers to access perform the following tasks:

- Direct Data Entry (DDE) of Fee-for-Service Claims
- Eligibility Verification
- Electronic Remittance Advice (RA)
- Trade Files

User roles can be delegated, including the capacity to add agents; an agent is any person or entity that has permission to access an account. Health plans are encouraged to regularly use secure Web Portal accounts because after 60 days of inactivity, an account is locked and after 120 days, it is terminated.

Additional information on the secure Web Portal can be found in the Secure Web Portal User Guide from the public Web Portal by hovering over the Provider Services tab and clicking Handbooks under the Support menu.

Florida Medicaid Enrollment

Providers who are not currently known to Florida Medicaid via a Medicaid ID have four options for acquiring one, two of which are applicable to Managed Care network Providers: Full Enrollment and Limited Enrollment. The other two options, Registered, and Referring, Ordering, Providing or Attending (ROPA) enrollment, are not applicable to Managed Care Network Providers.

Provider Enrollment for Medicaid Managed Care Network Providers

A provider can apply via the online Enrollment Wizard for Full or Limited Enrollment.

The Enrollment Wizard can be reached by hovering over Provider Services and clicking Enrollment. Any of these three options results in assignment of a Medicaid ID, which can be used by the health plans to submit encounter data.
Full Enrollment

This enrollment option is available via the web-based online Enrollment Wizard. The option is for providers who wish to receive Medicaid reimbursement directly from Florida Medicaid for services rendered to Medicaid recipients. The completed application is submitted and all applicable forms uploaded within the Enrollment Wizard. Additional enrollment information can be found on the Florida Medicaid Public Web Portal by hovering over the Provider Services tab, and clicking Enrollment, then following the directions contained in the section titled New Medicaid Providers.

Limited Enrollment

Limited Enrollment is available on the web-based online Enrollment Wizard. The streamlined application and corresponding review process allows approved providers to receive their Medicaid IDs faster than with traditional Full Enrollment. The limited enrollment option is for providers seeking to participate in Florida Medicaid as a network provider in a risk-based Medicaid health plan and to refer or order services. Limited Enrolled providers are not able to bill Florida Medicaid directly as fee-for-service providers. The provider must also complete a separate application process in order to be contracted with the health plan.

Additional information can be found in the Streamlined Credentialing Overview QRG available on the Florida Medicaid Public Web Portal by hovering over the Provider Services tab and clicking Quick Reference Guides under Training.

Other Enrollment Options

Registered Enrollment

Non-Medicaid providers must work with the Health Plan to complete and submit a Florida Medicaid Provider Registration form to request a Medicaid ID. Registered enrollment is not completed via the Wizard. Approved providers will be registered with Medicaid for purposes of submitting claims to a Medicaid health plan. See the Florida Medicaid Provider Registration Guide for guidance on how to successfully complete the form. The Guide can be found on the Florida Medicaid Public Web Portal by hovering over the Managed Care tab, and clicking Registration, then following the directions contained in the section titled Provider Medicaid IDs.

Referring, Ordering, Prescribing and Attending (ROPA) Enrollment

This enrollment type will be available to providers in late July 2018. The Patient Protection and Affordable Care Act (ACA) requires that all providers who refer, order, prescribe, or attend in conjunction with the provision of services to Florida Medicaid recipients be enrolled in the Florida Medicaid program. ROPA Enrollment is a streamlined enrollment process for physicians and other licensed practitioners, whose only relationship with the Medicaid program is as a ROPA provider. Additional information can be found on the Florida Medicaid Public Web Portal by hovering over the Agency Initiatives tab, and clicking Referring, Ordering, Prescribing, Attending (ROPA) Provider Enrollment under the Provider Screening Initiatives menu.

Provider Identification Listings

Provider Master List (PML)

Health plans may use the Provider Master List (PML) to verify whether providers in their networks are enrolled in Medicaid and to reconcile demographic data between the health plans’ databases and Medicaid. The PML is updated daily, Monday through Friday, and includes NPI crosswalk information as it exists in the Medicaid encounter processing system. Using the PML and NPI Crosswalk methodology, health plans can determine what NPI information is necessary for their providers to submit on claims in order to create a unique match, or a default match, to the provider NPI information in the Medicaid encounter processing system. The encounter NPI information does not have to match the PML exactly to make a match in the encounter system without data manipulation by the health plan.
PML resources available on the public Web Portal include:

- PML spreadsheet: An Excel file containing a list of all Medicaid providers currently registered or enrolled with Florida Medicaid with an active status within the last eighteen (18) months;
- PML pipe delimited text file: A text file containing the same data as the PML spreadsheet but in text file format;
- PML test files: A sample file of PML data; and
- PML Tip Sheet: A Word document providing additional information on PML.

The PML may be accessed from the public Web Portal by hovering over the Managed Care tab, and clicking Provider Master List under the Registration menu. On the Provider IDs and Information for Medical Health Plans page, in the section titled Provider Information Reports, the PML information and resources are listed toward the top.

The Provider Master List Tip Sheet can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Tip Sheets under the Support Menu.

Pending Provider List (PPL)

Florida Medicaid also provides a Pending Provider List (PPL) for the purpose of verifying if providers that currently do not have Medicaid IDs have applied for Medicaid.

PPL resources found on the public Web Portal include:

- PPL spreadsheet: An Excel file containing a list of all Medicaid provider applications that are currently pending with Medicaid;
- PPL pipe delimited text file: A text file containing the same data as the PPL spreadsheet but in text file format;
- PPL test file: A sample file of PPL data; and
- PPL Tip Sheet: A Word document providing additional information on PPL.

The PPL resources may be accessed from the public Web Portal by hovering over the Managed Care tab, and clicking Provider Master List under the Registration menu. On the Provider IDs and Information for Medical Health Plans page, in the section titled Provider Information Reports, the PML information and resources are listed toward the top.

The Pending Provider List Tip Sheet can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Tip Sheets under the Support Menu.

NPI Crosswalk

Florida Medicaid requires all Health Insurance Portability and Accountability Act (HIPAA) covered health care providers to obtain a National Provider Identifier (NPI) and include the NPI on paper or electronic claim submissions. Non-healthcare provider types are considered atypical and are therefore exempt from the NPI requirement.

Providers can navigate to the National Plan and Provider Enumeration System (NPPES) website, https://nppes.cms.hhs.gov, to obtain or verify their NPI. Using the NPI Registration Form, providers can either submit NPI Crosswalk information during initial enrollment with Florida Medicaid or maintain their existing provider file. The NPI Registration form can be reached by hovering over Provider Services and clicking Enrollment Forms under the Enrollment menu.

Only active NPI crosswalks are considered in the crosswalk methodology. Claim data used by the crosswalk methodology is submitted, which includes NPI, taxonomy, zip code, and zip+4 (only at the provider billing level).
Some providers have multiple Medicaid provider IDs sharing an NPI. These providers can combine a different Taxonomy and/or ZIP+4 with the NPI on each provider record in order to distinguish one record from another. This combination of NPI, Taxonomy, and ZIP+4 is referred to as the NPI Crosswalk.

Any 5010 X12 837 transactions submitted to Medicaid, or to a Medicaid health plan, should include the NPI Crosswalk information exactly as listed on the providers’ records. Submitting different identifiers in a transaction can cause the transaction to reject or deny. Paper claims can continue to have both the Medicaid ID and the NPI.

The requirement to submit the NPI Crosswalk information is not applicable to Web Portal Direct Data Entry (DDE) claims. Health plans should submit the NPI Crosswalk information as submitted by providers in their encounter transaction and should not modify the data.

**Methodology Used by FMMIS**

The Florida Medicaid Management Information System (FMMIS) utilizes the following methodology to determine the correct Medicaid provider ID to associate an encounter transaction.

**NPI Crosswalk Methodology for Encounters**

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
<th>Results</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Compare on NPI only.</td>
<td>The NPI will be mapped as a one-to-one match if a unique provider number is found.</td>
<td>• If there are multiple matches, go to step 2.</td>
</tr>
<tr>
<td>2</td>
<td>Load all Florida Medicaid provider IDs that match the NPI on the encounter.</td>
<td>All provider IDs which match by NPI only are considered.</td>
<td>• Go to step 3.</td>
</tr>
<tr>
<td>3</td>
<td>Filter by the provider’s <strong>NPI Crosswalk Effective Dates</strong>.</td>
<td>FMMIS will verify if encounter’s date of submission is within provider’s NPI crosswalk effective dates.</td>
<td>• Go to step 4.</td>
</tr>
<tr>
<td>4</td>
<td>Filter by NPI Crosswalk Effective Dates from step 3 with <strong>Date of Submission</strong> listed as the Date Used for Claims indicator.</td>
<td>FMMIS will default to NPI crosswalks based on Date of Submissions.</td>
<td>• If there is a match, go to step 5.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If there are no matches, go to step 6.</td>
</tr>
<tr>
<td>5</td>
<td>Match <strong>Date of Submission</strong> on the encounter within the NPI Crosswalk Effective and End Dates.</td>
<td>If there is only one match found, then the Florida Medicaid Provider ID is applied to the encounter.</td>
<td>• If there are multiple matches, keep the matched provider rows and go to step 10.</td>
</tr>
<tr>
<td>6</td>
<td>Filter by NPI Crosswalk Effective Dates with <strong>Date of Service</strong> listed as the Date Used for Claims indicator.</td>
<td>FMMIS will default to NPI crosswalks based on Date of Submission.</td>
<td>• Go to step 7.</td>
</tr>
<tr>
<td>7</td>
<td>Match <strong>Date of Service</strong> on the encounter within the NPI Crosswalk Effective and End Dates.</td>
<td>If there is only one match found, then the Florida Medicaid Provider ID is applied to the encounter.</td>
<td>• If there is no match, go to step 8.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If there are multiple matches, keep the matched provider rows and go to step 10.</td>
</tr>
<tr>
<td>Step</td>
<td>Action</td>
<td>Results</td>
<td>Comment</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>---------</td>
<td>---------</td>
</tr>
</tbody>
</table>
| 8    | Match NPI Crosswalk Effective date(s) prior to Date of Service. | If there is only one match found, then the Florida Medicaid Provider ID is applied to the encounter. | • If there is no match, go to step 9.  
• If there are multiple matches, keep the matched provider rows and go to step 10. |
| 9    | Match NPI Crosswalk Effective date(s) after Date of Service. | If there is only one match found, then the Florida Medicaid Provider ID is applied to the encounter. | • If there is no match, go to step 15.  
• If there are multiple matches, keep the matched provider rows and go to step 10. |
| 10   | Filter the list by NPI Crosswalk taxonomy if the taxonomy field is not blank. | If there is only one match found, then the Florida Medicaid Provider ID is applied to the encounter. | • If there are no matches (all IDs kept) OR multiple matches (only matched IDs kept) are found go to step 11. |
| 11   | Filter by NPI Crosswalk zip. | If there is only one match found, then the Florida Medicaid Provider ID is applied to the encounter. | • Spaces are allowed.  
• If there are no matches OR multiple matches are found, go to step 12. |
| 12   | Filter by NPI Crosswalk zip+4. | If there is only one match found, then the Florida Medicaid Provider ID is applied to the encounter. | • If there are no matches (all IDs kept) OR multiple matches (only matched IDs kept) are found, go to step 13. |
| 13   | Filter by NPI Crosswalk Enrollment Type-Registered or Limited (no fee-for-service). | If there is only one match found, then the Florida Medicaid Provider ID is applied to the encounter. | • If there is more than one match, go to step 14. |
| 14   | If Date of Used for Claims indicator is Date of Submission, go to step 6. | | • If the Date Used for Claims indicator is Date of Service, go to step 15. |
| 15   | If this is an encounter and no match was found using the NPI Crosswalk, proceed with locating NPI Default. | | • See the NPI Default Methodology table. |

**NPI Default**

If a unique provider file cannot be located using the NPI Crosswalk methodology, the system will move forward to find the information using the NPI Default methodology. The following methodology is used by FMMIS.
NPI Default Methodology

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
<th>Results</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Load all active Florida Medicaid provider IDs that match the NPI on the encounter.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Sort using <strong>Enrollment Type</strong> in descending order.</td>
<td>This will sort registered providers before fee-for-service providers.</td>
<td>• Go to step 3.</td>
</tr>
<tr>
<td>3</td>
<td>Sort by provider location in ascending order.</td>
<td></td>
<td>• This is sorted using the last two characters of the provider ID.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Go to step 4.</td>
</tr>
<tr>
<td>4</td>
<td>Sort by NPI end date in descending order.</td>
<td></td>
<td>• Go to step 5.</td>
</tr>
<tr>
<td>5</td>
<td>Select the first Florida Medicaid Provider ID from the results list where the date used for claims indicator is <strong>Date of Submission</strong>.</td>
<td>The first provider ID from the results list whose NPI crosswalk is based on Date of Submission will be the default provider ID.</td>
<td>• If no match is found, go to step 6.</td>
</tr>
<tr>
<td>6</td>
<td>Select the first Florida Medicaid provider ID from the results list.</td>
<td>The first provider ID from the results list will be the default provider ID.</td>
<td>• This provider ID will be applied to the encounter.</td>
</tr>
</tbody>
</table>

NPI Search Engine and Resources

NPI Search Engine

The NPI to Medicaid ID Search Engine tool on the public Web Portal allows users to review active NPI Crosswalk information stored in FMMIS using NPI-related search criteria. This tool contains a display of the Provider’s name, Medicaid Provider ID, NPI Crosswalk values, Date Used for Claims Indicator, NPI Crosswalk Effective and End Date, and Enrollment Type for NPI records displayed in the search results. This tool may also be used to verify if an NPI Crosswalk is already registered to a Florida Medicaid provider.

The NPI to Medicaid ID Search Engine can be accessed from the public Web Portal by hovering over the Provider Services tab and clicking NPI to Medicaid ID Search Engine under the Support menu.
NPI Resources

Health plans are to reject identified provider NPI crosswalk-related submission errors made by providers within their network and assist their providers to submit a corrected NPI Registration Form to Florida Medicaid. The following NPI references will help support this effort.

- **NPI Registration Form**: Health plans use this form to register their NPI crosswalk information that is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with Florida Medicaid.
- **NPI Registration Form Guide**: Health plans may use this guide as a supplemental document on how to fill out the NPI Registration.
- **NPI Quick Reference Guide**: Health plans may access this guide to understand NPI and the requirements for Florida Medicaid.

These resources may be accessed from the public Web Portal by hovering over the Provider Services tab and clicking Enrollment Forms under the Enrollment menu.

Claim Validation

X12 Validation

Health plans are required to have front end editing in order to reject claims for required missing or incomplete information. In addition, health plans are required to reject claims that fail transaction standard validity checks. Health plans must work with their providers to resolve any issues with rejected claims. Rejected claims must be resolved and resubmitted by the provider to the health plan prior to the health plan’s initial encounter submission to the Agency.

Medicaid policy requires *any* third-party acting on behalf of the health plan obtain a Medicaid ID by completing the Florida Medicaid Provider Enrollment application found on the Enrollment Forms page of the public Web Portal. In order for a third-party entity to submit and/or inquire using X12 transactions, the third-party must be linked to the health plan by completing an **Electronic Data Interchange Agreement** form found on the Registration Forms and Agreements page of the public Web Portal.

The EDI Agreement can be accessed from the public Web Portal by hovering over Provider Services and clicking Enrollment forms under the Enrollment menu. The EDI Agreement link may be found under the section titled Additional Enrollment Forms.

To access the Registration Forms and Agreements page from the public Web Portal hover over the Provider Services tab and click Registration Forms under the EDI menu.

Claim Validation Edits

All health plans must submit complete, accurate, and timely encounter data to DXC, as defined in the health plan’s contract and in accordance with generally accepted industry best practices. The health plan is responsible for errors or noncompliance resulting from the health plan’s own actions or the actions of authorized agents acting on behalf of the health plan.

The **CORE/CAQH Compliant EOB Clarification** document provides a description of the CARC/RARC that post on encounters. This document helps health plans identify if the edit is informational or repairable, and explains whether the edit occurred at the header or detail level.

The CORE/CAQH Compliant EOB Clarification document can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking 835 under the Encounter Transactions menu.
Florida Medicaid Encounter Submission

Health plans should refer to the Companion Guides found on the public Web Portal for instructions on how to submit a Florida Medicaid encounter. Pharmacy encounters should be submitted in accordance with the D.0 Payer Specification section found on the Pharmacy page of the public Web Portal.

For information on how to access the Companion Guides and D.0 Payer Specification guide, please see the Encounter and Managed Care Submissions Resources section of this document, above.

Common Medical Encounter Edits

The following are examples of common validation edits found in FMMIS. Detailed information may be found in the CORE/CAQH Compliant EOB Clarification document.

- Type of bill invalid (16_MA30).
- Calculated number of days is not equal to the number of days billed (16_MA33).
- Admit date missing (16_MA40).
- Missing occurrence code/date A3 (16_M45).
- Billed amount missing (16_M79).
- Primary surgical procedure code missing (16_M67).
- Missing or invalid Present on Admission indicator (16_N434).
- Revenue code requires HCPCS/National Drug Code combination (16_M119).
- HCPCS procedure requires a valid National Drug Code (16_M119).
- Referral code indicator invalid (16_N286).
- Plain paid zero for non-capitated claim (96_M79).
- Level of care on nursing home claim is missing (96_N188).
- Exact duplicate (97_N111).
- Mouth quadrant duplicate (97_N111).
- Possible duplicate (B13).
- Electronic adjustment/void claims do not match (449).

Health plans should validate claims received from the provider prior to submitting the encounter to ensure critical data elements are present. Common denials related to missing or invalid information include:

- Invalid or missing diagnosis code (16_M76);
- Procedure code invalid or missing (16_MA66);
- Level of Care missing (96_N188); and
- Billed amount missing (16_M79).

Health plans must include the appropriate contract type for successful encounter submissions. If a health plan has a capitated relationship with the servicing/treating provider, FMMIS will accept encounters containing zero-paid amounts. The CN101 segment within loop 2300 of the X12 837 transaction must be 05 if the CLM02 segment (monetary amount) equals zero (0). When billing encounters with 09 in the CLM02 segment (monetary amount) at least one service line has to have a payment greater than zero (0). Contract type information is discussed in the
Florida Medicaid Companion Guides. Failure to submit the appropriate contract type will result in the following denial:

- Contract Type is missing or invalid (CN1) (16_N229).

Data elements such as a recipient ID and provider ID cannot be adjusted. The following edits commonly occur when there is a discrepancy with the provider or recipient information listed on the encounter:

- Billing/Rendering provider is suspended or terminated (50_N180);
- Provider not enrolled at service location for program billed (170_M143);
- Recipient is not enrolled in the Health Plan (96_N52); and
- Recipient ineligible on detail date of service (177).

The following edits commonly occur when an adjustment or void is submitted incorrectly:

- Electronic adjustment void set to deny (96_MA67); and
- Credit adjustment of a denied claim (96_N142).

**Common Pharmacy Encounter Edits**

The following are examples of common NCPDP edits. Detailed information may be found in the Pharmacy Encounters: NCPDP Common Errors Crosswalk document.

- Provider does not match authorization on file (reject code: 7A).
- Submission clarification code count does not match number of repetitions (reject code: SG).
- Missing or invalid – other coverage code (reject code: 13).
- Non-matched pharmacy number (reject code: 50).
- Duplicate paid or captured claim (reject code: 83).
- Reversal not processed (reject code: 87).
- Missing or invalid prescriber last name (reject code: DR).
- Missing or invalid gross amount due (reject code: DU).
- Missing or invalid product or service ID qualifier (reject code: E1).

The Pharmacy Encounters: NCPDP Common Errors Crosswalk document can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Pharmacy under the Encounter Transactions menu.

**Provider/NPI-Related Errors and Edits**

The 5010 X12 837 encounter transactions for covered health services must contain the NPI for each provider included in a transaction. The NPIs in a transaction are used to identify the Medicaid provider IDs for each provider listed in a transaction. Submitting incorrect or invalid identifiers in a transaction can cause the transaction to reject or deny.
The following are common provider/NPI-related edits for submitted encounters. Detailed information may be found in the CORE/CAQH Compliant EOB Clarification document.

- Billing provider ID number not on file (16_N256).
- Provider not enrolled at service location for program billed (170_M143).
- Rendering provider not eligible to render service on this program (185_N684).
- Non-bill provider suspend-terminated for program billed (B7_N570).
- Billing or rendering provider is suspended or terminated (50_N180).
- Rendering provider not on provider database-HDR (16_N290).
- NPI required-billing provider-healthcare (206).

The CORE/CAQH Compliant EOB Clarification document can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking 835 under the Encounter Transactions menu.

**Reporting Third Party Liability (TPL) on Encounter Submissions**

**Medical**

Other Subscribers Information is required on all encounters. Health plans should always be reported as one of the other payers. When there is Third Party Liability (TPL), the TPL is primary and the health plan is secondary. When there is no TPL, the health plan is primary. The health plan must list the TPL information as the primary payer, and place the TPL paid amount on the detail level in order for the system to successfully process the encounter.

Payer Responsibility Sequences (SBR01) and Claim Filing Indicators (SBR09) are used to indicate the relationship each payer has to Medicaid. Please refer to Appendix A in the 5010 Version for 837I Companion Guide found on the public Web Portal.

The companion guides can be accessed by hovering over the Provider Services tab and clicking Companion Guides under the EDI menu. The list of 5010 Companion Guides can be found at the bottom of the page.

**Pharmacy**

In order to report the amount paid by the health plan to the pharmacy, a Coordination of Benefits (COB)/Other Payments Segment is required on all pharmacy encounter claims. The health plan must always be reported as one of the Other Payers and should be reported as Primary when there is no other TPL on the claim. When there is a TPL, the TPL is primary and the health plan is secondary. The amount paid to the pharmacy should be reported in the Other Payer Amount Paid field (431-DV) on the COB segment.

Health plans are encouraged to review the Tips for Reporting MCO Amount Paid for Florida Medicaid Encounters (Version D.0) document found on the public Web Portal for more detailed information on how to submit a pharmacy TPL.

This document can be accessed by hovering over the Managed Care tab and clicking Pharmacy under the Encounter Transactions menu.

**Resubmissions**

**Medical**

Health plans must accurately resubmit 100% of all encounters, for which encounters can be remedied, within thirty (30) days of an original encounter receiving denial from DXC. An encounter may be resubmitted only if the encounter was denied on the header level and was not previously resubmitted.
Health plans may identify an encounter resubmission within the 835 transaction by reviewing the region code. All encounter resubmissions will contain region code 71. Initial encounter resubmissions require both the Internal Control Number (ICN) of the original denied encounter and the appropriate reference identification qualifier D9 within the 2300 loop of the 5010 X12 837 transaction. The ICN of the most recent resubmission attempt must be included in each subsequent encounter resubmission.

The SMMC Encounter Data Submission and Timeliness Tip Sheet contains five (5) common error scenarios for denied encounters and how to correct these errors for resubmission.

This Tip Sheet can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Tip Sheets under the Support menu.

**Pharmacy**

Within thirty (30) days after encounters fail NCPDP edits, the health plan must correct and resubmit 100% of all encounters for which errors can be remedied. To identify an encounter resubmission, health plans must include the ICN field (993-A7) on the COB segment. The ICN field should be populated with the Authorization Number from the response file of the denied encounter. If multiple remediation attempts are made for the same pharmacy encounter, continue to use the Authorization Number received when the encounter originally denied.

For additional information on submitting pharmacy resubmissions, please refer to the Florida D.0 Payer Specification – Encounters document found on the public Web Portal.

The Florida D.0 Payer Specification – Encounter document can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Pharmacy under the Encounter Transactions menu.

**Health Plan Denied Services**

At this time, the Agency is not requiring encounters for health plan denied medical or pharmacy services. However, if a health plan would like to submit an encounter for a service it has denied, either at the detail or at the header level, it can do so.

**Medical Requirements**

While the Agency does not currently require reporting of health plan denied services, detailed individual denied services not noted within a health plan’s encounter submission would be treated by the Medicaid system as services covered by the health plan and may result in an inaccurate encounter reporting or may impact encounter accuracy monitoring by the Agency.

Do not submit encounters that are paid zero ($0) by the health plan due to third-party payments as health plan denied encounters. The additional third-party payments are to be included within the encounter submissions.

For more information on successfully submitting health plan denied medical services or third party payments, health plans can refer to the EDI Companion Guides.

The companion guides can be accessed by hovering over the Provider Services tab and clicking Companion Guides under the EDI menu. The list of 5010 Companion Guides can be found at the bottom of the page.

*Note:* Header level health plan denial submissions are not returned to the 5010 X12 835 remittance advice. Only the health plan detail denial submissions are returned to the 5010 X12 835.

**A1 Logic**

Health plan denied encounters are indicated by the use of the Claim Adjustment Reason Code A1 either at the header level or the detail level in the appropriate loop and segment as listed in the companion guides.
CARC/RARC 256/N310

Detail line items containing A1 will deny for CARC/RARC 256-N130/error 4182: Encounter detail was denied by the health plan. This is considered an informational error as the denied status is the expected result for health plan denied encounters.

Region Codes

ICN region code 72, health plan denied encounter, is assigned to encounters where A1 is indicated at the header level or where A1 is indicated at the detail level on all detail line items. Encounters with an assigned ICN region code 72 will not appear on the X12 835.

Encounters with both paid and health plan denied line items at the detail level process with a paid status at the header level and are assigned the appropriate ICN region code based on the submission type (70-original, 71-resubmission, or 69-adjustment). Health plans may refer to the list of encounter ICN region codes on the SMMC Encounter Support FAQ document for information on encounter region codes.

This document can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Contact Us under the Support menu.

Health Plan Denied Encounter Scenarios

The following chart shows common health plan denied services encounter reporting scenarios and expected results.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Method of Reporting</th>
<th>Expected Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>The health plan paid for services but denied one or more detail line items on the provider’s claim submission.</td>
<td>The health plan denied detail line(s) on the encounter should have Claim Adjustment Reason Code A1.</td>
<td>The ICN will appear on the 835 as accepted, and will post detail CARC-RARC 256-N130/error 4182: Encounter detail was denied by the health plan.</td>
</tr>
<tr>
<td>The health plan denied all detailed line items on the provider’s claim submission.</td>
<td>The encounter should have Claim Adjustment Reason Code A1 at the header.</td>
<td>The ICN will not appear on the 835. Health plan denied encounter ICN will start with 72 and will deny.</td>
</tr>
<tr>
<td>The health plan is submitting an encounter adjustment that includes one or more health plan denied detail line items.</td>
<td>The health plan denied detail line(s) on the encounter adjustment should have Claim Adjustment Reason Code A1.</td>
<td>The ICN will appear on the 835 with region code 69. The encounter adjustment will post detail CARC-RARC 256-N130/error 4182: Encounter detail was denied by the health plan.</td>
</tr>
<tr>
<td>The health plan is submitting an encounter adjustment reporting all line items as health plan denied.</td>
<td>The encounter adjustment should have Claim Adjustment Reason Code A1 at the header.</td>
<td>The ICN will appear on the 835 with region code 69. The encounter adjustment will deny and post header CARC-RARC 256-N130/error 4185: Encounter adjustment was denied by the health plan.</td>
</tr>
</tbody>
</table>

A complete listing of encounter testing scenarios can be found in the Encounter Testing Scenarios document available on the public Web Portal.

These are available on the public web portal by hovering over the Managed Care tab, and clicking Support. The Encounter Claims Testing section can be found toward the bottom of the page.
Pharmacy Requirements*

If a health plan would still like to submit health plan denied pharmacy encounters, despite no current requirement to do so by the Agency, the health plan must first complete the Denied Pharmacy Encounter testing process. Testing consists of a file submitted to Ramp Manager and a file submitted via SFTP.

Health plan denied pharmacy encounter files must be submitted in the D.0 format, which is similar to paid encounters. The following are the differences for health plan denied pharmacy encounter files:

- Batch Receiver ID field (880-K7) must be FLDENIED; and
- Other Payer Reject Count field (471-5E) and Other Payer Reject Code field (472-6E) are required in the COB segment to report the health plan denied error codes.

Batch files for health plan denied encounters must be submitted in a separate file from health plan paid encounters. A separate SFTP folder has been added to each health plan’s site specifically for uploading health plan denied encounter files.

Detailed information on denied pharmacy encounter testing can be found in the Plan Pharmacy Denied Encounters: Testing and Production document.

This document can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking on Pharmacy under the Encounter Transactions menu.

Auto Crossover*

Florida Medicaid has partnered with the Centers for Medicare & Medicaid Services (CMS) to develop the SMMC crossover pass through initiative, allowing all auto crossovers to be accepted by health plans. Crossover claims will only be processed once as providers are not required to submit dually-eligible claims to both the Benefit Coordination and Recovery Center (BCRC) and the health plan.

A Coordination of Benefits Administration Identification (COBA ID) is obtained through BCRC. Health plans are required to have a COBA ID dedicated to Florida Medicaid lines of business. Health plans new to Florida Medicaid will need to work with the DXC EDI team to obtain and test a new COBA ID from BCRC. Existing Florida Medicaid health plans will need to work with the DXC EDI team to reassign existing COBA IDs to their new provider ID(s).

Additional information on Auto Crossover, the CMS sample attachment, and a sample SFTP form can be found on the Auto Crossover page of the public Web Portal.

The Auto Crossover page may be accessed from the public Web Portal by hovering over the Agency Initiatives tab and clicking Auto Crossover.

FQHC/RHC Wraparound*

The automated Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Wraparound process has been in place since October 01, 2015. This was implemented to ensure more timely reconciliations of FQHC and RHC payments made by the health plan to the fully Medicaid-enrolled FQHCs and RHCs within the health plan’s network. This reconciliation is based on accepted encounter data received from a health plan and made directly to the FQHC or RHC by FMMIS.

The SMMC FQHC/RHC Wraparound Tip Sheet provides information for submitting encounters that will be used in the automated FQHC/RHC Wraparound process.
Expanded Benefits

Expanded benefits are benefits offered to all enrollees in specific population groups, covered by the health plan for which the health plan receives no direct payment from the Agency.

Medical Expanded Benefits

Expanded benefits are those services or benefits not otherwise covered or that exceed limits outlined in the Medicaid State Plan, the Florida Medicaid Coverages and Limitations Handbooks and Coverage Policies, or the Florida Medicaid Fee Schedules. The Agency implemented changes to its system to better allow the Agency to identify and categorize encounter data submissions related to expanded benefits reimbursed by the health plans.

The Expanded Benefits page on the public Web Portal contains a List of Approved State Plan Expanded Benefits as well as an Expanded and Other Benefits Tip Sheet.

Pharmacy Expanded Benefits*

Expanded Benefit Pharmacy Encounters are claims for over-the-counter (OTC) products not otherwise covered in the Medicaid State Plan, the Florida Medicaid Coverage and Limitations Handbooks, and the Florida Medicaid Fee Schedules. Not all health plans offer this benefit, but those that do must report all benefits and products provided to its enrollees in a separate batch file identified as expanded benefits. A Pharmacy Expanded Benefits Tip Sheet is posted on the public Web Portal to answer the common questions regarding submission requirements.

A list of approved State health plan pharmacy expanded benefits may be found on the Pharmacy Expanded Benefits section of the Pharmacy page on the public Web Portal.

The Pharmacy Expanded Benefits resources may be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Pharmacy under the Encounter Transactions menu.

Agency Initiatives

The Agency Initiatives section of the public Web Portal houses all the information pertaining to current and upcoming initiatives led by the Agency and DXC. These initiatives are aimed at furnishing our provider communities with accurate and educative information that they may continually provide the best uninterrupted health care possible. The following are examples of current Agency initiatives that will impact encounter claims submissions.

New Medicare Card Project

The New Medicare Card Project (NMCP) initiative is being implemented in order to meet requirements detailed in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which mandates the Centers for Medicare & Medicaid Services (CMS) remove all Social Security Numbers (SSNs) on all Medicare beneficiary cards. A unique, randomly assigned number, known as a Medicare Beneficiary Identifier (MBI), will replace the SSN-based Health Insurance Claim Number (HICN) currently used on Medicare beneficiary cards. The new Medicare beneficiary cards containing the MBI will be mailed out to beneficiaries starting April 2018. The MBI will be used for Medicare transactions, such as billing, eligibility status, and claim status. Much like an SSN, an MBI should be treated as Protected Health Information (PHI).
21st Century CURES Act

Federal regulations require that all network providers be enrolled with Medicaid. Being enrolled means the provider has made disclosures of ownership and controlling interest to, been screened by, and entered into an agreement with the Agency. As mentioned on previous calls, this requirement impacts all registered providers, who are not considered to be enrolled.

The Agency has developed processes and protocols by which registered network providers can transition to enrolled providers. It is important to coordinate the closing of registered IDs with the activation of newly enrolled IDs to avoid conflicts from shared NPIs. There is some challenge in this, as many providers were registered under employers’ tax IDs, and they will enroll using their own tax ID. This makes the matching of a provider’s registered ID to her or his enrolled ID difficult due to the lack of consistent identifiers.

Further outreach and communication related to the transition of registered providers including identifying and closing the registered IDs once a provider is enrolled, will be forthcoming after the first of the year. On a date to be determined, the Agency will notify health plans and providers of the process for transition and a deadline for provider compliance. Registered network providers can continue to provide services as they have been and health plans can continue submitting encounters, including registered providers, as they have been until the transition is complete. The Agency will not deny encounters submitted with registered providers at this time.

Referring, Ordering, Prescribing, and Attending Providers (ROPA)

Federal regulations require providers who furnish, order, or refer services be enrolled with Medicaid. The Agency will be implementing the Referring, Ordering, Prescribing, and Attending (ROPA) initiative to meet these federal regulations. The terms “ordering” and “referring” include prescribing drugs or other covered items, and certifying a beneficiary’s need for a service. The requirement to enroll applies to all providers under the State Plan, under a waiver of the plan, and those in the network of a risk-based managed care plan.

The Agency is developing an online, streamlined enrollment application for physicians and other licensed practitioners, whose only relationship with the Medicaid program is ordering and/or referring services. The streamlined process will feature an automated provider enrollment application that will self-populate using information downloaded from the providers’ professional licenses, NPI registrations, and their Medicare enrollments, when available. The application will also access the providers’ background screenings within the Care Provider Background Screening Clearinghouse. Practitioners with current screenings in the Clearinghouse will not need to be re-screened for Medicaid enrollment.

The Agency expects to implement the streamlined ordering and referring practitioner application in the spring of 2018 once the necessary system modifications are completed.

Affordable Care Act Project

CMS published a Final Rule in 2011 with provisions to be implemented as they relate to Medicare, Medicaid, and Children’s Health Insurance Programs (CHIP) for provider screening and prevention of provider fraud and abuse.

This rule implemented provisions to the Affordable Care Act (ACA) as well, which include that states are required to enhance provider screening processes completed prior to enrollment of a Medicaid Provider and at renewal. The federal regulations include the requirement to check provider applicants, enrolled providers, and their owners of record against the following provider screening information files and collect an enrollment application fee (pending legislative authority), as appropriate.

Provider Enrollment Chain of Ownership System (PECOS)

ACA requires the Agency to conduct pre-and post-enrollment screenings to ensure that providers initially meet and continue to meet the enrollment criteria for their provider type. As an enhancement to the screening process, the Agency has implemented automated checks of provider application data against Medicare’s Provider Enrollment Chain of Ownership System (PECOS) database.
Medicaid provider enrollment information will be checked against the PECOS data on a pre- and post-enrollment basis to ensure that accurate and consistent disclosures are made to each program. The Agency compares the provider name, tax ID, National Provider ID, ownership, birth date, date of death, status, service address, site visit results, screening level and fingerprint status.

**Death Master File (DMF)**

The DMF is provided by the Social Security Administration and contains well over 89 million records created from SSA payment records. All providers and owners will be checked against this file during enrollment, renewal, and owner changes/updates to verify the enrolling provider or owner is not deceased.

**National Practitioner Databank (NPDB)**

NPDB is a system intended to facilitate a comprehensive review of health care providers and owners. All Medicaid providers and owners will be checked against this file during enrollment, renewal, and owner changes/updates to check if any malpractice, adverse licensures, or any negative action has been reported for the provider/owner.

**State Master File (SMF)**

All Medicaid providers and owners will be checked against this file during enrollment, renewal, and owner changes/updates to check if the provider/owner is terminated by the other states.

**NPI Crosswalk Enhancement**

The NPI Crosswalk Enhancement initiative was enacted in an effort to mitigate NPI Crosswalk data issues and ensure each active provider has a unique NPI Crosswalk assigned. Changes impacted the process for registering, validating, and correcting NPI crosswalks for new and existing providers.

**EAPG Pricing**

The Florida Legislature has mandated that the Agency for Health Care Administration (Agency) implement a new ambulatory surgical center (ASC) and hospital outpatient payment method using 3M™ Enhanced Ambulatory Patient Grouping (EAPG) for Florida Medicaid. The Agency, along with its consultant, Navigant Healthcare, designed this new EAPG-based outpatient payment method. The Agency’s fiscal agent, DXC Technology (DXC), updated the Florida Medicaid Management Information System (FMMIS) to process claims according to this new pricing methodology. Since July 1, 2017, eligible hospital outpatient submissions, as well as ambulatory surgical center submissions for dates of service July 1, 2017 or greater, were priced based on EAPGs.

**DRG Pricing**

Florida Medicaid is now processing claims using an inpatient payment method utilizing Diagnosis-Related Groups (DRG) as mandated by the 2012 Florida Legislature. The majority of inpatient claims with dates of services July 1, 2013 or later are now processed under DRG.

**Monitoring Tools**

Health plans must submit complete, accurate, and timely encounter data to both the Agency and DXC, as defined in the health plan’s contract and in accordance with generally accepted industry best practices. Health plans are encouraged to review the Encounter Monitoring Tools tip sheet for information on how to submit encounters successfully.

The Tip Sheet can be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Tip Sheets under the Support menu.
Contacts

Florida Medicaid offers a variety of helpful resources to its health plan community, including educational materials located on both the Agency’s website, http://ahca.myflorida.com, and the Florida Medicaid Public Web Portal.

The following is a list of health plan contacts and resources, provided in the SMMC Encounter Support Contact Sheet available on the Managed Care Support page of the public Web Portal.

The contact sheet may be accessed from the public Web Portal by hovering over the Managed Care tab and clicking Contact Us under the Support menu.

The Magellan Medicaid Administration pharmacy team is available to assist with onboarding, assist with testing, and answer questions. Contact them at flmcosupport@magellanhealth.com.

<table>
<thead>
<tr>
<th>Inquiry Type</th>
<th>Contact</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health plan related questions, onboarding activities, testing, and training (non-EDI), including assistance with complex encounter denials and resubmissions, enrollment issues, and training assistance with Florida Medicaid billing requirements.</td>
<td><a href="mailto:healthplan.support@dxc.com">healthplan.support@dxc.com</a></td>
<td>This mailbox is managed by the DXC Health Plan Support Team.</td>
</tr>
<tr>
<td>EDI-related inquiries, and other electronic transactions, such as the X12 835, X12 837, and X12 834 transactions.</td>
<td><a href="mailto:healthplan.support@dxc.com">healthplan.support@dxc.com</a> 1-866-586-0961</td>
<td>The Florida Health Plan Support team offers assistance by phone and email.</td>
</tr>
<tr>
<td>Medical attestation files are submitted to this mailbox, along with medical attestation-related inquiries.</td>
<td><a href="mailto:encounter.attestation@dxc.com">encounter.attestation@dxc.com</a></td>
<td>This mailbox is managed by the EDI Florida Encounter Support team.</td>
</tr>
<tr>
<td>General provider enrollment-related inquiries, change of address, and NPI updates.</td>
<td>1-800-289-7799, option 4.</td>
<td>The Provider Enrollment Contact Center offers assistance by phone.</td>
</tr>
<tr>
<td>Secure Web Portal account assistance, along with general encounter claim status inquiries.</td>
<td>1-800-289-7799, option 7.</td>
<td>The Provider Services Contact Center offers assistance by phone.</td>
</tr>
<tr>
<td>NCPDP version D.0 transactions and format-related concerns.</td>
<td><a href="mailto:flmcosupport@magellanhealth.com">flmcosupport@magellanhealth.com</a></td>
<td>This mailbox is managed by Magellan Medicaid Administration.</td>
</tr>
<tr>
<td>Information on the SMMC Program.</td>
<td><a href="http://ahca.myflorida.com/medicaid/">http://ahca.myflorida.com/medicaid/</a> statewide_mc/index.shtml.</td>
<td>This website houses important information regarding the SMMC program.</td>
</tr>
<tr>
<td>Information for Managed Care Plans.</td>
<td><a href="http://portal.flmmis.com/FLPublic/">http://portal.flmmis.com/FLPublic/</a> Provider_ManagedCare/tabId/38/ Default.aspx.</td>
<td>This website houses important information regarding encounter submissions and resources.</td>
</tr>
</tbody>
</table>
Conclusion

This guide provides all of the reference tools and information necessary for health plans to successfully onboard with and submit encounters and fee-for-service claims to the Agency.

In order to stay up-to-date, it is extremely important that health plans routinely review the Florida Medicaid Web Portal references for updates in addition to being on the lookout for applicable policy transmittals, alerts, and emails.