



CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

January 11, 2010

Dear Medicaid Recipient:

Our records show that you are currently receiving Medicaid home health visits. The 2009 Florida Legislature made some changes in the law impacting Medicaid. As a result, Medicaid has changed the authorization requirements for home health services and we wanted to provide you with an update on how the approval process will work.

Home health visits will now require prior approval before Medicaid can pay for services. Your home health agency will apply for approval through the Agency's contracted reviewer, currently Keystone Peer Review Organization (KePRO).

KePRO has nurses and physicians with special training and experience who review the information provided by your home health agency to determine whether services are medically necessary. Your home health agency will need to provide KePRO with a copy of the plan of care and the order from the physician.

You will need to be examined by your doctor at least every 6 months in order to get approval for home health services. This will help to make sure that your medical condition is being monitored closely by a doctor. Your home health agency will need to send proof of this doctor visit to KePRO every 6 months. You can help by reminding your doctor that the home health agency will need this documentation in order to continue services. We have included a Physician Visit Documentation form with this letter, as an example.

You may contact your local Medicaid area office if you have questions about these changes. A list of contact information for the Medicaid area office in each area is also included with this letter.

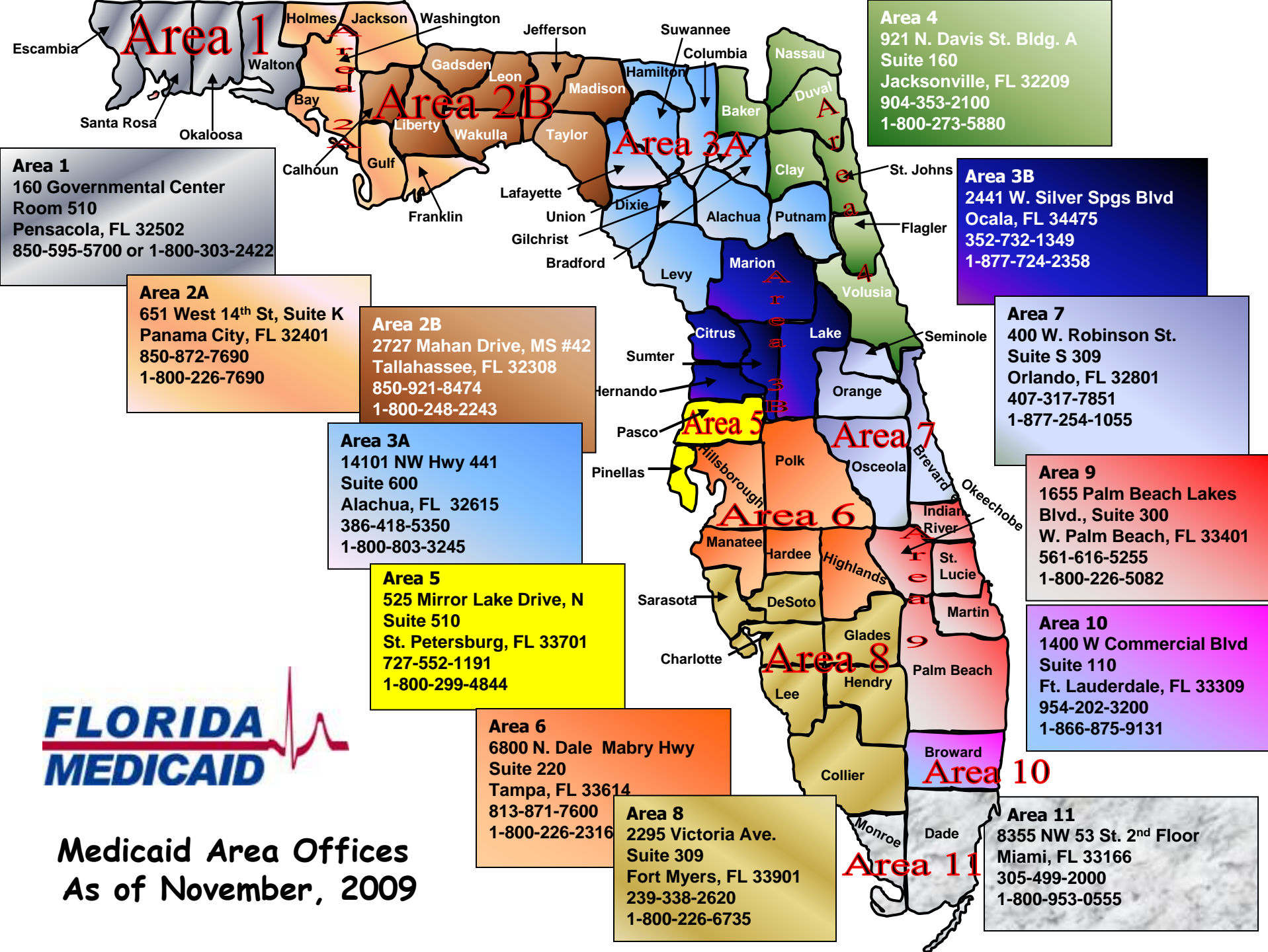
Sincerely,

Beth Kidder, Chief
Bureau of Medicaid Services

BK/cad

Enclosures: Medicaid Area Office Contact List
AHCA Physician Visit Documentation Form





**Medicaid Area Offices
 As of November, 2009**



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Physician Visit Documentation Form
(to be completed by the recipient's physician)

Date: _____

Medicaid Recipient Name: _____

Physician Name: _____

Physician Address: _____

Physician Telephone Number: _____

Diagnosis(es): _____

Please describe the patient's ongoing need for home health services:

Signature of Physician: _____

National Provider Identifier: _____

