

- Volume XI
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- Summer 2011

# Florida Medicaid Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION



## ICD-10 TRANSITION PLANS

Currently, health care entities are required by Federal regulations to use a standard code set to indicate diagnoses and procedures on transactions. For diagnoses, the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code set is used. For inpatient hospital procedures, the ICD-9 procedure code set (PCS) is used. Effective October 1, 2013, the standard code set that is required for diagnosis codes is changing to the ICD-10-CM and the standard code set that is required for inpatient hospital procedures is changing to the ICD-10-PCS. In preparation of the October 1, 2013 effective date, the Agency for Health Care Administration will undertake several activities over the next two years. Other procedure code sets known as Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) used in other claims transactions are not changing.

These codes are used in almost every clinical and administrative process and system, which will necessitate changes and adjustments in many areas of health care payment and reporting. Reasons for making these code set changes are required by the Code of Federal Regulations at 45 CFR 162.1002(c). The practice of medicine has changed dramatically in the last several decades. Many new conditions have been discovered, many new treatments developed, and many new types of medical devices have been made available to patients. The ICD-10 code set will enable a much better description of the current practice of medicine and has the flexibility to adapt as medicine changes.

Florida Medicaid policy and claims billing rules encompass a complex set of operations and standards. Compliance with the new standard set of diagnosis and inpatient hospital procedure codes will necessitate that the state revise not only the codes used, but the Medicaid policies that govern the application of the codes and in some cases, the reimbursement amounts for the services rendered to Medicaid recipients.

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The use of Agency throughout this publication refers to the Agency for Health Care Administration.

### Sign Up for Medicaid Health Care Alerts

The Florida Medicaid program has an email alert system to supplement the present method of receiving Provider Alerts information and to notify registered providers or interested parties of "late-breaking" health care information.

To sign up for Health Care Alerts, please visit <http://ahca.myflorida.com/Medicaid/alerts/alerts.shtml>.



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# A MESSAGE FROM SECRETARY ELIZABETH DUDEK

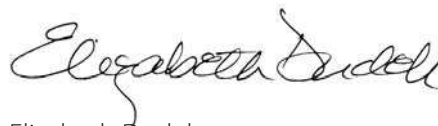
Dear Medicaid Provider:

As you know, the 2011 Legislative session concluded May 7. In the last bulletin I mentioned the House and the Senate were considering changes to the Medicaid program to ensure its longevity. Governor Scott signed House Bills 7107 and 7109, which require the Agency to implement managed care statewide by October 1, 2014. The Agency is working toward submitting several requests for federal authority by August 1. In mid-June, the Agency conducted 11 public meetings to gather input about the program. As I have said before, the goal of this legislation is to improve coordination of care, provide more budget predictability, enhance accountability, and reduce fraud and abuse. You can learn more about the statewide implementation of managed care by visiting [http://ahca.myflorida.com/Medicaid/statewide\\_mc/index.shtml](http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml).

In addition, the Agency recently released enhancements to the Florida Health Finder ([www.floridahealthfinder.gov](http://www.floridahealthfinder.gov)) tool that improve access to enforcement and sanction information for all Agency-licensed providers. While legal orders were previously available via the Agency's public records website, this enhancement connects those cases to the provider profile so a summary of sanctions can be seen at a glance. Florida Health Finder now also includes direct access to detailed health care provider complaint and inspection reports, emergency regulatory actions, and expanded information about specialty licenses and ownership. This level of transparency and accessibility to information about health care providers is important when making health care decisions. I encourage you to use this tool, and I ask that you recommend it to your patients as well.

Your continued commitment to serving the Medicaid population is appreciated. The Agency looks forward to your support, patience, and constructive participation as we undertake these important changes to the Medicaid program.

Sincerely,



Elizabeth Dudek  
Secretary

# MEDICAID COMPLIANCE CORNER

The Division of Medicaid has increased the training opportunities for Medicaid providers to help them ensure compliance with Medicaid regulations. Recent trainings have included substantive Medicaid policy regarding specific provider types, as well as general training on provider compliance programs. Providers are encouraged to develop a compliance program for their practice, and the Agency is directing providers to the guidance and recommendations provided by the Department of Health and Human Services, Office of Inspector General (HHS/OIG). The HHS/OIG website (<http://oig.hhs.gov/>) describes the seven basic elements of an effective compliance program.

According to HHS/OIG, a compliance program should include written policies that are available and known to all employees, and they should identify specific areas of risk within the provider's practice. In other words, they should be designed to address the vulnerability of the individual Medicaid provider, as opposed to being a "one-size fits all" program. They should include a Standard of Conduct for the provider's staff with an emphasis on preventing fraud and abuse. The standards should emphasize the organization's mission, goals, and ethical principles relative to compliance, and be distributed to, and comprehensible by, all affected employees. The policies should identify, by each area of risk, what the specific procedures are that personnel should follow to avoid the risks, monitor for compliance, and report non-compliance. The HHS/OIG recommends creating a manual that is accessible to all employees that contains the specific statutes, regulations, program instructions and bulletins that address the provider's identified risk areas. The goal of this manual would be to provide employees direction so they can properly address any concerns that may arise.

Providers may also consider designating an employee to serve as their compliance officer, to be responsible for ensuring the policies and procedures are written and implemented, to ensure that monitoring is routinely conducted, and to give staff a central point of contact for questions and reporting issues. Failure to comply with Medicaid rules can result in the recovery of overpayments and the imposition of sanctions. The Agency can also recover its investigative costs when it conducts audits of providers. Providers would want to do things to reduce the likelihood of operating contrary to Medicaid policy and the laws that govern their practice.

Providers may want to (and some are required to) conduct employee screening to avoid hiring staff with criminal histories that would exclude them from participation in the Medicaid program. Employees should be trained about anti-fraud efforts and how they can help, and providers should conduct internal monitoring and auditing of employee compliance. Providers should create an environment where employees are encouraged to assist in the effort to ensure program compliance, and when non-compliance is found, providers should take appropriate action regarding staff who participated in the non-compliance. Finally, providers should investigate all suspected non-compliance, take corrective action to prevent further occurrences, and return any Medicaid reimbursements that are found to be improper.


Providers are likely to have seen an increase in compliance activities within the Agency. While these efforts are not new, we are trying to make them more visible to you, our provider community. You are in the

best position to help us prevent fraud, abuse, and overpayments in the Medicaid program. We need your partnership to report suspected fraud and abuse so we can investigate or refer the allegations to the proper authority. The Agency's Bureau of Medicaid Program Integrity will be happy to accept referrals of suspected fraud, abuse, or overpayments in the Medicaid program at 1(888) 419-3456, or to report suspected fraud to the Agency you may fill out an electronic form on the Agency's website (see link to form below). Suspected fraud can also be reported to the Office of the Attorney General toll-free at 1(866) 966-7226. Those who report fraud to the Attorney General may be entitled to a reward if they report a criminal case that results in a fine, penalty, or forfeiture of property.



Training is available for providers to assist with compliance efforts. For details about upcoming trainings, and to obtain the training materials from past trainings, please visit <http://ahca.myflorida.com>. Select **Medicaid**, then **Deputy Secretary**, and then **Recent Medicaid Presentations**. Providers are also welcome to contact Kelly Bennett, the Medicaid Director's liaison regarding compliance matters and information about additional training to increase provider compliance: [Kelly.Bennett@ahca.myflorida.com](mailto:Kelly.Bennett@ahca.myflorida.com).

Finally, this article includes information you can print, cut out, and post in your office to assist with fraud prevention efforts. The electronic version includes links that you may wish to save in your web browser. It also includes the link to contact information for your local Medicaid area office.



**Helpful Information Regarding Florida Medicaid**

- AHCA website address: <http://ahca.myflorida.com/>
- Florida Medicaid information: <http://ahca.myflorida.com/Medicaid/index.shtml>
- Recipient information (DCF) 1-866-762-2237 or <http://www.myflorida.com/accessflorida/>
- About Florida Medicaid: <http://mymedicaid-florida.com/>
- Contact information for my local area office: \_\_\_\_\_
- Visit the [Florida Medicaid's Health Care Alerts](#) page to subscribe to an e-mail alert for system policy changes and clarifications

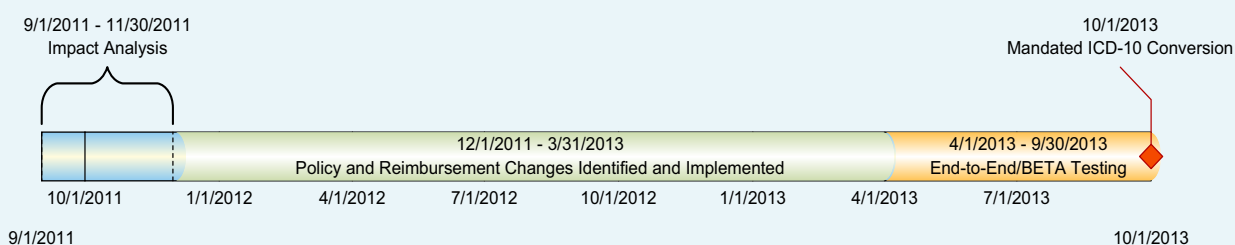
**Report suspected fraud, abuse, or overpayments to Medicaid Program Integrity:**  
1-888-419-3456 or online  
[https://apps.ahca.myflorida.com/InspectorGeneral/fraud\\_complaintform.aspx](https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx) or  
[ahca.myflorida.com/reportfraud](http://ahca.myflorida.com/reportfraud)  
You may be entitled to a reward if you report a criminal case that results in a fine, penalty or forfeiture of property.

Report suspected fraud, abuse, or overpayments to Medicaid Program Integrity: 1(888) 419-3456 or online at: [https://apps.ahca.myflorida.com/InspectorGeneral/fraud\\_complaintform.aspx](https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx) and <http://ahca.myflorida.com/reportfraud>. You may be entitled to a reward if you report a criminal case that results in a fine, penalty or forfeiture of property.

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The Agency for Health Care Administration is beginning the activities needed to prepare Florida Medicaid for the changes in the diagnosis code set. The ICD-10 Transition Project contains five distinct areas of activities and tasks:

- A. Impact Analysis: Conduct an ICD-10 Impact Analysis.
- B. Medicaid Policy Changes: Develop changes in Medicaid policy that govern the use of diagnosis and inpatient hospital procedure codes.
- C. Medicaid Reimbursement Rates: Develop the most appropriate reimbursement rates for the new diagnosis/procedure code system in a budget neutral manner.
- D. Outreach and Training: Conduct provider training for the Medicaid changes needed for the ICD-10 transition. This training will not be “code set training,” but rather an opportunity to explain the impact of changes in Medicaid policies and reimbursement rates required because of the change in the code set.
- E. Update the Florida Medicaid Management Information System (FMMIS) to reflect the new policy and reimbursement rates.



The plans that are being made now will follow a timeline, starting with the procurement of a consultant to assist the Agency in completing the tasks and activities required for a successful transition.

More information will be shared with providers through our usual communication channels as the work for this important Medicaid project progresses. Providers will need to make their own preparations for the mandated diagnosis code set change, including obtaining training on the new code sets for their staff.

## FIELD FOCUS

Providers, do you ever face puzzling billing questions or confusing Medicaid denials? Help is even closer than you may think. In every area of the state, HP, Florida Medicaid's fiscal agent, has designated Provider Field Service Representatives to serve that area's Medicaid providers. The Field Service Representative lives and works in the community in which he or she is assigned. The primary responsibility of the Provider Field Services team is to deliver provider training and assistance to Medicaid providers.

HP's 17 Field Service Representatives offer support activities for new and existing providers including training, claims resolution, and assistance with electronic billing issues. Assistance is free and the Field Service Representatives are happy to arrange site visits to meet with you and your staff. Visits can include training on the Florida Medicaid Web portal system and cover such items as Web portal eligibility verification, claim status, completion and submission of straight, crossover and Third Party Liability Medicaid claims, viewing of electronic remittance advice images and MediPass reports, verifying National Provider Identifier crosswalk elements on file with Florida Medicaid, and submitting adjustments and voids.

The Agency for Health Care Administration's local Medicaid area offices, in conjunction with the HP Provider Field Services staff, also offer a variety of monthly training sessions for Medicaid providers. For area specific information and training details visit <http://mymedicaid-florida.com>. Select **Public Information for Providers**, then **Area Offices**.

Contact your designated Field Service Representative today by visiting <http://mymedicaid-florida.com>. Select **Public Information for Providers**, then **Contact Us** or call 1 (800) 289-7799, option 7, to schedule a visit.



## PAYMENT ERROR RATE MEASUREMENT PROJECT (2011)

The Improper Payments Act of 2002 (HR 4878) requires federal government agencies to provide an estimate of their improper payments annually. The Centers for Medicare and Medicaid Services (CMS) has tested the process and methodology to implement a nationwide effort to measure improper payments in the Medicaid program. The Agency for Health Care Administration (Agency), as the single state agency responsible for administering the Medicaid program in Florida, will be participating in this effort.

CMS will measure the accuracy of Medicaid and Children's Health Insurance Program (CHIP) payments made by states for services rendered to recipients through the Payment Error Rate Measurement (PERM) program. Under the PERM program, CMS will use two national contractors to measure improper payments in Medicaid and CHIP. The first contractor, The Lewin Group, will provide statistical support to the program by selecting a sample of claims to be reviewed and then calculate Florida's error rate. The second contractor, A+ Government Solutions, will provide documentation/database support by collecting medical policies from the state and medical records from the providers. This contractor will also conduct medical and data processing reviews of the sample claims.

If a claim for a service that you rendered to either a Medicaid or CHIP recipient is selected to be in the sample, A+ Government Solutions will contact you for a copy of your medical records to support the medical review of that claim. Medical records will be needed for these reviews to determine if fee-for-service Medicaid and CHIP claims were correctly paid. From the date of contact, you must submit these medical records within 75 days.

### Consequences of Non-Response

If the requested supporting medical documentation is not submitted, the claim will be coded as an error, and any monies paid will be recouped. Since dollars estimated as being paid in error from the sample will be projected to the total claims, the actual impact of each claim error will be magnified several times. This will result in an exponentially negative impact on the Florida Medicaid program. If the error rate is excessive, the Agency may have to add controls or other limitations to address problem areas that are identified. It must be emphasized that even small claim amounts identified as payment errors can have a significant impact on how a particular service area is perceived. Therefore, it is important that providers submit requested medical records in a timely manner.

### Medical Record Requests

Please note that providers are required by Section 1902(a)(27) of the Social Security Act to retain the records necessary to disclose the extent of services provided to individuals receiving assistance, and to furnish CMS with information regarding any payments claimed by the provider for rendering services. Furnishing information includes submitting medical records for review.

The collection and review of protected health information contained in individual-level medical records is permissible for

payment review purposes via the Health Information Portability and Accountability Act of 1996 (HIPAA), as stated in 45 Code of Federal Regulations, parts 160 and 164:

*"...a covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits...or other activities necessary for the appropriate oversight of (1) the health care system; (2) government benefit programs for which health information is relevant to beneficiary eligibility; (3) entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or (4) entities subject to civil rights laws for which health information is necessary for determining compliance."*

In addition, Medicaid providers are required to comply with any medical records request from the CMS contractor. Follow-up contact regarding these medical record requests may be made by Florida Medicaid staff if any request is nearing the 75 day limit..

You can review subsequent Provider Bulletins for additional details regarding the 2011 PERM cycle (<http://ahca.myflorida.com/Medicaid/perm/>), which is underway for Federal fiscal year 2010-2011. Medical reviews by A+ Government Solutions will begin in September 2011. We will continue to send out specific information that pertains to medical record requests by A+ Government Solutions, as the information becomes available. If your claim has been selected as a sample, the billing and treating provider offices on the claim will be notified by a letter from the Agency. You will then need to provide medical records as requested by A+ Government Solutions.

Florida Medicaid reminds all providers to bill in accordance with the billing procedures outlined in the Provider General Handbook and within the program policy handbook for the specific procedure being billed.

Please also note, if you have changed your address or telephone number and have not updated your information with the Agency, this is a good opportunity to do so, as you are required to report any changes per the Provider General Handbook (page 2-44). "To report a change of address, the provider must obtain and complete the Medicaid Provider Change of Address Request, AHCA Form 220-0004, July 2008. The form is available by calling the Provider Contact Center at 800-289-7799 and selecting Option 4. It is also available from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Select Secure Information for Providers, then Demographic Maintenance, and Location Name Address."

If you would like more information related to PERM and your role in this process, please visit the CMS PERM website at <http://www.cms.hhs.gov/perm/>. All documentation specific to 2011 participating states will be located under **Cycle 3**. General state provider information will be located under **Providers**.

We appreciate your continued cooperation with the Florida Medicaid program. If you have any questions, please contact Jason Ottinger, Office of Medicaid Program Oversight, by telephone at (850) 412-4695 or via email at [Jason.Ottinger@ahca.myflorida.com](mailto:Jason.Ottinger@ahca.myflorida.com).

## TEAM UP AND TRY OUT DIRECT SECURE MESSAGING

Direct Secure Messaging (DSM) is one of the first services to be offered by the Florida Health Information Exchange (Florida HIE) operated by the Agency's vendor, Harris Corporation. DSM is a new health information exchange service enabling the secure exchange of documents containing protected health information (PHI) among Florida health care providers. It will be available starting in July 2011 at no cost to physicians, dentists, hospitals, clinical laboratories, skilled nursing facilities, hospices and community mental health centers that register for DSM at the Florida HIE website: <http://Floridahie.harris.com>.

Health care providers will first register as an organization, and then other individuals within the organization can register for an individual mailbox upon verification by the organization's DSM administrator. Each registrant will have his or her own DSM e-mail address. DSM will use the format: Username@Florida-HIE.net. Once registered, providers can look up the DSM e-mail address of other providers who have registered in the DSM Provider Directory.

DSM can be used to send documents that contain PHI for purposes of treatment, health care operations, and in the future, public health and quality measures reporting. Providers may use DSM to send PHI related to a referral, transition of care, or in response to a request for information.

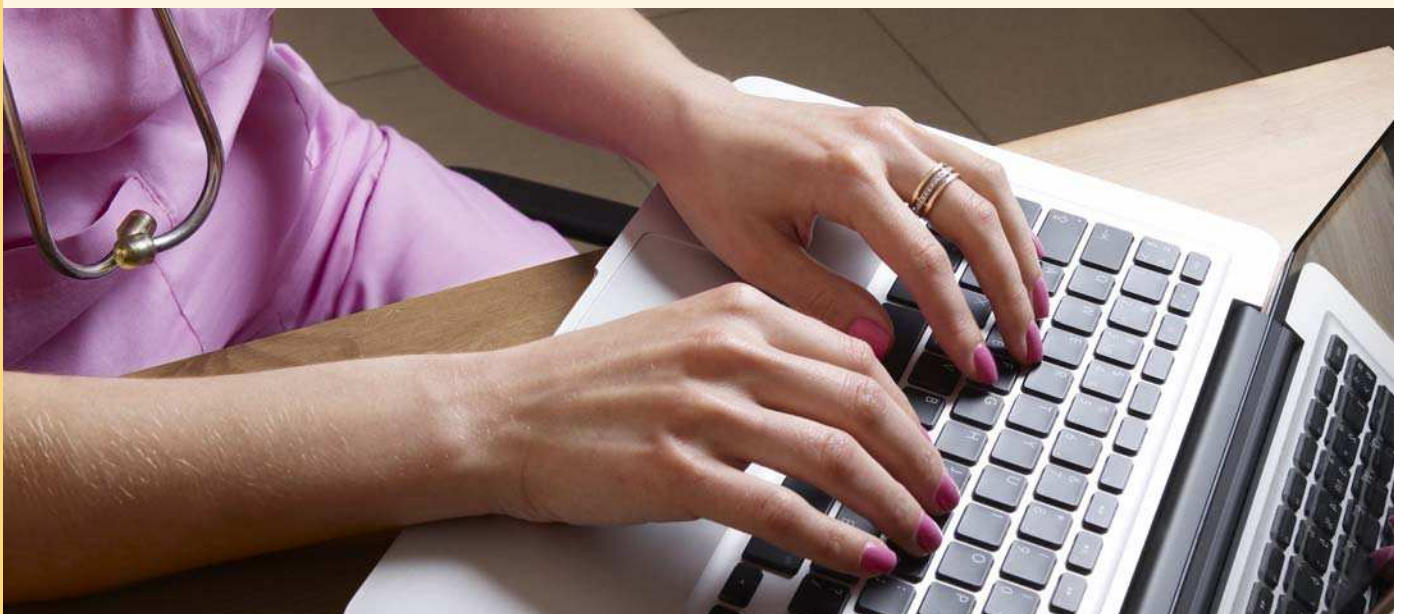
DSM may assist providers in qualifying for Electronic Health Record (EHR) meaningful use incentives by sending electronic data that can be put into an EHR. As a first step, ask your EHR vendor if the necessary DSM, or Direct, specifications for interface have been incorporated in the EHR.

The registration process for DSM requires a National Provider Identifier. To avoid any delays, providers should check that all NPI related information is current at: <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>. Training guides will be provided on-line to explain the DSM registration process step-by-step. A vendor help desk is available by calling 1 (888) 810-1078. To use DSM, you must have access to the Internet, but broadband is not required.

To help you get started, if there is another provider organization with which you often FAX documents, and you would like to try DSM as an alternative, think about suggesting that they register so you can both try the new system right away.

Registrants will be required to read and agree to a subscription agreement that explains the correct use of the service and expectations about safeguarding PHI. Registrants will also be required to read a check list of security best practices related to the use of mobile devices or other computer equipment that might be used to send, retrieve, or store PHI obtained through DSM. Please keep in mind that while the DSM network is secure and registrants are vetted, providers should not respond to e-mails received from unknown senders without checking the source.

You are welcome at any time to let the Harris Help Desk know what you think, and ideas you may have for improvements, by sending an e-mail to [FloridaHIE@Harris.com](mailto:FloridaHIE@Harris.com).



# REMINDERS OF CRITICAL BILLING REQUIREMENTS FOR REIMBURSEMENT OF NURSING FACILITIES SERVICES

## Eligibility

Prior to billing Medicaid, a nursing facility provider must have written documentation on file from the Department of Children and Families (DCF) that the recipient has been determined eligible for the Medicaid Institutional Care Program (ICP) on the dates of service billed. This paperwork must be maintained in the recipient's file, and made available to a state agency or state contractor upon request.

Please note that DCF must determine ICP Medicaid eligibility even for individuals who receive Supplemental Security Income (SSI) or who have already been determined eligible for other Medicaid benefits.

The only exception to this policy is that a nursing facility may bill Medicaid for Medicare Part A coinsurances (level of care "X" claims) and Medicare B Crossover claims when the recipient is not eligible for ICP Medicaid, but is eligible for Qualified Medicare Beneficiary (QMB), with or without other Medicaid coverage. Someone who is SSI and has Medicare is automatically considered to be QMB eligible.

To be determined eligible for Florida Medicaid nursing facility services, applicants must meet certain financial, technical, and medical criteria. DCF is responsible for determining if the applicant meets the ICP Medicaid financial criteria (such as income and assets) and the technical criteria (such as citizenship and disability if the individual is under age 65). DCF also calculates the amount of the recipient's share in the cost of nursing facility services, also known as patient responsibility.

The Comprehensive Assessment and Review for Long-Term Care Services (CARES) program, within the Department of Elder Affairs, is responsible for determining that an applicant meets the medical criteria for ICP Medicaid, a process known as the level of care. There are two components to the level of care determination: 1) the CARES medical assessment and 2) completion of the Pre-Admission Screening and Resident Review (PASRR) process. State and federal regulations require level of care determinations to include both of these requirements in order to ensure the recipient is appropriate for the nursing home setting.

## Pre-Admission Screening and Resident Review (PASRR)

Federal law requires a Pre-Admission Screening and Resident Review (PASRR) process for all nursing facility applicants and residents suspected of mental illness or mental retardation regardless of payment source (payor). The Code of Federal Regulations (42 CFR 483.100-483.138) mandates that a Medicaid certified nursing facility may not admit an applicant with serious mental illness, mental retardation, or a related condition, unless the individual is properly screened, thoroughly evaluated, found to be appropriate for nursing facility placement, and will receive all specialized services necessary to meet the individual's unique needs.

The PASRR process must be completed in a timely and accurate manner. Pre-Admission Screening (PAS) is required once in a lifetime, regardless of payor, and is typically done by hospital discharge planners as a step in the process of transferring an individual from a hospital to a nursing facility. Subsequent to the PAS, a Resident Review (RR) must be performed any

time there is a significant change in the resident's condition or subsequent to the patient continuing to reside in the facility in excess of the PAS exemption period. PASRR paperwork must be maintained in the nursing facility's files, even after the recipient is discharged from the nursing facility.

To comply with federal reporting requirements, CARES must maintain data related to PASRR. Nursing facilities must provide the CARES program with copies of all PASRR paperwork on a timely basis, even when individuals are not Medicaid recipients. Nursing Facilities are responsible for maintaining PASRR paperwork in their patients' files. The following entities cannot provide you with copies of historical PASRR paperwork: CARES program, Children's Medical Assessment Team, Agency for Persons with Disabilities, or APS Healthcare. Also, it is not permissible for providers or state entities to back date paperwork.

Please keep in mind completion of the PASRR process is federally mandated prior to every admission to a nursing facility, not just patients discharged from the hospital or other acute care facilities. The PASRR process must be completed for individuals transferred between nursing facilities or admitted to the facility from an assisted living facility or other community setting. Each nursing facility is ultimately held responsible for ensuring the PASRR process was completed in an accurate manner and has determined the recipient is appropriate for the nursing home setting.

Per 42 CFR 483.122(b) a nursing facility is only eligible for Medicaid reimbursement after completion of the PAS or the RR. In addition to recoupment of payment for services, the Agency for Health Care Administration is entitled to recover investigative, legal, and expert witness costs and will apply sanctions which may include a fine, suspension, or termination from the Medicaid program for violations of federal and state laws or Medicaid policy.

## Patient Responsibility (PR)

Prior to billing Medicaid, the amount of patient responsibility (PR) must be documented with either a recent DCF Notice of Case Action or a print screen from the Provider View feature on the Medicaid web-portal: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). If used to document the amount of PR billed, the My Account History screen must be printed within at least 6 months of the month of service. For instance, a My Account History printed screen for services rendered from January 1st through January 21st must be printed sometime between January 1st and July 21st. Also, providers should double check the My Account History screen periodically for retroactive adjustments to the PR, and amend paid claims accordingly.

Please note that there is no patient responsibility for Medicare coinsurance claims if the recipient is a Qualified Medicaid Beneficiary (QMB) with or without other Medicaid coverage.

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## REMINDERS OF CRITICAL BILLING REQUIREMENTS FOR REIMBURSEMENT OF NURSING FACILITIES SERVICES (CONTINUED)

### Requirements for Payment of Bed Hold Days

A nursing facility must have at least 95 percent of its Medicaid certified beds filled during the previous quarter in order to bill Medicaid for bed hold days. Please refer to pages 2-21 through 2-24 of the Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook for Florida Medicaid's bed hold reimbursement policies. A resident or the resident's responsible party may pay privately to hold a bed after the paid bed hold days expire. If a resident is unwilling or unable to make private payment to continue to hold the bed, the facility may discharge the resident when the bed hold days run out. However, a facility must readmit the resident to the first available Medicaid bed in a semi-private room, as specified in 42 CFR 483.12(b)(3).

Medicaid nursing facilities are required to establish and follow a written bed hold policy which includes the duration of the bed hold days and the facility's policy permitting the resident to return. This information must be included in the admission contract. The nursing facility must inform residents and their designated representatives in writing about the facility's bed hold policy at the time of admission, and when a resident leaves the facility for a hospitalization or therapeutic leave.

### Where To Go For Help

#### Department of Children and Families (DCF)

Please work with the recipient and DCF to resolve any issues with Medicaid ICP eligibility or the amount of a recipient's patient responsibility. Nursing home providers may contact DCF by calling 1 (866) 762-2237 or emailing the facility's DCF Customer Call Center in Jacksonville: [NFCCC\\_CCC@dcf.state.fl.us](mailto:NFCCC_CCC@dcf.state.fl.us), Tampa: [sr\\_call\\_center@dcf.state.fl.us](mailto:sr_call_center@dcf.state.fl.us), or Miami: [D11\\_SFL\\_CallCenter@dcf.state.fl.us](mailto:D11_SFL_CallCenter@dcf.state.fl.us).

#### Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program

Please contact the CARES program for information about nursing home level of care determinations and the PASRR process. You can find the contact information for your local CARES office, as well as information about the PASRR by visiting [www.elderaffairs.state.fl.us](http://www.elderaffairs.state.fl.us).

#### Medicaid Area Office

The local Medicaid area offices provide information about Medicaid reimbursement policy and claims submission. You may access contact information for your local Medicaid area office on the Agency website: [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select **Area Office Map** and then the appropriate county.

#### Medicaid Fiscal Agent

Please contact the HP call center at 1 (800) 289-7799 for technical questions related to billing Medicaid. Information and training materials about billing Medicaid electronically are available on the Medicaid fiscal agent website: <http://mymedicaid-florida.com>. Click on **Public Information for Providers**, then select **Provider Support**, then **EDI**, and then select the appropriate handbook, such as the billing Companion Guides.

#### Email Alerts

Florida Medicaid has an e-mail alert system to notify registered providers or interested parties of "late-breaking" health care information. An e-mail will be delivered to your mailbox when Medicaid policy clarifications or other critical health care information is available that is appropriate for your selected provider type. You may subscribe to the automated alert system on the Agency website at this link: <http://ahca.myflorida.com/Medicaid/alerts/alerts.shtml>.

#### Training Materials

You may access training materials for billing Medicaid, Medicaid Provider Bulletins, Provider Notices, and Provider Alerts on the Medicaid fiscal agent website: <http://mymedicaid-florida.com>. Click on **Public Information for Providers**, then **Provider Support** and then the appropriate topic. Provider bulletins, notices, and alerts provide critical information such as changes in policies, policy clarifications, and policy reminders.

#### Provider Handbooks

*The Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook*, the *Florida Medicaid Provider General Handbook*, the *Florida Medicaid Provider Reimbursement Handbook*, and UB-04 Claim Form are also on the Medicaid fiscal agent website: <http://mymedicaid-florida.com>. Click on **Public Information for Providers**, then **Provider Support**, then **Provider Handbooks**, and then select the appropriate handbook.

#### Reimbursement Rates

Information about nursing facility rates can be found on the Agency website [www.ahca.myflorida.com](http://www.ahca.myflorida.com). Click on **Medicaid**, then **Providers**, then **Medicaid Cost Reimbursement**, then **Medicaid Institutional Cost Reimbursement**, and then select the appropriate topic. You may also access information about how nursing home rates are set from **Medicaid Institutional Cost Reimbursement** by selecting **Reimbursement Plans**.

These sites provide current and historical nursing home rates, but are not updated for increases or decreases in rates due to revisions to cost data (such as amended cost reports or audits). For individual updated rates, please contact your local Medicaid area office, or the Medicaid Cost Reimbursement Unit at (850) 412-4104.

#### Licensure and Certification

Information about nursing facility licensure and Medicare certification are accessible on the Agency website: [www.ahca.myflorida.com](http://www.ahca.myflorida.com) by clicking on **Health Quality Assurance**, then **Licensing and Regulation**, then **Long Term Care Unit**, then **Nursing Homes**, and then select the appropriate topic. You may also contact the Bureau of Long Term Care Services for more information at (850) 412-4303.



# Child Health Check-Up (CHCUP)

## Early Periodic Screening, Diagnosis and Treatment AND.....

As licensed health care professionals, you understand the importance of preventive care. The Child Health Check-Up (CHCUP) program includes comprehensive physical exams, developmental assessments and anticipatory guidance. The Child Health Check-Up Coverage and Limitations Handbook can be accessed by visiting [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select **Public Information for Providers**, then **Provider Support**, then **Provider Handbooks**, and then the **Child Health Check-Up Handbook**. This is a reminder of other important components to include:

### Fluoride Varnish

(See article "More on Fluoride Varnish for Children..." in this Provider Bulletin.)

Oral evaluation and fluoride varnish application are preventive services which should be provided to high risk patients, preferably within six months of eruption of the first primary tooth. Medicaid covers the application of fluoride varnish when provided to Medicaid-eligible children in a physician's office. Physicians, physician assistants, and advanced registered nurse practitioners may provide this service and bill Medicaid using CPT procedure code 99499 SC.

Fluoride varnish may be applied to a child's teeth at the time of the CHCUP visit. Medicaid reimbursement for 99499 SC is \$27.00 for both the application of fluoride varnish and the oral evaluation for a child 6 months to 3 1/2 years of age.

The CHCUP visit should also include counseling the child's caregiver.

### Dental Referrals

Dental referrals are required beginning at 3 years of age; earlier as medically indicated. CHCUP providers must refer Medicaid children who are 3 years old and older for an assessment by a dentist and document the referral. The provider may refer a younger child if it is medically necessary. Following the initial dental referral, subsequent visits to a dentist are recommended every 6 months, or more frequently as prescribed by a dentist or other authorized provider.

### Blood Lead Testing

Performing a blood test for lead is a federal requirement at specific intervals during the CHCUP. This note is to remind you how important it is to document the blood tests you are performing. Failure to provide documentation can lead to a federal audit and the requirement to repay Medicaid for fees received. The federal regulation as referenced in the Child Health Check-Up Coverage and Limitations Handbook, October 2003, pages 2-13 and 2-14, and page 3-6, requires that all Medicaid children receive a screening blood lead test at the ages of 12 months and 24 months, and between the ages of 36 months and 72 months if they have not been previously screened for lead poisoning. The procedure code for blood lead testing is 83655. The Child Health Check-Up Coverage and Limitations Handbook can be accessed by visiting [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select **Public Information for Providers**, then **Provider Support**, then **Provider Handbooks**, and then the **Child Health Check-Up Handbook**.



## MORE ON FLUORIDE VARNISH FOR CHILDREN...

Medicaid is excited about the availability of fluoride varnish provided in the physician's office. We encourage you to be a part of this wonderful opportunity to prevent dental decay in very young children. Fluoride varnish is a high concentration of fluoride which is applied to a child's teeth to protect against dental decay. Since pediatricians see young infants and children frequently for preventive health care visits, they are in an excellent position to identify children at risk for dental health problems. The child's pediatrician can coordinate care, provide counseling with the child's primary caregiver, and apply fluoride varnish.

Since the implementation of this very important preventive measure in April 2008, Medicaid has experienced a steady increase in physician offices that are providing fluoride varnish. Approximately 30,000 high risk children have received fluoride varnish applications in their physician's office. Fluoride varnish may be applied four times a year from 6 months to 3 1/2 years of age. Reimbursement is \$27.00. The procedure code for the application of fluoride varnish and counseling by the child's primary provider is 99499 SC.

Dr. Frank Catalanotto, a pediatric dentist and professor at the University of Florida, provides a mini course in dental education and training for applying fluoride varnish. The training takes about an hour and a half and could be done during the lunch hour. Dr. Catalanotto's contact information is provided below.

Frank Catalanotto, D.M.D.  
University of Florida College of Dentistry  
Office: 352-273-5970/352-273-5971  
Cell: 352-256-5909  
[FCATALANOTTO@dental.ufl.edu](mailto:FCATALANOTTO@dental.ufl.edu)

This training is not required by Medicaid, but is highly recommended.

In order to establish a dental home and receive further dental treatment, the practitioner should refer the child to a dentist. The list of dental providers is available on the Medicaid fiscal agent website: <http://mymedicaid-florida.com>. Under the **Area Offices** column, select the county where the child lives. On the area office page, scroll down to **Area Office Information** and select **Dental Providers**.

We hope you will join us in the prevention of early childhood dental decay.



## 2011-2012 MEDICAID DENTAL REIMBURSEMENT FEE INCREASE

The Medicaid dental program received legislative funding to increase reimbursement for dental procedures provided to children ages 0 to 20. The increase to dental reimbursement rates for children is effective July 1, 2011.

The new Dental General Fee Schedule effective July 1 is posted on the Medicaid fiscal agent website. You can download a copy of the Dental General Fee Schedule by visiting: <http://mymedicaid-florida.com>. Under the **Providers** column, select **Public Information for Providers**. From the **Providers** call-out box select **Provider Support**, and then **Fee Schedules**. Scroll down to **Dental General**. The 0-20 Fee column indicates the amount of reimbursement for dental procedures provided to children. Please refer to the 21+ Fee column for the reimbursement amount for dental procedures provided to adults.

If you would like to find out how to become a Medicaid provider, or re-enroll in the Medicaid program, please visit the Agency website at <http://ahca.myflorida.com/Medicaid/index.shtml>. Click on the **Providers** tab under **Florida Medicaid**.

If you have any questions about the Dental General Fee Schedule or Medicaid dental services for children, please call your local Medicaid area office. You can find contact information for your local Medicaid area office by visiting [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select **Area Office Map** and then the appropriate county.





# FLORIDA MEDICAID LAUNCHES ELECTRONIC FINGERPRINTING FOR PROVIDERS

A newly expanded version of the Enrollment pages on the Florida Medicaid public web portal is now available featuring new pages for Background Screening, Provider Reenrollment, and a reorganized Enrollment Forms page. This is the first phase in a multi-step process to improve the tools providers have available to support their needs. Over the next few months we plan to install additional refinements to these pages as well as a new version of the On-line Provider Enrollment Wizard.

The most exciting change is that applicants may now submit fingerprints electronically through a Livescan vendor. This is a major process improvement that provides greater accuracy due to fewer rejections of fingerprints and improved timeliness of the background investigation process. The new Background Screening page includes:

- Information about available options for electronic submission
- Links to Livescan vendor lists
- A description of all personal information applicants should have available at the time of screening are available on the new Background Screening page

Providers	Background Screening
<ul style="list-style-type: none"> <li>• Home</li> <li>• Area Offices</li> <li>• Contact Us</li> <li>• Provider Support</li> <li>• Enrollment               <ul style="list-style-type: none"> <li>◦ Background Screening</li> <li>◦ Enrollment Status</li> <li>◦ Enrollment Forms</li> <li>◦ Provider Re-Enrollment</li> <li>◦ Out-of-State Enrollments</li> </ul> </li> <li>• EDI</li> <li>• Managed Care</li> <li>• Pharmacy</li> <li>• TPL</li> <li>• Admin</li> <li>• Host</li> </ul>	<p>Each applicant seeking to participate in the Medicaid program must submit a complete set of fingerprints for each person declared on an initial or renewal application for the purpose of conducting a criminal history record check. Details of the requirement are documented in the <a href="#">Florida Medicaid Provider Enrollment Guide for Completing Application</a>.</p> <p>In an effort to streamline the background screening process, AHCA is now encouraging providers to use vendors offering electronic fingerprint scanning services. This process avoids the traditional fingerprint card process where finger prints are "rolled" in ink onto an FBI fingerprint card and mailed hard copy with a check for processing. This improves accuracy with fewer rejections (no ink smudges) and improves timeliness of the background investigation process.</p> <p>This enhancement to the provider enrollment process allows providers to enroll without mailing any hard copy documentation. Rather, with electronic scanning of fingerprints handled by approved vendors, applicants may submit their application and all remaining supporting documents through the online <a href="#">Enrollment Wizard</a>.</p> <p>The following provides detailed information on how to take advantage of this new option:</p> <p><b>Level of Screening Required</b></p> <p>Provider applicants to Florida Medicaid require a Level 2 screening which involves a fingerprint check of state and federal criminal history information conducted through the Florida Department of Law Enforcement (FDLE) and the Federal Bureau of Investigation (FBI).</p> <p><b>Submission of Fingerprints</b></p> <p>All provider applicants are encouraged to submit their fingerprints electronically.</p> <p><b>Forms of Electronic Screening</b></p> <p>The most common form of electronic screening involves use of a LiveScan device which is a type of equipment used to directly capture fingerprints through a scanning function. Persons being screened place their hands directly on the scanner for reading. Fingerprint scanning using a LiveScan device provides faster results and generally costs less than hard card scanning as there is less handling involved. LiveScan capture also produces a better quality print, so has a lower rejection rate of illegible prints (no ink smudging, etc).</p>

Please take a moment to familiarize yourself with the new electronic fingerprint information as well as the other tools available to providers by visiting the portal at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Choose **Public Information for Providers** and then **Enrollment**.

NOTE: Applicants who use a Livescan vendor to electronically submit their fingerprints must supply the vendor of their choice with the Originating Agency Identifier (ORI) assigned to Florida Medicaid. The ORI is a nine-digit code used to identify agencies in the law enforcement network. It acts as an address to ensure screening results are delivered to the requesting agency. For Florida Medicaid, the ORI is **FL922013Z**. If a different ORI is used, Florida Medicaid will not receive the results and a second screening and processing fee may be required.

