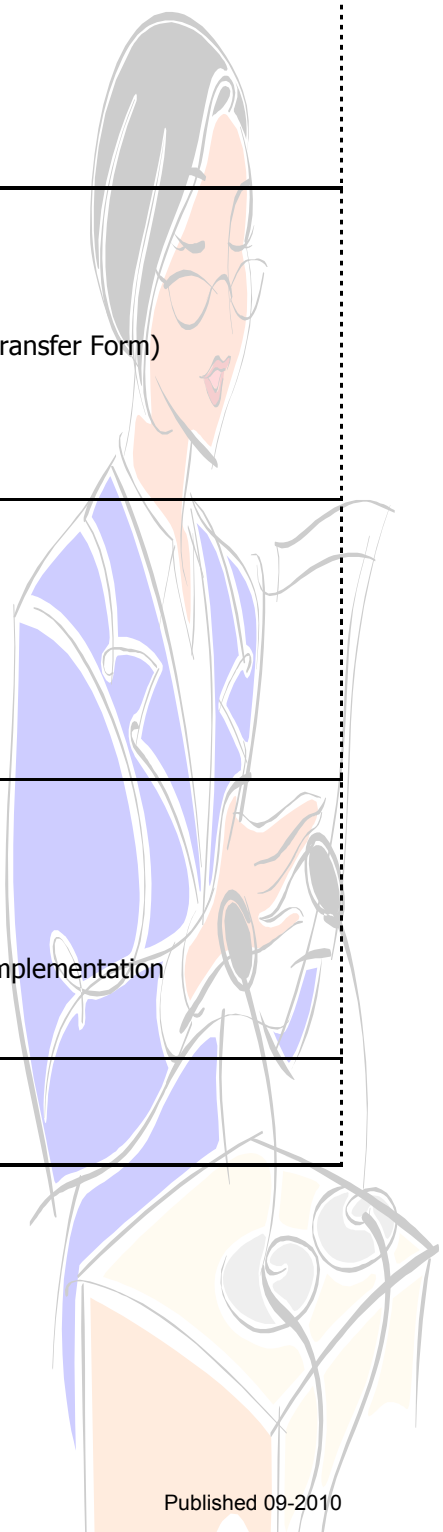
First Coast Advantage **Better Network. Better Options.**

Nemours Provider In-Service Agenda

September 16, 2010
8:30 am to 12:00 P.M.

Three (3) Sessions @ 45 Minutes Each,
Nemours Clinic Auditorium - 807 Children's Way

5 Minutes	**Veronica Walton,** Contract Manager - Introduction of Staff - Outline of Presentation - Expansion - AHCA 2010 Audit ➢ Fraud & Abuse Training
15 Minutes	**Angela Creppel,** Provider Relations Coordinator - Provider Visits - NewsFlash/Newsletter - Reform Medicaid Enhanced Benefits - Disenrollments (Voluntary Disenrollment/PCP Transfer Form) ➢ Out of County ➢ Third Party Insurance - Website Demonstration - Q & A
10 Minutes	**Veronica Walton**, Contract Manager & **Pat Armstrong,** Utilization/Performance Manager - Service Alerts ➢ Pre-Authorization Changes ➢ Pre-Authorization Form Updated ➢ OMFS Pre-Authorization Process ➢ Circumcision Guidelines - Q & A
10 Minutes	**Debbie Shelton** Claims Manager - Eligibility Verification - Direct Submission - Service Alerts ➢ Medicaid Timeline for NPI and 5010 Implementation ➢ Paper Claim Policy 10-02 - Q & A
5 Minutes	**Open Discussion** **Closing Remarks**



Published 09-2010

First Coast Advantage

Fraud & Abuse Training 2009 - 2010

Published 09-2010

First Coast Advantage Fraud and Abuse Education 2010

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FRAUD AND ABUSE

It is essential that all Providers and Vendors of First Coast Advantage (FCA) understand health care fraud and abuse, how to detect it and how to assist members, providers, vendors or employees to report any suspicious activities or potential violations.

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TRAINING REQUIREMENTS

FCA is required by federal law to make available fraud and abuse training to our Providers and Vendors.

This training program provides a general overview of fraud and abuse regulations, potential fraud indicators, and procedures for reporting fraud and abuse.

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PURPOSE

Health care fraud has a significant effect on the private and public health care payment system and is estimated to account for over 10% of annual health care costs.

Taxpayers pay higher taxes because of fraud in public programs such as Medicaid and Medicare. Employers and individuals pay higher private health insurance premiums because of fraud in the private sector health care system.

Recognizing the serious implications of fraud, FCA's Fraud and Abuse Program is dedicated to detecting, investigating and preventing all forms activities related to possible health care fraud and abuse.

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TRAINING OVERVIEW

This training will provide answers to the following questions:

- What is fraud and abuse?
- What are the types of fraud?
- What are the indicators of potential fraud?
- What laws regulate fraud and abuse?
- What is a fraud and abuse violation?
- What are the sanctions and penalties for fraud and abuse violations?
- How is suspicious activity reported?

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INTRODUCTION

First Coast Advantage, in compliance with both federal and State of Florida regulatory and contractual obligations, has in place a program designed to monitor, detect and investigate and report, as necessary potential fraud and abuse in the delivery of health care services to FCA Members and/or in the submission of claims submitted to FCA for payment for services provided to our Members.

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INTRODUCTION (cont)

It is the policy of First Coast Advantage…

to review and investigate all allegations of fraud and/or abuse, whether internal or external;

to take corrective actions for any supported allegations after a thorough investigation; and

to report confirmed misconduct to the appropriate parties and/or Agencies

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WHAT IS FRAUD AND ABUSE ?

Fraud:

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse:

Provider, vendor or employee practices that are inconsistent with sound fiscal, business, or medical practices that result in unnecessary costs to FCA; or in reimbursement for services that are not medically necessary; or, fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to FCA.

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EXAMPLES OF HEALTH CARE FRAUD

Individual participating or non-participating providers who deliberately submit claims for services not actually rendered, or bill for higher-priced services than those actually provided.

Providers of medical equipment and home health services who defraud the Medicare program and private payers, often paying kickbacks to dishonest physicians who prescribe unnecessary products and services.

Charges are submitted for payment for which there is no supporting documentation available, such as office visits, x-rays or lab results.

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RED FLAG WARNINGS OF POTENTIAL FRAUD AND ABUSE

Upcoding (billing for a higher level of service than provided)

Repeated patterns of duplicate claim submission

Billing for services not rendered

Misrepresentation of services/supplies

Substitution of services or supplies

Misspelled medical terminology

Diagnosis does not correspond to treatment rendered

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RED FLAG WARNINGS
OF POTENTIAL FRAUD AND ABUSE (cont.)

Delivery of Services

Denial of access to member services/benefits
Limiting access to member services/benefits
Failure to refer for medically necessary services
Over or Under Utilization

Member Eligibility Fraud

Ineligible person using eligible member's identification card or identity
Misrepresentation of medical condition in order to receive benefits
Failure to report other third-party health plan benefits
Misrepresentation in the eligibility determination process

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WHAT LAWS REGULATE HEALTH CARE FRAUD AND ABUSE?

False Claims Act (FCA)

Stark Law

Anti-Kickback Statute

HIPAA

Deficit Reduction Act

State of Florida False Claims Act

Criminal Penalties for Acts involving Federal Health Care Programs

The False Claims Whistleblower Employee Protection Act

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FEDERAL FALSE CLAIMS ACT

Under the federal False Claims Act (FCA),**31 U.S.C. §§3729-3733**, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

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STARK LAW

The Stark Law, also known as the physician self-referral statutes, regulates physician referrals to other providers under the Medicare and Medicaid programs. Referrals for the provisions of certain designated health care services are prohibited if the referring physician or an immediate family member has a financial relationship with the entity that receives the referral.

A provider who violates the Stark Law may also have liability under the False Claims Act if Medicare/Medicaid claims were generated and paid as a result of prohibited referrals.

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FEDERAL ANTI-KICKBACK STATUTE

Under the federal anti-kickback Statute, it is a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration for any item or service that is reimbursable by any federal healthcare program. Penalties many include exclusion from federal health care programs, criminal penalties, jail and civil penalties for each violation.

A provider who violates the Anti-kickback statute may also have liability under the False Claims Act if Medicare/Medicaid claims were generated and paid as a result of prohibited referrals.

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Anti-Kickback Statute (cont)

Examples of Kick-Backs:

- Payment of money
- Discounts
- Gratuities
- Gifts
- Credits
- Commissions

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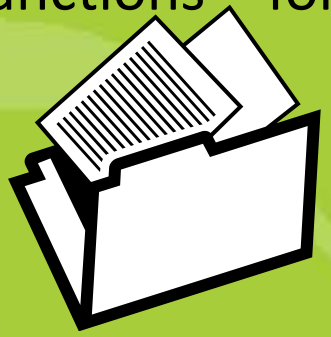
HIPAA

The Health Insurance Portability and Accountability Act (HIPAA), **45 CFR, Title II, §201-250**, provides clear for the establishment of Fraud & Abuse control programs, and sets forth of criminal, civil penalties and sanctions for noncompliance.



Florida False Claims Act

Florida False Claims Act provides remedies for obtaining treble damages and civil penalties for state government when money is obtained from state government by reason of a false or fraudulent claim by persons who knowingly cause or assist in causing state government to pay claims that are false or fraudulent.

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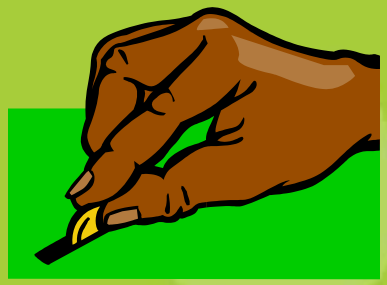
Deficit Reduction Act



The Deficit Reduction Act (DRA), **Public Law No. 109-171, §6032**, passed in 2005, is designed to restrain Federal spending while maintaining the commitment to the federal program beneficiaries.

The Act requires compliance for continued participation in the programs. The development of policies and education relating to false claims, whistleblower protections and procedures for detecting and preventing fraud & abuse must be implemented.

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Criminal Penalties for Acts Involving Federal Health Care Programs

This legislation,**42 U.S.C. §1128B, 1320a-7b**, states that criminal penalties will result in conviction of a felony and a fine of not more than $25,000 and/or imprisonment for not more than 5 years if false statements are knowingly and willfully made for benefits or payments, or misrepresents services or fees to beneficiaries of federal health care programs.

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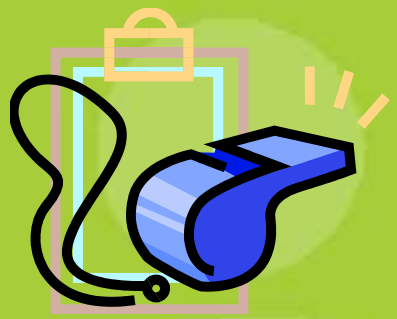
The False Claims Act
Whistleblower Employee Protection Act



Under this legislation, **31 U.S.C. §3730(h)**, an employer is prohibited from discharging, demoting, suspending, threatening, harassing or discriminating against any employee because of lawful acts done by the employee on behalf of the employer or because the employee testifies or assists in an investigation of the employer.

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Provider Responsibilities

FCA Providers and Vendors are responsible for full cooperation with investigations undertaken by FCA and/or Florida Medicaid, and agencies of state and federal government.

They are also responsible for understanding:

Coding Standards:

Select appropriate CPT code for that most accurately reflects the service provided

FCA Provider Standards:

Understand roles & responsibilities as participating providers in the FCA network

Know licensure responsibilities and restrictions

Documentation Standards:

FCA adheres to national standards for documentation

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Reporting Suspected Fraud and Abuse to FCA

Any employee, Member, vendor or provider has the right to make a Fraud & Abuse-related complaint to FCA or any one of the agencies listed at the end of this presentation if he/she feels suspects potential fraud and or abuse.

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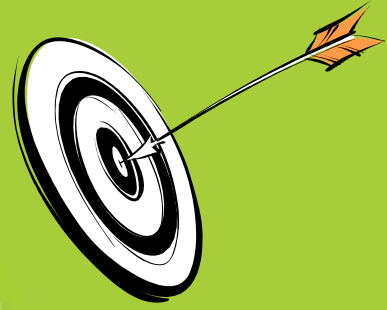
Our Goal: Eliminating Fraud & Abuse



In order to successfully eliminate program fraud and abuse providers, facilities and vendors must work together with FCA to prevent and identify inappropriate and potentially fraudulent practices. This may be accomplished by:

Monitoring claims submitted for compliance with billing and coding guidelines;

Adherence by providers and facilities to documentation standards; education of all staff responsible for charging, billing, coding; and

Referral of suspected fraud and abuse activities.

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Telephone Contacts to Report Suspected Fraud and/or Abuse

FCA Compliance Hotline 1-800-329-3569 (24hours a day/7 days a week)

State of Florida, Consumer Complaint Hotline: 1-888-419-3456

Sate of Florida, Office of the Attorney General: 1-866-966-7226

Medicaid Program Integrity: 1-888-419-3456

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First Coast Advantage
Fraud & Abuse
Commitment Statement

Date: ___/____/_____

FCA is required by Federal Law to make available Fraud and Abuse Training annually to our Providers and Vendors. It is essential that all Providers and Vendors of First Coast Advantage (FCA) understand Health Care Fraud and Abuse, how to detect it and how to assist Members, Providers, Vendors or Employees, to report any suspicious activities or potential violations.

In order to successfully eliminate program Fraud and Abuse, providers, facilities and vendors must work together with FCA to prevent and identify inappropriate and potentially fraudulent practices.

I _____, am committed to working with FCA to eliminate program Fraud and Abuse. I have reviewed the Fraud and Abuse Overview Training.
(Please Print Name)

Signature: _____ Title: _____

Clinic Name or Office Location: _____

Address: _____

City: _____ State: _____ Zip: _____

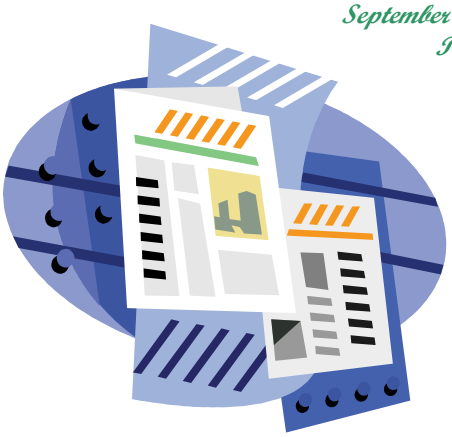
Phone #: (___) _____-_____ Fax Number: (___) _____- _____ Email: _____

Please complete this page return via fax to (904)244-9409 or mail to:

First Coast Advantage
580 West 8th Street, T-20
Jacksonville, FL 32209

If you have any questions regarding the Cultural Competency Plan please contact First Coast Advantage Provider Services at 1-866-270-2468

Network News Flash



Documents Updated on Website:

FCA September 2010 Newsletter
FCA Education Tab **(New Articles)**
- Series 4: Attention Deficit Hyperactivity Disorder
- Florida Medicaid NPI Timeline and 5010 Implementation
- Florida Medicaid Fraud & Abuse Complaint Form
- Florida Medicaid Fraud & Abuse Prevention Presentation March 2010

FCA Provider Directory
FCA Provider Manual
- **Section: 14 Clinical Guidelines (Updated)**
- **Section: 25 Fraud & Abuse (Updated)**
- **Section: 27 FCA Forms (New)**

FCA Service Alert – NPI Implementation 2011
Pre-Authorization Form **(Updated)**

Effective August 1, 2010, First Coast Advantage (FCA) Fraud & Abuse Policy Now on Website:

FCA is required by AHCA (Agency for Healthcare Administration) to provide certain policies and procedures for our contracted providers upon written or oral request. For easy reference, we have posted the FCA Fraud and Abuse policy on the FCA Website under Provider Information at www.firstcoastadvantage.com

FCA will provide written notice, which may be via electronic transmission or by mail, of material changes to this policy. If anyone has any questions regarding these policies you can contact Provider Relations at 904-244-9174.

Effective August 1, 2010, Two Florida Medicaid Fraud & Abuse Links on FCA Website:

- First Coast Advantage (FCA) has added two new links on the FCA Website at www.firstcoastadvantage.com to the Florida Medicaid website for Fraud and Abuse.
- The following links are located under the Education Tab:
  - ◊ Florida Medicaid Fraud and Abuse Prevention Presentation March 2010 – This presentation is on Fraud and Abuse Prevention in Medicaid Managed Care Organization by Roberta Bradford, Deputy Secretary for Medicaid that was presented to House Select Council on Strategic and Economic Planning.
  - ◊ Florida Medicaid Fraud And Abuse Complaint Form – This form is from The Office of the Inspector General at AHCA that accepts complaints alleging wrong-doing of an Agency employee and suspected fraud and abuse in the Florida Medicaid system.

- If you suspect Medicaid fraud, you can contact the fraud and abuse hotline at (1-888-419-3456).

Effective August 2010, Florida Medicaid Provider Alerts for Change in Coverage for CPT Code 90649:

- Effective August 2010**,** Provider Type(s): 25, 26, 29, 30, 66, 68, 77, Florida Medicaid is changing coverage for CPT Code 90649 (Quadrivalent HPV vaccine).
- This code has previously been reimbursed for females only, ages 9-20. Effective June 18, 2010, coverage is extended to males, ages 9-20.
- If you have any questions, please contact your Medicaid area office.

Published 09-01-2010

Effective September 1, 2010, Florida Medicaid Provider Alert for Therapy Services Public Forum:

- Effective September 1, 2010**,** Provider Type (s): 83, Florida Medicaid is holding a public forum to discuss subjects related to the Therapy Services program, including proposed and recent changes.
- The Agency for Health Care Administration announces a public meeting to which all persons are invited.

DATE: Wednesday, September 1, 2010, 10:00 a.m. – 12:00 Noon

PLACE: Agency for Health Care Administration
2727 Mahan Drive, Building 3, Conference Room A
Tallahassee, FL 32308

- A copy of the meeting agenda will be posted August 18, 2010, on the Agency for Health Care Administration Web site: http://ahca.myflorida.com/Medicaid/childhealthservices/therapyserv/index.shtml.
- For questions contact: John Loar, Therapy Services Program Analyst, Agency for Health Care Administration, Bureau of Medicaid Services, 2727 Mahan Drive, Mail Stop 20, Tallahassee, Florida 32308, or email: john.loar@ahca.myflorida.com

Effective September 2010, Florida Medicaid Provider Alerts for Updated DME Fee Schedule:

Effective September 2010**,** Florida Medicaid is updated the 2010 Durable Medical Equipment fee schedules and are posted on Florida Medicaid fiscal agent's Web Portal at http://www.mymedicaid-florida.com//. Select **Public Information for Providers,** then **Provider Support**, and then **Fee Schedules** in the left hand margin.

The under 21 DME fee schedule contains newly opened disposable incontinence product codes, their rates, and limits. These codes are for children ages four (4) through twenty (20). These codes will be effective September 1, 2010.You may contact your local Medicaid area office for further information.

Effective August 2010, Florida Medicaid Provider Alerts for Change Interactive Pharmacy Prior Authorization Forms:

- Effective August 2010, Florida Medicaid Provider Alerts for Provider Type(s): 20, 25, 26, 30, Change Interactive Pharmacy Prior Authorization Forms Interactive prior authorization forms are now available on the Medicaid Pharmacy Services website.
- The new user friendly forms are designed to be downloaded to your computer for the convenience of typing information into the form to be printed out, signed by the provider, and faxed to the fax number on the form.
- Please note: the PDF format does not allow the user to save information in the form or to email the completed form. To access the new forms click on the link below: http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/paforms.shtml
- If you have any questions, please contact your Medicaid area office.

Effective August 2, 2011, Florida Medicaid NPI Timeline and 5010 Implementation Posted on FCA Website:

- Effective August 2, 2010, Florida Medicaid NPI Timeline and 5010 Implementation is now posted on the FCA Website at www.firstcoastadvantage.com in two locations.
- The document is located under the following Tabs:
  - ◊ Provider Information / Claims
  - ◊ Education
  - ◊ Service Alert / Medicaid Policies
- For information regarding this document you can contact your local Medicaid area office.

Published 09-01-2010

Effective August 2010, Florida Medicaid Provider Alerts for CMS Education Series for Providers – Electronic Health Record (HER) Incentive Programs:

- Effective August 2010**,** Florida Medicaid notification on CMS Education Series for Providers on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.
- The Centers for Medicare & Medicaid Services (CMS) invites you to join Florida Medicaid for a series of national provider calls addressing the specifics of the Medicare and Medicaid EHR incentive programs for hospitals and individual practitioners.
- Materials will be made available prior to each training at the following Web address: http://www.cms.gov/EHRIncentivePrograms/05_Spotlight_and_Upcoming_Events.asp
- **Cannot attend?** A transcript and MP3 file of the call will be available approximately 3 weeks after the call at http://www.cms.gov/EHRIncentivePrograms/05_Spotlight_and_Upcoming_Events.asp on the CMS Web site.
- Be sure to visit CMS' Web section on the Medicare & Medicaid EHR Incentive Programs at: http://www.cms.gov/EHRIncentivePrograms/ to get the latest information.
- Information on how to register for these calls is forthcoming.
- Learn the specifics on what you need to participate in the these incentive programs –
  - ◊ Who is eligible (Requirements for EHR Incentive Program)
  - ◊ How much the incentives are, and how they are calculated
  - ◊ What you need to do to get started
  - ◊ When the program begins and other major milestones regarding participation and payment
  - ◊ How to report on Meaningful Use measures
  - ◊ Where to find helpful resources and more

EHR Incentive Programs for Eligible Professionals
A session just for individual practitioners
Tuesday, August 10, 2010
2:00-3:30 pm EST

EHR Incentive Programs for Hospitals
A session just for hospitals
Wednesday, August 11, 2010
2:00-3:30 pm EST

EHR Questions and Answers
For Hospitals and Individual Practitioners:
Thursday, August 12, 2010
2:00-3:30 pm EST

Effective January 1, 2011, Florida Medicaid Provider Alert, NPI Implementation:

- Effective January 1, 2011, Florida Medicaid will require that all providers must obtain an NPI and include their NPI on all claims submitted to Medicaid, including First Coast Advantage (FCA) claims. This will include all claims, whether submitted on paper or electronically.
- The Medicaid provider number will be allowed to accompany the NPI on claims; however, claims that do not contain the NPI will be denied.
- The Health Insurance Portability and Affordability Act (HIPAA) of 1996 mandated the implementation of a National Provider Identifier (NPI).
- Most health care providers must register with the National Plan and Provider Enumeration System and receive a unique NPI.
- The intent of the HIPAA regulations was to require all health plans to convert their claims processing systems to use only the NPI for claims processing and reporting for providers required to obtain an NPI.
- Because of the complexities of this conversion by health care plans and providers, the use of the NPI has not yet been strictly enforced.
- However, Medicaid claims submitted on and after January 1, 2011, will have new requirements for the use of the NPI.
- Look for further instructions from Florida Medicaid in the near future for these new requirements. If you have any questions, please contact your local Medicaid area office.

Published 09-01-2010

Effective June 1, 2010, First Coast Advantage (FCA) Began Series of Articles on Attention Deficit Hyperactivity Disorder (ADHD):

·In June FCA began a series of articles on ADHD. The articles are highlighted from June 2010 – November 2010 on the following issues:

- ◊ 06-2010 What is Attention Deficit Hyperactivity Disorder (ADHD)?
- ◊ 07-2010 What Causes ADHD?
- ◊ 08-2010 How is ADHD Diagnosed?
- ◊ 09-2010 What are the Symptoms of ADHD in Children
- ◊ 10-2010 Treatment of ADHD
- ◊ 11-2010 HEDIS Measures for ADHD
- ◊

In November 2010, all six articles will be placed on the FCA website in its entirety for providers to review. For questions regarding these articles, you can contact FCA Medical Management Department at (904) 244-9780.

First Coast Advantage 4th Series on - What are the symptoms of ADHD in Children?

Inattention, hyperactivity, and impulsivity are the key behaviors of ADHD. It is normal for all children to be inattentive, hyperactive, or impulsive sometimes, but for children with ADHD, these behaviors are more severe and occur more often. To be diagnosed with the disorder, a child must have symptoms for 6 or more months and to a degree that is greater than other children of the same age.

Children who have symptoms of **Inattention** may:

- Be easily distracted, miss details, forget things, and frequently switch from one activity to another
- Have difficulty focusing on one thing
- Become bored with a task after only a few minutes, unless they are doing something enjoyable
- Have difficulty focusing attention on organizing and completing a task or learning something new
- Have trouble completing or turning in homework assignments, often losing things (e.g., pencils, toys, assignments) needed to complete tasks or activities
- Not seem to listen when spoken to
- Daydream, become easily confused, and move slowly
- Have difficulty processing information as quickly and accurately as others
- Struggle to follow instructions

Children who have symptoms of **Hyperactivity** may:

- Fidget and squirm in their seats
- Talk nonstop
- Dash around, touching or playing with anything and everything in sight
- Have trouble sitting still during dinner, school, and story time
- Be constantly in motion
- Have difficulty doing quiet tasks or activities

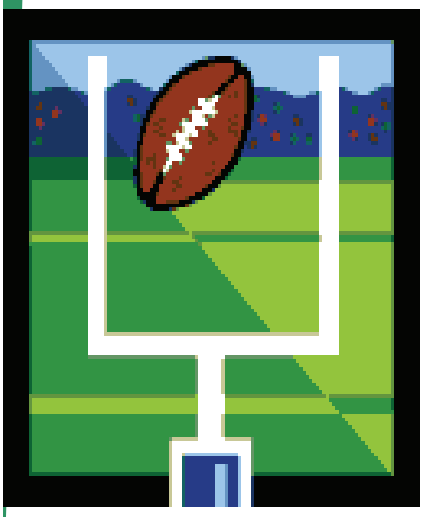
Children who have symptoms of **Impulsivity** may:

- Be very impatient
- Blurt out inappropriate comments, show their emotions without restraint, and act without regard for consequences
- Have difficulty waiting for things they want or waiting their turns in games
- Often interrupt conversations or others' activities

Published 09-01-

Effective August 2010, Florida Medicaid Provider Alerts for Electronic Health Record (EHR) Programs Survey:

- The Florida Medicaid program received federal funds this year to plan for the implementation of the Electronic health records (EHR) incentive program, established by the American Recovery and Reinvestment Act of 2009 (ARRA), to promote the adoption and use of health information technology.
- Florida received federal funds to develop the State Medicaid Health Information Technology Plan that will include a survey of health care providers who treat Medicaid recipients to assess the current health information technology landscape of the state, and a plan for the implementation of the EHR incentive program.
- The *Florida Medicaid Electronic Health Record Incentive Program* will provide monetary incentives for eligible Medicaid providers in Florida to adopt, implement, upgrade and meaningfully use EHR systems in their practices.
- Beginning August, 2010, select hospitals, Federally Qualified Health Care Centers, Rural Health Care Clinics, non-hospital based physicians, dentists, nurse practitioners and certified nurse midwives will begin receiving surveys regarding their level of health information technology adoption and use, as well as their ability and interest to adopt certified EHR systems.
- The results of the survey will provide the Agency for Health Care Administration (Agency) with an analysis of the adoption and use of health information technology in Florida.
- This information will be used to develop Florida's State Medicaid Health Information Technology Plan and the *Florida Medicaid Electronic Health Record Incentive Program*.
- Florida Medicaid encourages all health care providers who treat Medicaid recipients to complete and return the survey by August 18 to ensure the Agency receives an accurate assessment of Florida Medicaid's current health information technology environment.
- To further explain the Medicaid Electronic Health Record Incentive Programs, the Centers for Medicare and Medicaid Services (CMS) are hosting a series of conference calls to give details to providers next week, August 10 – 12.
- The Agency encourages eligible providers and hospitals to listen in and learn about the program. These calls will answer providers' questions, such as:
  - ◊ Who is eligible?
  - ◊ How much are the incentives and how are they calculated?
  - ◊ What providers will need to do to get started?
  - ◊ When the program begins and other major milestones regarding participation and payment?
  - ◊ How to report on Meaningful Use measures?
  - ◊ Where to find helpful resources?
- For more information about the *Florida Medicaid Electronic Health Record Incentive Program* and Florida's State Medicaid Health Information Technology Plan, please visit FHIN.net or email the Agency at MedicaidHIT@AHCA.MyFlorida.com



Effective April 1, 2011, Florida Medicaid X12 Claim Transactions Modification (5010):

Effective April 1, 2011, Florida Medicaid X12 Transactions mandated by HIPAA are being modified with a new version, known as 5010. As Florida prepares to convert electronic transactions to the new version of HIPAA, further changes in the electronic claims are needed for the use of NPI for providers who must obtain an NPI.

The 5010 version of the claims transactions will no longer allow providers to include the Medicaid provider number as part of the transaction and will allow only the NPI. This affects only electronic claims. Consequently, in preparation for the 5010 implementation, Florida Medicaid will no longer accept X12 claim transactions that contain the Florida Medicaid provider number starting in April 2011. Electronic claims that contain the Medicaid provider number will be denied.

Florida Medicaid will provide further instructions in the near future on the 5010 implementation and associated changes that will be required later in 2011. If you have any questions, please contact your local Medicaid area office.

Published 09-01-2010

Effective August 1, 2010, Florida Medicaid Enrollment Reports Now on First Coast Advantage (FCA) Website:

- Effective August 1, 2010, Florida Medicaid Enrollment Report is now on FCA website at www.firstcoastadvantage.com under Links.
- This link provides you enrollment reports for the following categories:
  - ◊ Comprehensive Report by Program and Assignment Plan
  - ◊ Medicaid Comprehensive Report By County
  - ◊ Medicaid Comprehensive Report By County and By Category of Eligibility
  - ◊ Market Share Report by Program and Plan
  - ◊ Medicaid Managed Care Plan [1915(b)] – HMO Enrollment by County
  - ◊ Medicaid Managed Care Plan [1915(b)] – HMO Enrollment by Category of Eligibility
  - ◊ Medicaid Managed Care Plan [1915(b)] – HMO TANF Enrollment by Age Group
  - ◊ Medicaid Managed Care Plan [1915(b)] – HMO SSI Enrollment by Age Group
  - ◊ Medicaid Pilot (1115) – Plan Enrollment by County
  - ◊ Medicaid Pilot (1115) – Plan Enrollment by Category of Eligibility
  - ◊ Medicaid Pilot (1115) – Provider TANF Enrollment by Age
  - ◊ Medicaid Pilot (1115) – Provider SSI Enrollment by Age
- If you have any questions about this comprehensive enrollment report or the data it contains, please contact Jason Campbell, MCO, Health Systems Development, at (850) 412-4037 or via email at Jason.Campbell@ahca.myflorida.com.

Effective August 2010, Florida Medicaid Provider Alerts for Durable Medical Equipment (DME) Providers Level Two Background Screening Requirement:

- Effective August 2010**,** Provider Type(s): 20, 90, Florida Medicaid for Durable Medical Equipment (DME) Providers Level Two Background Screening Requirement.
- Level two background screening, as described in s. 435.04, F.S., is required as a condition of employment for provider staff in direct contact with and providing direct services to recipients of DME and medical supply services in or at their homes.
- This requirement includes repair and service technicians, fitters, and delivery staff.
- If DME Providers have not recently received a letter regarding level two background screening, please visit http://ahca.myflorida.com/Medicaid/dme/index.shtml for more information.

Note: If DME Providers do **not** have staff in direct contact with and providing direct DME and medical supply services to recipients at the recipient's place of residence, please e-mail Medicaid at bgscreen@ahca.myflorida.com. Please include your company name, Medicaid provider identification number(s) and statement declaring your company's compliance.

Important Information:

- For potential new hires, results of a level two background screening must be received by Florida Medicaid and the person determined eligible **before they can be hired.**
- This applies only to staff who will be in direct contact with and providing direct services to recipients of DME and medical supply services in or at their homes.
- Screening must be performed at time of employment and every **five** years thereafter. It is the responsibility of the provider to ensure the request for screening or re-screening is submitted for processing in a timely manner.
- Level two background screening is **not** required for employees who remain solely at your place of business.
- Copies of background screening applications and results must be maintained in the employees' personnel record and made available for review upon request.
- As of August 1, 2010, all level two screening requests must be submitted electronically through a LiveScan Vendor approved through the Florida Department of Law Enforcement (FDLE) to provide such services. **LiveScan vendors are listed on the FDLE Web site:**
- http://www.fdle.state.fl.us/Content/getdoc/04833e12-3fc6-4c03-9993-379244e0da50/livescan.aspx.
- If you are having problems submitting or processing level two background screening requests, please contact Florida Medicaid Background Screening Section at (850) 412-4503 or e-mail bgscreen@ahca.myflorida.com.
- To show compliance, at a minimum, providers must maintain documentation that applications for level two background screening requests were submitted for all affected employees no later than September 1, 2010.

Published 09-01-2010

Welcome...

New Providers :

Ancillary		
Shands Jax Outpatient Surgery Center	Shands Jax Outpatient Surgery	Surgery Center
PCP		
Thomas, Jacob, M.D.	South Jacksonville Family Health Center	Pediatrics DCHD
Covering Only		
Gharzuzi, Yosef, ARNP	UF Commonwealth Family Med. & Peds	Nurse Practitioner Acute Care
Specialist		
Moore, Susan S., M.D.	Developmental Pediatric Center	Pediatrics
McKenzie, Alicia, SLP	Holistic Speech Therapy	Speech Language Pathologist
Salem, Whitney B., ARNP	The Otolaryngology ENT Clinic at Shands	Nurse Practitioner Adult
Ianov, Igor, M.D.	UF Anesthesia	Anesthesiology
Worri, Betty, M.D.	UF Anesthesia	Anesthesiology
Garancosky, Marlene I., ARNP	UF Cntr. for Geriatric Med. at River Garden	Nurse Practitioner Family
Hopkins, Akshata, M.D.	UF Neonatology	Pediatrics
Thomas, Jacob, M.D.	UF Neonatology	Pediatrics
Van Laningham, Julianne M., ARNP	UF Neonatology	Nurse Practitioner Neonatal
Khetpal, Vijay, M.D.	UF Ophthalmology/UF Eye Institute	Ophthalmology
Petrisor, Daniel, MD, DMD	UF Oral Maxillofacial	Oral & Maxillofacial Surgery

The difference between a successful person and others is not a lack of strength, not a lack of knowledge, but rather in a lack of will.

Vince Lombardi, NFL Football Coach and Pro Football Hall of Famer

Published 09-01-2010

WWW.
firstcoastadvantage
.com

Better Network. Better News.

By First Coast Advantage

Summer

June 2010

INSIDE THIS ISSUE:

We're on the WEB!

www.firstcoastadvantage.com

Administrative Office:
904-244-9016
Provider Services:
1-866-270-2468

FCA In-Service Slide Presentation on Website

First Coast Advantage (FCA) hosted another provider In-service May 2010. The entire presentation is on the FCA website at www.firstcoastadvantage.com under In-service. The In-services included the following Topics:

- Pre-Authorization Procedures & Changes
- Claims/Billing
- FCA On-Line Status (Web Portal)
  - ◊ Viewing Comments for Pre-Auths
  - ◊ Understanding Auth Codes for Denied, Approved and Pending
  - ◊ DME Authorizations
- Website Demonstration
- Disenrollment Guidelines

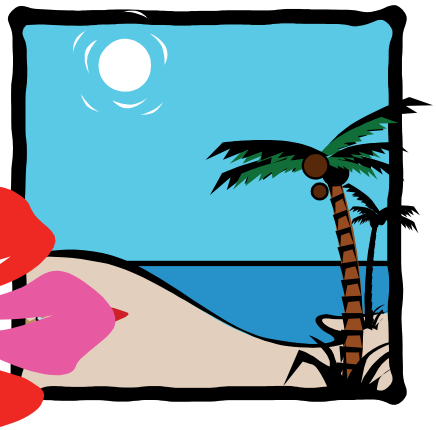
For more information contact FCA Provider Services at 1-866-270-2468.

FCA Pre-Authorization List Updated on the Website

Effective April 2010 the following services and/or items have been added to the FCA Pre-authorization list:

- Hearing Aids - Even though hearing aids have always required pre-authorization they have now been added to the FCA pre-authorization list.
- Wound care supplies and other consumable medical supplies – and other consumable medical supplies have been added for clarification.

For questions contact FCA Provider Services at 1-866-270-2468.



Happy Summer

Provider Manual Updated with Community Outreach Representative

Effective June 2010, FCA has updated the Provider Manual to reflect the changes from Marketing to Community Outreach.

◊ The Agency for Health Care Administration (AHCA) has revised its agreements with the Medicaid Plans to remove Marketing from its policies and procedures.

◊ These Marketing policies have been replaced with Community Outreach policies and the changes are reflected in the Provider Manual on pages 2, 4, 5, 11, 28, 27, 35 and 42.

For more information on these changes you can contact FCA Provider Relations at (904) 244-9174.

Published 09-2010

Fraud & Abuse Education on FCA Website

Effective June 1, 2010 FCA has placed a slide presentation for Fraud and Abuse Education on the FCA Website under the Education Tab.

First Coast Advantage (FCA) entered into a new PSN Agreement with the Agency for Healthcare Administration (AHCA) effective September 1, 2009.

FCA is required under both the federal Deficit Reduction Act of 2005 and its PSN contract with AHCA to provide its enrolled providers and vendors with fraud and abuse education.

FCA Provider Support Assignment Updated

FCA has updated the Provider Support Assignment to include the new providers that have been added to its network. This document can found on the FCA website at www.firstcoastadvantage.com under Provider Information. This document will continue to be updated when we add more providers to our plan.

For questions contact FCA Provider Services at 1-866-270-2468.

Florida Medicaid New Programming for Anticonvulsant Medication

Effective June 2, 2010, the maximum number of narcotic prescriptions defined by Federal Controlled Substance, Schedule II (multiple drugs and multiple strengths) that will be allowed per month for provider types **20, 25, 26** without a prior authorization will be as follows:

- ◊ Oncology and sickle cell patients can receive up to six (6) CII prescriptions per month. The prior authorization process is available for recipients whose pain management needs exceed the monthly limit of six (6) CII narcotic prescriptions.
- ◊ All other pain management patients can receive up to four (4) CII prescriptions per month. The prior authorization process is available for recipients whose pain management needs exceed the monthly limit of four (4) CII narcotic prescriptions.

The edit includes all CII narcotic medications and all combinations of short-acting, long-acting and prior authorized CII narcotics.

For questions contact your local Medicaid area office. The Medicaid area offices' addresses and phone numbers are available on the Area Offices Website or on the FCA website at www.firstcoastadvantage.com under Links.

Florida Medicaid Provider Alert: Telephone Scam Warning

Florida Medicaid is dedicated to protecting provider's personal information against fraud and scams. Providers can help protect their license and personal bank accounts by being cautious in giving out their own personal information such as first name, last name, business name, email address, user I.D/password, financial information (credit card, bank account number, PIN), social security number and driver's license number.

Florida Medicaid will never request personal credit card or bank account information over the telephone. If Medicaid require information from providers, they will notify the providers in writing and request that they provide the information by mail or online only after they have safely and securely logged in to their account.

If providers believe that someone may be using their account without their permission, please contact Florida Medicaid immediately. You can contact your local Medicaid area office for further information.

Florida Medicaid Pro-rated Patient Responsibility for Institutional Hospice

On April 5, 2010, Florida Medicaid published a Policy Clarification for Pro-rated Patient Responsibility for Institutional Hospice. Hospice providers are to submit claims to Florida Medicaid with the full amount of a recipient's patient responsibility.

The system is now programmed to pro-rate patient responsibility; therefore providers should not submit claims with pro-rated amounts of patient responsibility. For detailed billing instructions see page 1-28 of the UB-04 Provider Reimbursement handbook at the link below.

http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx.

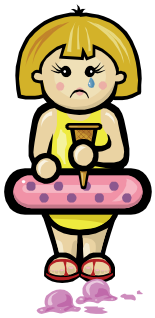
Providers may access HP Enterprise Services Web Portal billing manuals on the fiscal agent Web site: http://mymedicaid-florida.com.

Florida Medicaid Spring 2010 Provider Bulletin Now Available

On April 2, 2010, Florida Medicaid published the Spring 2010 Medicaid Provider Bulletin. The bulletin contains policy clarification and important Florida Medicaid information. You can view the Spring Bulletin on the FCA website under Links / Medicaid Provider Bulletin.

You can also view the bulletin on the Medicaid website at http://ahca.myflorida.com/Medicaid and click on "Spring 2010 Medicaid Provider Bulletin" under the "What is occurring in Medicaid?" heading.

For more information contact your local Medicaid Representative.



AHCA Child Health Check Up Collaborative Letter on FCA Website

In conjunction with the State of Florida, the Medicaid Health Maintenance Organizations (HMOs) and Provider Service Networks (PSNs) were required to send out a 10-page letter in April 2010 to Primary Care Providers in the State of Florida. The HMO's and PSN's in Florida are committed to working with all providers to improve Florida children's access to preventive health services.

Enrollees under age 21 should receive preventive visits according to the American Academy of Pediatrics periodicity schedule, which can be found in the Medicaid Child Health Check-Up (CHCUP) Coverage and Limitations Handbook. FCA has posted the letter in its entirety on the FCA website at www.firstcoastadvantage.com under the Education tab.

If you have any questions regarding this information you can contact FCA Provider Relations at (904) 244-9174.

Florida Medicaid Provider Alert Message Regarding Out-Of-State Authorization Revised

June 2010

In March 2010, Florida MediPass Providers were reminded that should a recipient require services that cannot be provided in Florida, the PCP may refer the recipient for out-of-state care.

Prior-authorization for out-of-state services require a unique authorization granted by the Medicaid Services/Medicaid Prior-Authorization Unit within the Agency for Health Care Administration (AHCA).

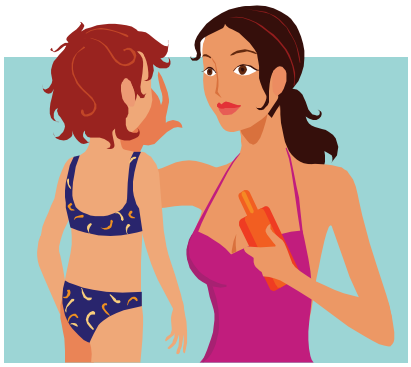
Providers should not provide their MediPass authorization number to providers for out-of-state services, as these providers will not be paid without the AHCA issued unique authorization number.

1. The referral process for a MediPass patient for out-of-state care should include the following:
   a. Completed prior-authorization form (PA01), available in the Medicaid Provider General Handbook, filled out by the recipient's Florida Medicaid primary care or specialist physician (cover page).
   b. Documentation that justifies the need for the service, such as medical history, lab reports, etc.
   c. Documentation from the requesting physician indicating the requested service (s) is/are not available in the state of Florida.
   d. Contact information for the requesting primary care or specialist physician.
   e. Name and address of the out-of-state facility.
   f. Name and telephone number of the out-of-state facility's contact.

The request cannot be processed without the above information. Send the out-of-state request packet to:

Bureau of Medicaid Services,

Out-of-State Prior Authorization Unit
2727 Mahan Drive, Mail Stop 20
Tallahassee, Florida
32308



Once the agency's physician consultant has reviewed the request, the Out-of-State Prior-Authorization Coordinator will notify the Florida Medicaid primary care or specialist physician of the determination. The Out-of-State Prior Authorization Coordinator will also notify the requested out-of-state hospital of the physician consultant's determination.

The review process takes an average of two weeks from the day the packet is received by the Out-of-State Prior-Authorization Coordinator. The review must be completed before service is authorized. Post-authorizations are not given for out-of-state services.

Note: If the Florida Medicaid recipient is in Children's Medical Services, the request for out-of-state services must be initiated through Children's Medical Services.

Florida Medicaid Removed Xopenex ® (Levalbuterol) Nebulizer for Children Under Six

On January 13, 2009, Florida Medicaid voted to remove Xopenex nebulizer (Inhalation) for children less than six years of age from the Medicaid Preferred Drug List. Xopenex for children older than six years of age and adults remains off the PDL, along with Xopenex HFA. Levalbuterol is the R-isomer of racemic Albuterol (RS-albuterol). R-albuterol is primarily responsible for beta-2 adrenergic receptor mediated bronchodilation, while the S-albuterol appears to have no pharmacologic activity. When given in equimolar doses of R-albuterol (i.e., 2.5 mg of racemic albuterol or 1.25 mg of levalbuterol), levalbuterol produces bronchodilation and clinical activity similar to the parent drug (racemic albuterol).

Additional studies further demonstrate that R-albuterol is not superior to racemic albuterol with respect to systemic effects. Systemic effects are a direct result of the amount of R-albuterol delivered. Therefore, the equivalent doses of racemic albuterol (instead of levalbuterol), a smaller amount of R-albuterol, or both should be administered, whichever delivers a lesser amount of R-albuterol with proper efficacy and minimal systemic effects. Therefore, Florida Medicaid is recommending that providers Prescribe the correct therapeutically equivalent dose of racemic albuterol as compared to the Xopenex dose:

- ◊ 2.5mg/3ml Albuterol = 1.25mg/3ml Xopenex
- ◊ 1.25mg/3ml Albuterol = 0.63mg/3ml Xopenex
- ◊ 0.63mg/3ml Albuterol = 0.31mg/3ml Xopenex
  - Reduce the amount of nebulization therapy time of Albuterol Sulfate to 5 minutes.
  - Instruct on the use of Albuterol HFA with a spacer - AND/OR -
  - Ensure that there is combined maintenance therapy (eg. inhaled corticosteroid) in the existing medication regimen to obtain the desired therapeutic effects.

Service Alert for Circumcision Guidelines

Effective May 12, 2010, FCA sent out a service alert on the guidelines for Circumcision.

- ◊ A Circumcision is covered by FCA when performed at Shands Jacksonville during the first 10 days of life.
- ◊ After the first 10 days of life, Circumcision is covered by Medicaid only when medically necessary.

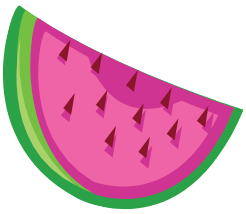
The complete guideline is located on the FCA website at www.firstcoastadvantage.com under Education and the Service Alert Tab. For questions, contact FCA Provider Services at 1-866-270-2468.

FCA Provider Manual Section: 20-Claims Updated on Website

June 2010

Effective May 1, 2010, the FCA Claims Information document was updated on the website under Provider Information and in the Provider Manual Section 20. The Updates to the Claims Section include:

- ◊ Florida Medicaid Program New Fiscal Agent, HP Enterprise Services, LLC (formally EDS).
- ◊ Under Paper Claims - Providers are reminded to submit all paper claims to FCA Third Party Administration (TPA) and the providers' Medicaid Provider ID numbers must be on the claim.
- ◊ The Claims Appeals process has been revised. See claims appeals process information in this monthly NewsFlash.



For more information contact FCA Provider Services at 1-866-270-2468.

Medicaid Fiscal Agent Name Change to HP Enterprise Services, LLC

Florida Medicaid Fiscal Agent has changed their corporate name from Electronic Data Systems (EDS), LLC, to HP Enterprise Services, LLC, and a contract amendment recognizing the official name change was executed in April.

All other contact information, such as addresses, telephone numbers and Medicaid staff Members have not changed. Please use the Medicaid Fiscal Agent's new name (HP Enterprise Services, LLC) in all future correspondence and communications.

For more information contact your local Medicaid Representative.

Florida Medicaid Updated ICN Region Codes and Adjustment Reason Codes on HP Enterprise Website

Effective March 18, 2010, Florida Medicaid Fiscal Agent HP Enterprises web portal was updated for ICN region codes and adjustment reason codes. Please forward this information to your staff as appropriate or click on the link below:

http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_Training/tabId/47/Default.aspx#trmwaiv

For more information contact your local Medicaid Representative.

We're on the WEB!

www.firstcoastadvantage.com

Provider Manual Updated for Sections 2,7,9,10 & 22

Under FCA's new PSN Agreement with The Agency for Healthcare Administration (AHCA), marketing restrictions have been added to the agreement and these restrictions are listed in the FCA Provider Manual in Sections, 2, 9, and 10 for Provider Responsibilities.

The Sections are outlined as follows:

- ◊ Section 2: Quick Reference Guide (Marketing Removed)
- ◊ Section 9: Behavioral Health Services (Provider Responsibilities)
- ◊ Section 10: Provider Responsibilities (Community Outreach Responsibilities)

Section 7 of the Provider Manual has been updated to reflect changes to Covered Services. Co-pay information, language changes for most covered services and service restrictions has been update.

- ◊ Some of the changes in covered services have already been updated on the most current FCA Pre-authorization list.
- ◊ Section 22 of the Provider Manual has been updated to reflect changes for Member Grievance Procedures for the Beneficiary Assistance Program (BAP) address & telephone number and all references to Marketing have been removed.

The Manual can be found on the FCA website at www.firstcoastadvantage.com under Provider Services. For questions, contact FCA Provider Services at 1-866-270-2468.

FCA Begins Series of Articles on Attention Deficit Hyperactivity Disorder (ADHD)

In June FCA began a series of articles on ADHD. The articles are highlighted from June 2010 – November 2010 on the following issues:

- ◊ 06-2010 What is Attention Deficit Hyperactivity Disorder (ADHD)?
- ◊ 07-2010 What Causes ADHD?
- ◊ 08-2010 How is ADHD Diagnosed?
- ◊ 09-2010 What are the Symptoms of ADHD in Children
- ◊ 10-2010 Treatment of ADHD
- ◊ 11-2010 HEDIS Measures for ADHD

In November 2010, all six articles will be placed on the FCA website in its entirety for providers to review. For questions regarding these articles, you can contact FCA Medical Management Department at (904) 244-9780.

First Coast Advantage 1st Series of Articles on ADHD:

What is Attention Deficit Hyperactivity Disorder?

- Attention-Deficit/Hyperactivity Disorder (ADHD) is one of the most common neurobehavioral disorders of childhood. It is sometimes referred to as Attention Deficit Disorder (ADD).
- It is usually first diagnosed in childhood and often lasts into adulthood. Children with ADHD have trouble paying attention, controlling impulsive behaviors (may act without thinking about what the result will be), and, in some cases, are overly active.

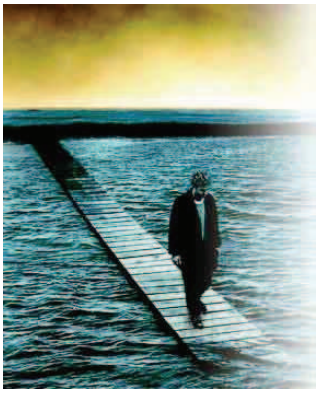
ADHD has Three Subtypes:

Predominantly Hyperactive-Impulsive – Most symptoms (six or more) are in the hyperactivity-impulsivity categories. Fewer than six symptoms of inattention are present, although inattention may still be present to some degree.

Predominantly Inattentive – The majority of symptoms (six or more) are in the inattention category and fewer than six symptoms of hyperactivity-impulsivity are present, although hyperactivity-impulsivity may still be present to some degree. Children with this subtype are less likely to act out or have difficulties getting along with other children. They may sit quietly, but they are not paying attention to what they are doing. Therefore, the child may be overlooked, and parents and teachers may not notice that he or she has ADHD.

Combined Hyperactive-Impulsive and Inattentive– Six or more symptoms of inattention and six or more symptoms of hyperactivity-impulsivity are present. Most children have the combined type of ADHD. Treatments can relieve many of the disorder's symptoms, but there is no cure. With treatment, most people with ADHD can be successful in school and lead productive lives. Researchers are developing more effective treatments and interventions, and using new tools such as brain imaging, to better understand ADHD and to find more effective ways to treat and prevent it.

First Coast Advantage
Series of Articles on Depression: Series 3



Beginning February 1, 2010, FCA began presenting a series of articles on Depression. The articles are highlighted from February 2010—May 2010 on the following issues:

- ◊ 02-2010 What is Depression? Why do People get Depression? What are Symptoms of Depression?
- ◊ 03-2010 Treatment of Depression
- ◊ 04-2010 Diagnosis Categories of Major Depression
- ◊ 05-2010 Suggestions for Improving Medication Compliance for Patients taking Anti-Depressant Medication

In May 2010, all four articles will be placed on the FCA website in it's entirety for providers to review. For questions regarding these articles, you can contact FCA Behavioral Health Department at 244-9780.

First Coast Advantage 3rd Series on Depression:
Diagnosis Categories for Major Depression

- 296.20-296.25, 296.30-296.35, 298.0, 300.4, 309.1, 311

FCA ranked 5th out of 6 Medicaid Managed Care Plans in the State of Florida for Antidepressant Medication Management during the Acute Phase in 2008, and 2nd out of 6 Managed Care Plans for the Continuation Phase.

	Antidepressant Med. Mgmt. Effective Acute Phase Treatment 2008
Access Health	60.80%
United	59.00%
SFCCN	58.30%
Staywell	50.00%
FCA	**44.70%**
HealthEase	38.70%

	Antidepressant Med. Mgmt. Effective Continuation Phase Treatment 2008
SFCCN	50.00%
FCA	**36.80%**
United	33.30%
Staywell	31.00%
Access Health	28.90%
HealthEase	21.00%

Nationally, FCA's rate for Antidepressant Medication Management during the Acute Phase in 2008 was 44.74%, which placed FCA between the 25th and 50th percentile among Medicaid Plans. The rate during the continuation phase was 36.84% in 2008, which placed FCA in the 90th percentile among Medicaid Plans.

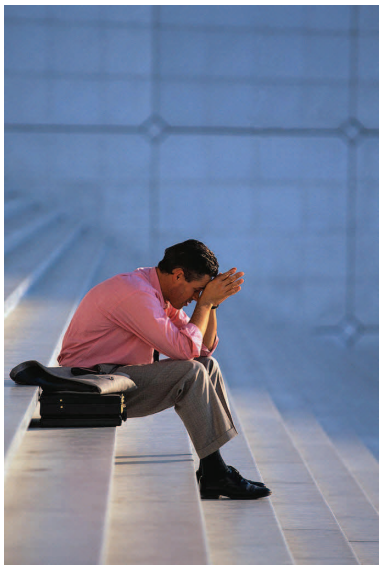
Scoring Criteria (Percentile Ranking)						
Key Measures	**Rate 2008**	**90th**	**75th**	**50th**	**25th**	**10th**
Antidepressant Medication Mgmt. Acute Phase	44.74%	49.90%	48.30%	45.10%	39.60%	30.60%
Antidepressant Medication Mgmt. Continuation Phase	36.84%	33.70%	31.30%	28.30%	24.90%	19.30%

To improve the rate of this important treatment for depression, FCA is implementing a corrective action plan approved by AHCA. FCA would like to stress the importance of members adhering to their anti-depressant medication regimen for optimal results.

First Coast Advantage
Series of Articles on Depression: Series 4

Beginning February 1, 2010, FCA began presenting a series of articles on Depression. The articles are highlighted from February 2010—May 2010 on the following issues:

- ◊ 02-2010 What is Depression? Why do People get Depression? What are Symptoms of Depression?
- ◊ 03-2010 Treatment of Depression
- ◊ 04-2010 Diagnosis Categories of Major Depression
- ◊ 05-2010 Suggestions for Improving Medication Compliance for Patients taking Anti-Depressant Medication



In May 2010, all four articles will be placed on the FCA website in it's entirety for providers to review. For questions regarding these articles, you can contact FCA Behavioral Health Department at 244-9780.

First Coast Advantage 4th and Final Series on Depression:

Suggestions for Improving Medication Compliance for Patients taking Anti-Depressant Medication

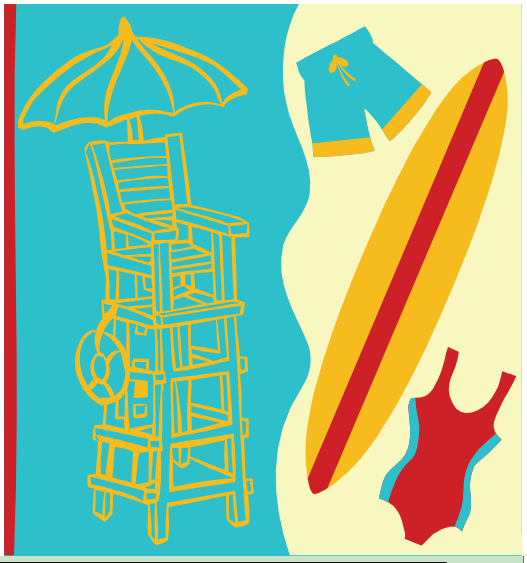
- Causes reported by patient for non-compliance:
  - ◊ Weight Gain
  - ◊ Sexual Problems (e.g. loss of sex drive, or inability to achieved an orgasm)
  - ◊ Fatigue during the day
  - ◊ Began to feel better
  - ◊ Medication is ineffective
  - ◊ Problems remembering to take the medication
  - ◊ Stigma of taking psychotropic medication
  - ◊ Poor understanding of the benefits of treatment
  - ◊ Poor interactions among the patient, health care provider, and health care system

- Strategies to improve adherence:
  - ◊ Telephone follow up within 1-3 weeks may be helpful to assess side effects or compliance
  - ◊ Actively engage the patient in the treatment plan
  - ◊ Encourage patients to discuss issue and concerns
  - ◊ Provide the patient with simple written instructions
  - ◊ Provide a number for the patient to call if questions or problems occur
  - ◊ Simplify regimen, fit the treatment with patients lifestyle
  - ◊ Have the patient call if they are thinking about stopping the medication

For more information on depression, please visit the National Institute of Mental Health's Web site: **http://www.nimh.nih.gov**

Summer...when we hit the sunny beaches where we occupy ourselves by keeping the sun off our skin, the saltwater off our bodies, and the sand out of our belongings.

– Erma Bombeck



Florida Medicaid Ombudsman Program

As a result of a settlement agreement in the Hernandez vs. Medows lawsuit, effective May 14, 2004, Florida Medicaid began providing the services of an Ombudsman to facilitate the timely resolution of claim reimbursement rejections when the problems cannot be resolved through self-help by the recipient or intervention by the pharmacy or the prescriber.

Information Pamphlets in English and Spanish, along with pharmacy guidelines, have been provided to Medicaid pharmacy providers explaining in detail who should receive the pamphlets and what rights a recipient has if a prescription claim is denied by Medicaid, as well as what the recipient's responsibilities are, and what the prescriber's responsibilities are.

A toll free number is included in the pamphlets for the recipient to contact an Ombudsman if all conditions are met and the recipient continues to believe the claim should be approved by Medicaid.

In addition to providing the Information Pamphlets, Medicaid pharmacy providers are also required to post in a conspicuous location within each pharmacy both English and Spanish language signs which include the Ombudsman's toll free telephone number (1-866-490-1901).

FCA NewsFlash/ Newsletter Page Updated on Website

In April 2010, FCA added an additional section on the NewsFlash/Newsletter page call NewsFlash/Newsletter Important Quarterly Articles. This section will list the most important Newsletter articles from the quarter. This is another way for providers to stay on top of important updates for First Coast Advantage.

Please continue to keep a look out for the important updates on the FCA website. For questions contact FCA Provider Services at 1-866-270-2468.

FCA New Education Tab on Website

In April 2010, FCA added a new Education tab on the website for educational topics of interest. These topics will provide access to a faster way to find out what's happening with First Coast Advantage. Items will include:

- ◊ Documents updated on the website
- ◊ FCA Depression Series link
- ◊ FCA In-Service link
- ◊ Quarterly Newsletter
- ◊ And much more….

For questions contact FCA Provider Services at 1-866-270-2468.

Medicare Cross-Over Denial Edit 2091 ONLY Can Be Processed

In March 2010, the Agency for Healthcare Administration (AHCA) has informed FCA that Medicare Cross-Over Denial Edit 2091 can now be reprocessed.

- The Service Alert is posted on the FCA Website at www.firstcoastadvantage.com under / **Service Alerts.**
- See details on submitting denial 2091 for repayment in the FCA Service Alert sent out on March 18, 2010.

For Questions, you can contact FCA Claims Manager, Debbie Shelton at (904) 244-1836 or FCA Provider Services at 1-866-270-2468.

Florida Medicaid Pro-Rated Patient Responsibility for Institutional Hospice

On April 5, 2010, Florida Medicaid published a Policy Clarification for Pro-rated Patient Responsibility for Institutional Hospice. Hospice providers are to submit claims to Florida Medicaid with the full amount of a recipient's patient responsibility. The system is now programmed to pro-rate patient responsibility; therefore providers should not submit claims with pro-rated amounts of patient responsibility.

For detailed billing instructions see page 1-28 of the UB-04 Provider Reimbursement handbook at the link below.

http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_ProviderHandbooks/tabId/42/Default.aspx.

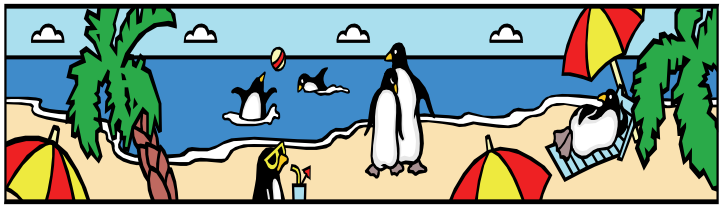
Providers may access HP Enterprise Services Web Portal billing manuals on the fiscal agent Web site: http://mymedicaid-florida.com.

Developmental Disabilities Waiver Services Notice

Effective March 12, 2010, some providers type 67 may see prior year and older current year claims listed on their remittance advice dated 3/12/2010 with an "ISSUE DATE of 3/17/2010". These claims were retrieved in a review conducted by the Agency for Persons with Disabilities and AHCA to reconcile the two agency's service authorization and billing systems, "ABC" and "FMMIS".

If any provider claims were pulled for this review effort, they will appear on the provider's remittance advice with the date indicated above, with an associated set of codes, "1004", "8700", and "8701". Claims identified by these 3 codes are informational only and do not affect the dollars paid to providers, for this remittance advice payment period.

Providers may call the EDS Provider Inquiry line at 1-800-289-7799, Option 7, if you have any questions.



EDS X12 Adjustment Code List Now on FCA Website

As of March 2010, EDS X12 Adjustment Code List was put on the FCA website at www.firstcoastadvantage.com under Links. This is the link to get to the X12 adjustment codes filed Electronically to EDS.

For questions contact FCA Provider Services at 866-270-2468.

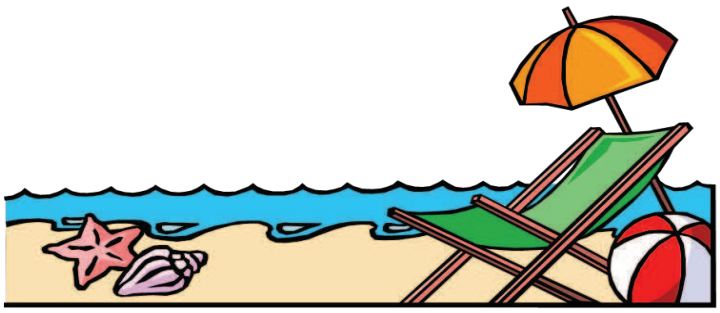
High (Excessive) Dose Warnings on Pharmacy Claims

Effective March 15, 2010, pharmacists will no longer be allowed to use the codes listed below to override pharmacy claims that are rejected because of a high (excessive) dose warning (HD-88 DUR reject). When the submitted dose per day is in excess of maximum dosing limits defined by First Data Bank, the pharmacy claim will reject and the medical provider will have to fax a prior authorization (PA) request on a Miscellaneous PA Request form to the Agency for Health Care Administration (AHCA) at (850) 922-0685.

You can access these forms on the FCA website at www.firstcoastadvantage.com under the **Preferred Drug List** tab. The forms are also located on the AHCA website at the following link: http://ahca.myflorida.com/Medicaid/Prescribed_Drug/pharm_thera/pafoms.shtml

Miscellaneous PA Request: Most non-PDL medications and high dose requests Medication specific forms: Required for some medications (for example, Oxycontin, Vfend, Valcyte, and Procrit). Providers must add sufficient medical documentation (progress notes, etc.) to justify all types of prior auth requests.

Intervention/Professional Service Code/Description	Outcome/Result of Service Code
00/no intervention	**1A**/filled as is, false positive
M0/prescriber consulted	**1B**/filled prescription as is
P0/patient consulted	**1C**/filled with different dose
R0/pharmacist consulted other source	**1D**/filled with different directions
	1E/filled with different drugs
	1F/filled with different quantity
	1G/filled with prescriber approval
	2A/prescription not filled
	2B/not filled, directions clarified



Florida Medicaid Number of Covered Days on Hospice Room and Board Claims

Effective April 5, 2010, some vendor-supplied billing software used by Hospice providers for electronic billing is populating the "covered days" field with a random number. Since the amount of patient responsibility on room and board claims is pro-rated based on the number in the "covered days" field, this error often results in an overpayment.

This problem can only be corrected by the Hospice's billing software vendor. Programming for the "covered days" field is contained in loop 2300. For more information contact your local Medicaid Representative.

FCA Claims Appeals Process Updated In Provider Manual Section: 20-Claims

Effective May 2010, FCA Claims Appeals Process has been revised with the below information. Your appeal must be submitted to us within 12 months from the date of payment or denial shown on the EOB. All Appeals are to be sent to the following address:

First Coast Advantage
580 W. 8th Street, T-20
Jacksonville, FL 32209
Attn: Claims Appeals

Timely Filing Appeals: If you are appealing a claim that was denied because it was not filed on time, perform the following actions:

- Letter of Appeal requesting for exception for timely filing.
- For electronic claims - include confirmation that your claim was received and accepted.
- For papers claims - include a copy of a screen print from your accounting software to show the date you submitted the claim. Submit a new clean UB-04 or CMS-1500 paper claim

If you disagree with the outcome of the claims appeal, an arbitration proceeding may be filed as described in your provider agreement.

Appeals for No Authorization:

- Submit letter requesting review of Services
- Submit clean UB-04 or CMS-1500 paper claim
- Submit all Medical Documentation to support services
- Submit Authorization number if given or FCA or HP claim number

HP Services Appeal of denial or incorrect payment:

- Submit letter of Appeal requesting HP to review
- Submit clean UB-04 or CMS-1500 paper claim
- Submit HP EOB showing incorrect denial or payment
- Submit supporting documentation if necessary
- Submit claim to above FCA Appeals address

Local Area 4 Office Claims:
Claims that need to be submitted to the Area 4 office should come to the FCA Appeal address. Please ensure each claim has the following information:

- Letter explaining why claim should be sent to Area 4 Office
- Clean paper UB-04 or CMS-1500 claim
- All documentation needed for Area 4 to process claim such as HP remits of voids, previous submissions or any other necessary information. For more information contact FCA Provider Services at 1-866-270-2422.

First Coast Advantage New Providers...

June 2010

Welcome

PCP

Pound, Majorie T., ARNP	UF New Berlin Family Medicine	Nurse Practitioner
Wallizada, Fatah A. M.D.	Fatah A. Wallazada, M.D.	Pediatrics

Specialist

Abshire, Kyle, O.D.	Abshire and Hoffman, PA	Optometrist
Bowman, Christina, O.D.	Abshire and Hoffman, PA	Optometrist
Hoffman, James, O.D.	Abshire and Hoffman, PA	Optometrist
Larson, Karen, O.D.	Abshire and Hoffman, PA	Optometrist
Reed, Keven, O.D.	Abshire and Hoffman, PA	Optometrist
Albert, George Louis, DC	Theramed Medical clinics	Chiropractor
Bowman, Kristin, SLP	Hope Haven Family Center, Inc.	Speech Language Pathologist
Shearer, Patricia D., M.D.	Internal Medicine Primary Care	Pediatric Hematology Oncology
Zeilman, Pamela Ruth, ARNP	Multi Specialties @ Shands Plaza	Nurse Practitioner
Emerson, Brian R., M.D.	UF Anesthesia	Anesthesiology
Petrino, Layne., ARNP	UF Neonatology	Nurse Practitioner Neonatal
Smith, Virginia Gladys, ARNP	UF&Shands Ortho Surgery & Medicine	Nurse Practitioner
Green, Valerie Mcelveen, PA-C	Shands @ UF - Medical Specialties	PA Surgical
Baldwin, Maria Inslee Felix, ARNP	Women's Center @ Magnolia Park	Nurse Practitioner, OBGYN
Bartell, Andrew Keith, D.P.M.	Andrew K. Bartell, DPM	Chiropractor
Charles, Brandee Lee, SLP	The Speech Therapy Closet, Inc.	Speech Language Pathologist
Cosby, Christie, O.T.	The Speech Therapy Closet, Inc.	Occupational Therapist
Haislip, Christina Lynn, SLP	The Speech Therapy Closet, Inc.	Speech Language Pathologist
Hastay, Anne Austin, SLP	The Speech Therapy Closet, Inc.	Speech Language Pathologist
Leonard, Carolyn Paige, SLP	The Speech Therapy Closet, Inc.	Speech Language Pathologist
Lieberman, Lisa Marie, SLP	The Speech Therapy Closet, Inc.	Speech Language Pathologist
Stilley, Lauren Ann, SLP	The Speech Therapy Closet, Inc.	Speech Language Pathologist
Watson, Carrie Lyn, SLP	The Speech Therapy Closet, Inc.	Speech Language Pathologist
Urchek, Vanessa Marie, SLP	The Speech Therapy Closet, Inc.	Speech Language Pathologist
Miller, Jennifer M., CRNA	UF Anesthesia	CRNA
Van Liere, Christine S., CRNA	UF Anesthesia	CRNA
Shujaat, Adil, M.D.	UF Critical Care	Critical Care Medicine
Shujaat, Adil, M.D.	UF Pulmonology	Pulmonary Disease
Gibbs, Charles Parker, M.D.	UF& Shands Ortho Surgery & Medicine	Orthopedic Surgery

Ancillary

Bogers Shoes, Inc	DME
Shands Jax. Imaging Cntr @ Emerson	Diagnostic Radiology
Suwannee Medical Personal	Home Health

Covering Only:

D'Amico, Cara M., ARNP	Jax Pediatrics Assoc.	Nurse Practitioner
Cardoza, Ayumi E.., PA-C	Middleburg Pediatrics	Physician Assistant
Lane, Karen, ARNP	Gloriosa Antiporda, M.D., P.A.	Nurse Practitioner
Belony, Assoye, PAC	Duval County Health Department	Family Practice
Grieve, Carol, ARNP	Duval County Health Department	Family Practice
Permenter, Lisa, ARNP	Duval County Health Department	Family Practice

First Coast Advantage

We're on the WEB!

Contact Us...

Administrative Office:
904-244-9016
Provider Services:
1-866-270-2468

ENHANCED BENEFITS REWARD$ PROGRAM

Welcome to Florida Medicaid Reform. Each family member listed above is a part of a new reward program called the Enhanced Benefits Reward$ Program. This program allows you to earn credits that you can spend on health-related products. All you need to do to earn credits is take part in an approved healthy behavior in the chart listed on the back. Examples of healthy behaviors on the list are: immunizations for children; dental check-ups for children; taking your maintenance drugs as prescribed; and weight loss programs.

FREQUENTLY ASKED QUESTIONS

Who is eligible?

If you are enrolled in a Florida Medicaid Reform Plan, you are eligible to earn credits in the Enhanced Benefits Reward$ Program.

How do I earn credits?

You earn credits by taking part in healthy behaviors, like the ones listed in the chart.

How much can I earn?

Each person listed above may earn credits worth up to $125.00 per year. See chart for activity credit limits.

How will I know when I have credits in my account?

When you earn credits, you will get a statement from Florida Medicaid showing how many credits you have earned. It may take up to 90 days after completing a healthy behavior for the credits to show up in your account.

How do I buy items using my earned credits?

You may use your credits at any Florida Medicaid participating pharmacy to purchase over the counter health related products. You must provide your Florida Medicaid ID number and a picture ID. You must take the item(s) to the pharmacy counter to check out.

What is the Enhanced Benefits Universal Form?

The Enhanced Benefits Universal Form is used to record an approved healthy behavior that is not provided by your health plan. Please see the chart for more information.

Letter_Number / Area_Number / Page_Number *First 7 digits of the first Recipient ID#*

Remember … it's easy to get help. Call toll-free: 1-866-421-8474

8 a.m. – 8 p.m. Monday-Thursday; 8 a.m. - 7p.m. Friday

TTY users ONLY call 1-866-467-4970

If you need Enhanced Benefits materials in large print, audiotape or Braille, contact the Call Center.

	Behavior Name	Behavior Reported By	Credit Amount Per Behavior	Behavior Limit Per Year
Children	Childhood Dental Exam	Doctor	$25.00	3
	Childhood Vision Exam	Doctor	$25.00	1
	Childhood Preventative Care (age-appropriate screenings and immunizations)	Doctor	$25.00	Any Combination, up to 5
	Childhood Wellness Visit	Doctor	$25.00	
	Keep all Primary Care Appointments	Doctor	$7.50	
Adults	Keep all Primary Care Appointments	Doctor	$7.50	1
	Mammogram	Doctor	$25.00	1
	Pap Smear	Doctor	$25.00	1
	Colorectal Screening	Doctor	$25.00	1
	Adult Vision Exam	Doctor	$25.00	1
	Adult Dental Cleaning (Preventative Services)	Beneficiary	$15.00	3
	PSA Blood Test (Men only)	Health Plan	$15.00	1
Adults & Children	Compliance with Prescribed Maintenance Medications	Doctor	$7.50	4
	Diabetes Maintenance Blood Test	Health Plan	$15.00	1
	Healthy Start Screening – Office Visit (during 1st 3 months of pregnancy)	Health Plan	$15.00	1
Additional Behaviors/Universal Form	Disease Management Participation	Beneficiary/ Health Plan	$25.00	1
	Alcohol and/or Drug Treatment Program	Beneficiary	$25.00	1
	Alcohol and/or Drug Treatment Program 6 Month Success	Beneficiary	$15.00	2
	"Stop Smoking" Program Participation	Beneficiary	$25.00	1
	"Stop Smoking" Program Participation 6 Month Success	Beneficiary	$15.00	2
	Weight Loss Program Participation	Beneficiary	$25.00	1
	Weight Loss Program Participation 6 month Success	Beneficiary	$15.00	2
	Exercise Program Participation	Beneficiary	$25.00	1
	Exercise Program Participation 6 Month Success	Beneficiary	$15.00	2
	Flu Shot When Recommended By Physician	Beneficiary/ Health Plan	$25.00	1

How do I get more information?

You may call the Enhanced Benefits Call Center at **1-866-421-8474** or go to our web site at **http://ahca.myflorida.com/Medicaid/Enhanced _Benefits**

Remember … it's easy to get help. Call toll-free: 1-866-421-8474
8 a.m. – 8 p.m. Monday – Thursday; 8 a.m. – 7 p.m. Friday
TTY users ONLY call 1-866-467-4970
If you need Enhanced Benefits materials in large print, audiotape or Braille, contact the Call Center.

	Behavior Name	Behavior Reported By	Credit Amount Per Behavior	Behavior Limit Per Year
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	Childhood Preventative Care (age-appropriate screenings and immunizations)	Doctor	$25.00	Any Combination, up to 5
	Childhood Wellness Visit	Doctor	$25.00	
	Keep all Primary Care Appointments	Doctor	$7.50	
Adults	Keep all Primary Care Appointments	Doctor	$7.50	1
	Mammogram	Doctor	$25.00	1
	Pap Smear	Doctor	$25.00	1
	Colorectal Screening	Doctor	$25.00	1
	Adult Vision Exam	Doctor	$25.00	1
	Adult Dental Cleaning (Preventative Services)	Beneficiary	$15.00	3
	PSA Blood Test (Men only)	Health Plan	$15.00	1
Adults & Children	Compliance with Prescribed Maintenance Medications	Doctor	$7.50	4
	Diabetes Maintenance Blood Test	Health Plan	$15.00	1
	Healthy Start Screening – Office Visit (during 1st 3 months of pregnancy)	Health Plan	$15.00	1
Additional Behaviors/Universal Form	Disease Management Participation	Beneficiary/ Health Plan	$25.00	1
	Alcohol and/or Drug Treatment Program	Beneficiary	$25.00	1
	Alcohol and/or Drug Treatment Program 6 Month Success	Beneficiary	$15.00	2
	"Stop Smoking" Program Participation	Beneficiary	$25.00	1
	"Stop Smoking" Program Participation 6 Month Success	Beneficiary	$15.00	2
	Weight Loss Program Participation	Beneficiary	$25.00	1
	Weight Loss Program Participation 6 month Success	Beneficiary	$15.00	2
	Exercise Program Participation	Beneficiary	$25.00	1
	Exercise Program Participation 6 Month Success	Beneficiary	$15.00	2
	Flu Shot When Recommended By Physician	Beneficiary/ Health Plan	$25.00	1

How do I get more information?

You may call the Enhanced Benefits Call Center at **1-866-421-8474** or go to our web site at **http://ahca.myflorida.com/Medicaid/Enhanced _Benefits**

Remember … it's easy to get help. Call toll-free: 1-866-421-8474
8 a.m. – 8 p.m. Monday – Thursday; 8 a.m. – 7 p.m. Friday
TTY users ONLY call 1-866-467-4970
If you need Enhanced Benefits materials in large print, audiotape or Braille, contact the Call Center.

Florida Medicaid Reform
Enhanced Benefits Universal Form

Instructions:

Step 1: Participate in an approved healthy behavior listed below.
Step 2: Fill in all areas of this form and sign.
Step 3: If the healthy behavior has a line under it, write the name of the behavior that has taken place.
Step 4: Have this form signed by the provider/sponsor of the healthy behavior.
Step 5: Mail or fax the completed and signed form to your health plan. See contact list on page 2.

Beneficiary's Florida Medicaid ID# or **Beneficiary's Health Plan ID#**

Beneficiary's Last Name **Date of Birth (mm/dd/yyyy)** __/__/____

Beneficiary's First Name

Beneficiary's Address **City** **State** **Zip**

Healthy Behavior Participation: (*please check single behavior*) **Only one "Behavior" will be processed for each form completed.**

- ☐ Congestive Heart Failure Disease Management Program (*EB 001*)
- ☐ Diabetes Disease Management Program (*EB 002*)
- ☐ Asthma Disease Management Program (EB 003)
- ☐ HIV/AIDS Disease Management Program (EB 004)
- ☐ Hypertension Disease Management Program (EB 005)
- ☐ Other Disease Management Program (EB 006)

  _____
- ☐ Flu Shot (EB 007)
- ☐ Adult Dental Cleaning (preventive services) (*EB 008*)
- ☐ Alcoholic Treatment Program (*EB 009*)
- ☐ Alcoholic Treatment Program 6 Month Success (*EB 109*)
- ☐ Narcotic Treatment Program (*EB 010*)
- ☐ Narcotic Treatment Program 6 Month Success (*EB 110*)
- ☐ Smoking Cessation (*EB 011*)
- ☐ Smoking Cessation 6 Month Success (*EB 111*)
- ☐ Exercise Program (*EB 012*)
- ☐ Exercise Program 6 Month Success (*EB 112*)
- ☐ Weight Management (*EB 013*)
- ☐ Weight Management 6 Month Success (*EB 113*)

Medicaid Beneficiary Signature _____ **Date** _____

Provider/Sponsor Information

Date(s) of Participation: Start Date_____ **End Date**_____

Name _____ (*Please Print*) **Organization Name**_____

Phone # _____ **Address** _____

Signature _____ _____

Provider/Sponsor and Beneficiary Certification:

I certify that the information provided on this form is true and correct to the best of my knowledge. I understand that if I give information that is not true or if I withhold information I can be lawfully punished for fraud. I understand that the information will be kept confidential in accordance with Florida and federal law.

For Plan Use Only

Date Received: _____ **Complete Form:** _____

Incomplete Form: _____ **Notified if Incomplete:**_____

Information about the form

- This form may be completed by the beneficiary or the provider/sponsor of the qualifying behavior on behalf of the beneficiary.
- This form must be completed in full in order to be processed (signatures from the provider and beneficiary are required for processing).
- The beneficiary should make and keep a copy of the completed and signed form for their records.
- Participation of a healthy behavior is determined by the provider/sponsor of the healthy behavior.
- Only one healthy behavior, up to the set limit for each behavior, is allowed for each form.
- If you have any questions or concerns about the form or the Enhanced Benefit program, please visit the Florida Medicaid Reform website at http://ahca.myflorida.com/Medicaid/Enhanced_Benefits. You may also contact the Enhanced Benefits Call Center at 1-866-421-8474.

Florida Medicaid Health Plan Contact Information

Broward Only

HUMANA FAMILY
3501 SW 160th Avenue
Miramar, FL 33027
1-800-477-6931
1-877-258-5904 Fax

CMSN-BROWARD
1525 NW 167th Street, Suite 103
Miami, FL 33169
Telephone number: 1-866-209-5022
North fax: 1-954-767-5604
South fax: 1-954-602-2810
www.sfccn.org

SOUTH FLORIDA COMMUNITY CARE NETWORK
1525 NW 167th Street, Suite 103
Miami, FL 33169
1-866-899-4828
North Broward Hospital District
954-767-5604 Fax
Memorial Healthcare System
954-602-2810 Fax
www.sfccn.org

MEDICA HEALTH PLANS OF FLORIDA, INC.
4000 Ponce De Leon Blvd., Suite 750
Coral Gables, FL 33166
Telephone number: 1-888-871-9624
Fax: 1-305-448-5102

TOTAL HEALTH CHOICE
8701 SW 137 Avenue, Suite 200
Miami, FL 33183
1-800-213-1133
305-408-5861 Fax
www.totalhealthchoiceonline.com

FREEDOM HEALTH, INC.
5403 N Church Ave.
Tampa, FL 33614
Phone: 1-877-655-2424
Fax: 1-813-506-6151
www.freedomhealth.com

BETTER HEALTH, LLC
12905 S.W. 42nd Street, Suite 211
Miami, Florida 33175
(800) 514-4561
(877) 915-0553 Fax
www.betterhealthflorida.com

MOLINA HEALTH CARE OF FLORIDA, INC.
8300 NW 33rd Street, Suite 400
Doral, FL 33122
1-866-472-4585
Fax 1-866-422-6445
www.molinahealthcare.com

Duval Only

CMS DUVAL/PED-I-CARE
1701 SW 16th Avenue, Building A
Gainesville, FL 32608
1-866-376-2456
352-955-6518 Fax
www.pedicare.peds.ufl.edu

FIRST COAST ADVANTAGE
580 West 8th Street, T-20
Jacksonville, FL 32209
1-866-270-2422
904-244-9409 Fax
www.firstcoastadvantage.com

Broward/Duval

UNIVERSAL HEALTH CARE
100 Central Ave, Suite 200
St. Petersburg, FL 33701
phone 1-866-690-4842
www.univhc.com

Broward/Duval/Baker/ Clay/Nassau

SUNSHINE STATE HEALTH PLAN, INC.
400 Sawgrass Corporate Parkway,
Suite 100
Sunrise, FL 33325
1-866-796-0530
www.sunshinestatehealth.com

Duval/Baker/ Clay Nassau

UNITED HEALTHCARE OF FLORIDA, INC.
13621 NW 12th. Street
Sunrise, FL 33323
Telephone number:
1-888-216-0015
www.uhcmedicaid.com

First Coast Advantage

PLEASE FAX TO 904-244-9409

MEMBER DISENROLLMENT / PCP TRANSFER FORM

(ALL FIELDS MUST BE COMPLETED BEFORE DISENROLLMENT / TRANSFER OCCURS)

Today's Date: _____

Members Last Name: _____ Members First Name: _____

Date of Birth: _____ Medicaid ID Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Member Home Phone: _____ Member Alternate Phone: _____

Reason for Disenrollment *(Select One):*

☐ Member moved out of Duval County service area
New address: _____
_____

☐ Member death (Date of expiration _____)

☐ Member ineligible for plan enrollment (Reason _____)
- ☐ Hospice (Date of Admission_____)
- ☐ Skilled Nursing/Nursing Home/TCU
- ☐ FACT Team Member
- ☐ Other _____

For a complete list of Ineligible Populations please see Page 2 of the FCA Disenrollment Process found on the FCA website under the Provider button

☐ Member does not comply with plan of care (Please include documentation of non-compliance)
- ☐ Excessively misses appointments (Please include documentation of missed appointments)
- ☐ Non-Compliant with plan of care from Physician (Please include documentation of non-compliance)

PCP is requesting member to be transferred to another clinic
YES ☐ NO ☐

☐ Other Insurance is Primary
Third Party Insurance Company Name:_____
Third Party Insurance Phone Number: _____
Third Party Insurance Policy Number: _____
Policy Holder's Name: _____
Coverage Effective Date: _____
(Please include proof of other insurance – Medifax or copy of ID card)

Person who is completing this form: _____
Phone number: _____ Date completed: _____
Clinic or Office Location: _____

FOR FCA OFFICE USE ONLY:

Date added to AHCA disenrollment report: _____

Date letter sent to Member: _____ Date PCP Transfer letter sent to Member: _____

Disenrolled as of: _____

******** High Priority ********

Service Alert Notification

Subject: FCA Authorization Process for Incomplete or Missing Information

Date: August 3, 2010

First Coast Advantage (FCA) has revised the pre-authorization form due to the large volume of incomplete preauthorization requests received in the FCA Pre-authorization Department. Effective immediately, FCA will no longer process authorization requests that are ***incomplete***.

*An **Incomplete*** pre-authorization is defined as any request that does not contain the information needed to process the request.

Examples:

- Missing or incomplete Certificate of Medical Necessity for DME *(Durable Medical Equipment)*.
- Missing or incomplete clinical information.
- Missing ICD-9 *(Diagnoses)* and CPT *(Procedure)* codes
- Missing patient demographic information.
- Missing all required information on authorization form
- All lines on authorization form must be completed or N/A *(Not Applicable)* indicated.

Incomplete authorization requests will be handled in the following manner:

- All incomplete authorization request forms will be faxed back to the requesting provider.
- The incomplete authorization **will not** be located in the FCA Webportal.
- The date the incomplete pre-auth request was faxed back to the requesting provider and the information needed to process the request, will be added to the bottom of the preauthorization form. (See attached revised preauthorization form)
- Any incomplete pre-authorization request with be discarded. (No matter how many times it was submitted).
- **It will be the responsibility of the requesting provider to resubmit a new authorization request that includes the missing or incomplete information.**
- All timeframes for completion of an authorization will start when a completed and workable authorization request is received in the FCA Pre-Authorization Department.

Any incomplete authorization currently in the FCA Pre-Authorization Department will not be discarded. However, staff will still be required to resubmit authorization request with the incomplete or missing information.

Effective August 9, 2010, any incomplete authorization request received by FCA Pre-Authorization Department will be discarded. If you have any questions regarding this new process, you can an e-mail to the pre-authorization department at **pre.authorizations@jax.ufl.edu.**.

First Coast Advantage

This authorization satisfies the pre-authorization requirement. It does not guarantee payment
E-mail: pre.authorizations@jax.ufl.edu

PRE-AUTHORIZATION FORM

Fax to: 904-244-9744
Hospital / Inpatient Rehab Discharge Requests
Fax to: 904-244-9740

Today's Date: _____/_____/_____ New Request: ❑ Updated Request: ❑

Patient Last Name: _____ First Name: _____ DOB: ____/_____/____

Patient Address: _____ City: _____

State: _____ Zip Code: _____ Patient Home Phone: (_____) _____ Patient Work Phone: (_____) _____

Payor/Insurance (Primary): _____ Insurance ID #: _____

Payor/Insurance (Secondary): _____ Insurance ID #: _____

PCP Last Name: _____ First Name: _____ Office Name: _____

Requesting Physician Last Name: _____ First Name: _____

Office Name: _____ E-mail address: _____

Contact Phone: (____) _____Contact Fax: (____) _____ ICD 9 Code(s):_____

ICD9 Descriptions: _____

Date of Service: ____/____/____ If Pregnant-LMP: ____/____/____ EDC: ____/____/____CPT/HCPC Code(s) _____

_____ CPT/HCPC Description(s):_____

Place/Type of Service: ❑ Outpatient Office ❑ Outpatient Surgery ❑ 23 Hr Observation ❑ Inpatient Stay
❑ DME ❑ Diagnostic Procedure ❑ Home Health

NOTE: If Requesting Wheelchairs (Power); Beds; etc. Use DME Pricing Pre-Auth Form

****

THIS SECTION TO BE COMPLETED BY THE PROVIDER OR CLINICAL STAFF

REFERRING TO: (Complete areas that apply: Attach Medical information if available)

A. Provider/Physician Last Name: _____ First Name: _____

Medicaid ID #: _____ Specialist Fax: (____) _____ Specialty Type: _____

B. Reason for Pre-Authorization: ❑On FCA Pre-auth List ❑ Out of Network ❑ Other: _____

C. Brief History: Include Prior Auth and Surgery: Clinicals Attached: ❑ N ❑ Y Number of Pages: _____

_____

D. How soon does patient need to be seen? ❑ STAT Appointment. ❑ First Available: ❑ Routine:

Attending Physician Signature:_____ Physician Medicaid ID #: _____

****

THIS SECTION IS FOR FCA PRE-AUTHORIZATION DEPT USE ONLY

❑Auth Incomplete: Date Sent Back to Provider: ____/_____/____ Incomplete Submittals: ❑1st ❑2nd ❑3rd ❑4th

Incomplete Authorizations must be resubmitted with New Pre-auth Request and requested information/documentation listed below:

Documentation Needed: _____

==========

❑New: ❑Updated:

Auth #: _____ **Effective Date:** _____/_____/_____ **Exp. Date:** _____/_____/_____

Total # of Visits/Units: _____ **Other:** _____

For Billing Information, Please Call Provider Services: (866) 270-2468
Claims submissions: First Coast Advantage, P. O. Box 3620, Akron, OH 44309-3620

First Coast Advantage Pre-Authorization List

PHONE NUMBER: 904-244-3539 FAX NUMBER: 904-244-9744

Pre-Authorization Requirements	Authorization/Notification Requirements

• All out of network service (non-par First Coast Advantage Providers) includes diagnostic test, labs, x-rays, MRI, ultrasounds and PET Scans.
• All Shands/UF Gainesville services require pre-authorization.
• All Adult Dermatology, consult, evaluation and treatment.
• Proton Beam Therapy
• Abortions, Sterilizations, and Hysterectomies
• Non-emergency inpatient hospital/observation and acute rehab admissions (includes Behavioral Health and elective surgeries).
• Skilled Nursing Facility admissions.
• Plastic Surgery evaluations/consultation and surgery (cosmetic/reconstructive procedures) and related care.
• Medically Necessary Circumcision, consults, evaluation and treatment.
• Oral surgery (OMFS services)
• Outpatient Behavioral Health authorization required for all services.
• DME/Medical supplies.
  ○ Customized wheelchairs specially sized and constructed
  ○ Power wheelchairs and scooters
  ○ Substantial repairs/parts member owned medical equipment
  ○ Hospital/specialty beds
  ○ Augmentative/alternative communication devices
  ○ Oxygen related equipment and services. No authorization required for nebulizers.
  ○ Ventilator and respiratory equipment
  ○ Enteral feedings
  ○ Wound care supplies and other consumable medical supplies
• Cochlear Implant (Evaluation & Procedure)
• Hearing Aids
• Growth Hormone
• Hyperbaric oxygen therapy
• Obstetrical Care (auth required from OB for professional services, plus notification from hospital).
• Home Health Care or Infusion
• Orthotics, Prosthetics and Braces
• Transplants and related care
• Medically Necessary Circumcisions
	Hospital: (Medical & Behavioral)
	• Emergency Room visits within 24 hours or next business day.
	• Emergency inpatient admissions and observations (within 24 hours or one business day).
	
	Transportation: Verbal authorization required by **TMS** for transportation of members 60 miles or greater in one direction.
	
	Member may self-refer with no authorization to the following services, but may be limited to the number of visits indicated.
	
	Chiropractic:
	Chiropractic patients are allowed 24 visits per calendar year without authorization. Chiropractic visit 25 will be denied for benefits exhausted.
	
	Podiatry:
	Podiatry patients are allowed 24 visits per calendar year without authorization. Podiatry visit 25 will be denied for benefits exhausted.
	
	Dermatology:
	No limit
	
	Family Planning:
	No limit
	
	Note: No authorization required when Medicare is primary.

******** High Priority ********

Service Alert Notification

Subject: First Coast Advantage (FCA) Pre-Authorization Requirements For Oral Maxillofacial Surgery (OMFS)

Date: November 4, 2009

EFFECTIVE IMMEDIATELY

The following procedures should be followed for a pre-authorization request to Oral Maxillofacial Surgery (OMFS):

- When requesting prior authorization **from FCA** to OMFS, the FCA authorization form should be completed in its entirety.
  - ✓ No line should be left blank.
  - ✓ If information not required, N/A should be written on the line.
  - ✓ If the pre-authorization form is sent to FCA with a blank line it will be returned to the requesting provider.
- A pre-authorization request for OMFS with a diagnosis of dental caries and/or with extractions should include a work up by a general dentist and this documentation must be submitted to FCA along with the pre-authorization request (this includes clinicals).
- If a Dentist determines that restorative treatment is not an option and does in fact need to be seen by an Oral Surgeon a pre-authorization must be obtained **from FCA**.

Once an **FCA** pre-authorization is obtained it will be processed, if all supporting documentation is provided, within 72 hours of the request. The authorization will be posted on the FCA Webportal. If you do not have access to the FCA Webportal, you can obtain an FCA On-Line Access Status Form at www.firstcoastadvantage.com under Provider Information / Forms. The form is an interactive form and can be completed on the computer. Your password will be sent to you within 24 hours of the request.

Any MCNA pre-authorization received by OMFS for services will be returned to the requesting provider for an authorization from FCA. For questions, please contact FCA Provider Relations Coordinator, Angie Creppel, at 244-9174.

******** High Priority ********

Service Alert Notification

Subject: Guidelines for Medically Necessary Circumcision

Date: May 11, 2010

Circumcision is covered by FCA when performed at Shands Jacksonville during the first 10 days of life. After the first 10 days of life, Circumcision is covered by Medicaid only when medically necessary. The PCP must send a request for authorization to FCA. The request needs to include medical records that reflect clear documentation of medical necessity as outlined in the following Circumcision Preauthorization Criteria Guidelines. A parent guide to care of uncircumcised penis has been developed and may be used by the PCP as appropriate.

Circumcision Preauthorization Criteria Guideline

Criteria Guideline Name: Circumcision (Single Procedure for Medical Necessity)

Guideline:
Circumcision (as a single procedure) beyond the first ten days of life is a covered benefit only for those patients who demonstrate clear medical necessity and for whom the procedure has been preauthorized. Requests for a circumcision will be reviewed on a case-by-case basis during which time medical necessity will be determined.

- Interqual Criteria is used as the guideline to determine medical necessity.
- Approval of medically necessary circumcision requires documentation of a medical condition resulting from either the uncircumcised foreskin or from complications of the previous circumcision.
- Circumcisions are performed as outpatient surgery, unless specific need for inpatient status is documented in the request.

Indications for medically necessary circumcisions, adults and children (adapted from Interqual Criteria):

1. Paraphimosis: defined as painful swelling of the glans that results when a tight foreskin is retracted behind the head of the penis. This may be a medical emergency that requires a dorsal slit procedure.
2. Balanitis xerotica obliterans: defined as chronic sclerosis and atrophic process of the glans penis and prepuce of unknown etiology. Genetic factors have been implicated. Associated phimosis, if present, is characterized by white scarring and induration.
3. Phimosis: defined as narrowing of the preputial orifice leading to non-retractability of the prepuce that in rare instances may be a congenital condition, but which is more commonly associated with balanitis xerotica obliterans or balanoposthitis.

4. Non-retractile foreskin due to preputial adhesions (a normal developmental process whereby the prepuce gradually separates from the glans as epithelial cell layers become keratinized and smegma is produced) when complicated by:

    a. One or more episodes of balanitis that do not respond to:
        - Use of topical antibiotics/topical steroids
        - Teaching and practice of proper penile hygiene
        - Improved blood sugar control if diabetic
    b. Posthitis: defined as inflammation of the foreskin.
    c. Penile cellulitis
    d. Obstruction of urination (e.g., the foreskin balloons during voiding).
    e. Painful or incomplete erection.

    [Note: a non-retractile foreskin is a normal finding during development. Over the first several years of life, the prepuce gradually separates from the glans as epithelial cell layers become keratinized and smegma is produced.]

5. Non-retractile foreskin due to preputial adhesions that persist beyond the 3rd birthday despite implementation of an appropriate regimen of penile hygiene. [Providers should educate parents and caretakers of male infants who are not circumcised during the initial birth hospitalization about penile hygiene routines.]
6. Recurrent urinary tract infections where it has been documented that other urinary tract abnormalities do not coexist, using one or more of the following studies:
    - IVP – not indicated in children
    - VCUG
    - US
7. Revision of a prior circumcision due to inadequate removal of foreskin or correction of operative complication.

****

Caring for Your Son's Uncircumcised Penis

First few months:

- Clean and bathe your baby's penis with soap and water like the rest of the diaper area.
- No special cleaning with cotton swabs or special soaps is needed.
- Do not try to pull the foreskin back. The foreskin is attached to the head of the penis. Pulling the foreskin back can cause pain and bleeding.
- If stream of urine is no more than a trickle, notify the baby's doctor.
- The baby's doctor will tell you when it is safe to pull back your baby's foreskin. This will not happen for several months or years.

As your son gets older:

After the baby's doctor tells you it is safe, teach your son how to clean his penis by:

- Gently pulling the foreskin back away from the head of the penis
- Rinsing the head of the penis and inside fold of the foreskin with soap and water.
- Pulling the foreskin back over the head of the penis.

Verification

- Providers should verify eligibility using the HP web portal or the FCA On Line Status Check

- Due to the timing of the FCA enrollment files from the State the first 5-10 days of each month the verification should be done via the HP web portal

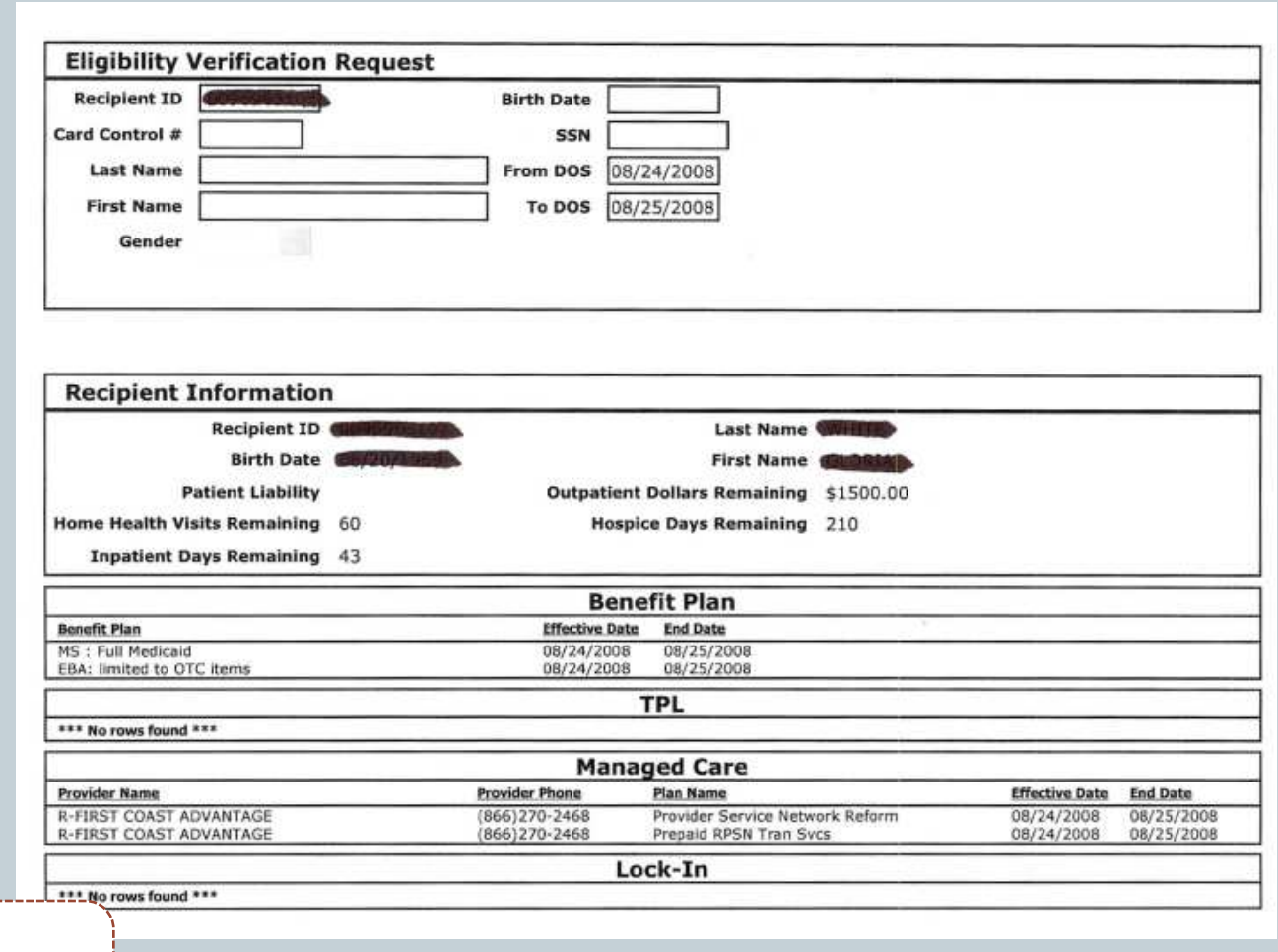
Verification

- Due to the timing of managed care enrollment cycles, there could appear to be a discrepancy between a beneficiary's Medicaid eligibility effective dates and their Managed Care plan enrollment effective dates.

- In order to confirm a beneficiary's Medicaid eligibility, please review the eligibility status effective date information located in the Benefit Plan panel.

- The beneficiary's enrollment effective date information in the Managed Care panel should not be used to determine a beneficiary's Medicaid

Example of FCA Member



Eligibility Verification Request

Recipient ID	[redacted]	Birth Date	
Card Control #		SSN	
Last Name		From DOS	08/24/2008
First Name		To DOS	08/25/2008
Gender			

Recipient Information

Recipient ID	[redacted]	Last Name	[redacted]
Birth Date	[redacted]	First Name	[redacted]
Patient Liability		Outpatient Dollars Remaining	$1500.00
Home Health Visits Remaining	60	Hospice Days Remaining	210
Inpatient Days Remaining	43		

Benefit Plan

Benefit Plan	Effective Date	End Date
MS : Full Medicaid	08/24/2008	08/25/2008
EBA: limited to OTC items	08/24/2008	08/25/2008

TPL

*** No rows found ***

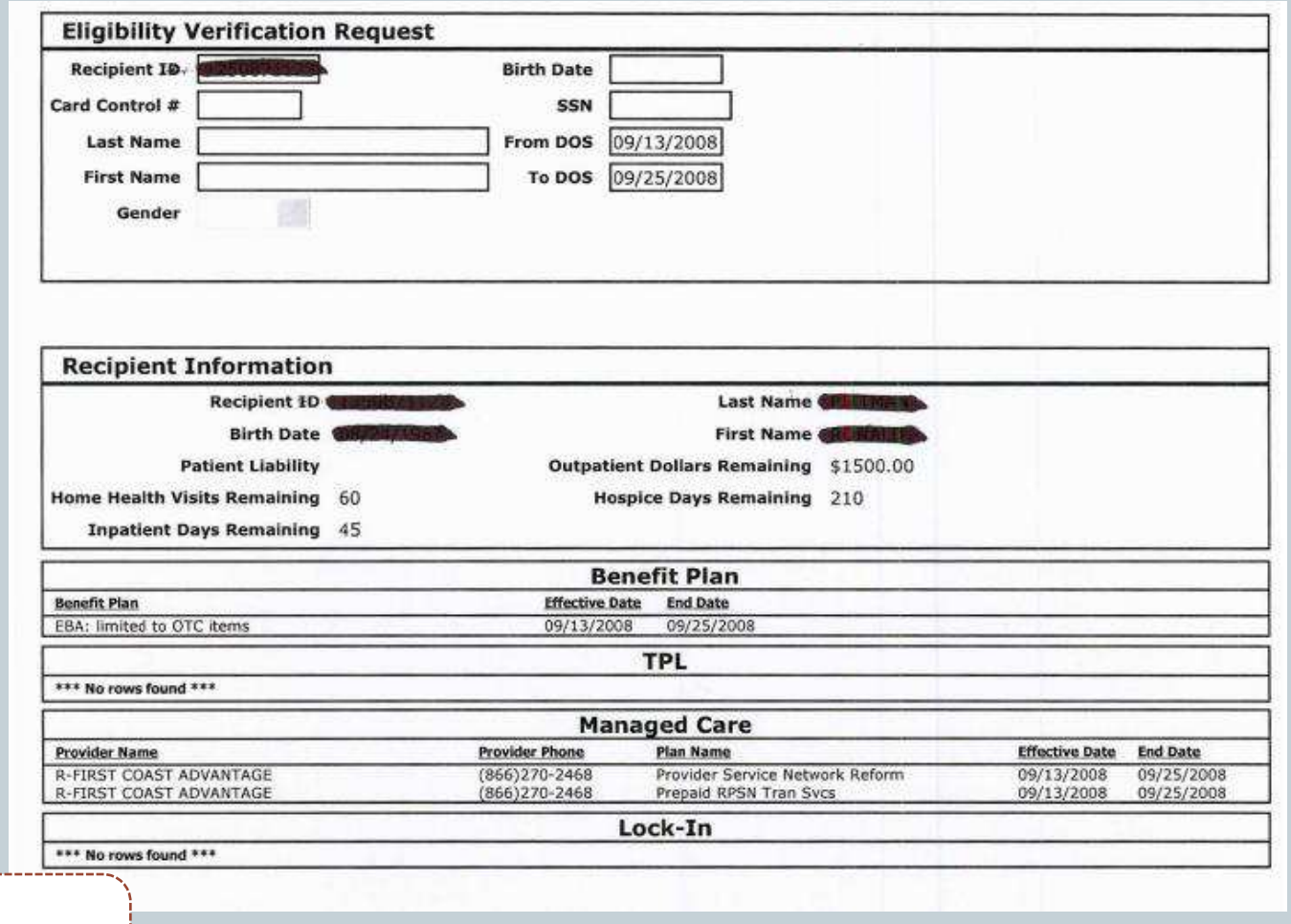
Managed Care

Provider Name	Provider Phone	Plan Name	Effective Date	End Date
R-FIRST COAST ADVANTAGE	(866)270-2468	Provider Service Network Reform	08/24/2008	08/25/2008
R-FIRST COAST ADVANTAGE	(866)270-2468	Prepaid RPSN Tran Svcs	08/24/2008	08/25/2008

Lock-In

*** No rows found ***

Example of Person Not Eligible



Eligibility Verification Request

Recipient ID	[redacted]	Birth Date	
Card Control #		SSN	
Last Name		From DOS	09/13/2008
First Name		To DOS	09/25/2008
Gender			

Recipient Information

Recipient ID	[redacted]	Last Name	[redacted]
Birth Date	[redacted]	First Name	[redacted]
Patient Liability		Outpatient Dollars Remaining	$1500.00
Home Health Visits Remaining	60	Hospice Days Remaining	210
Inpatient Days Remaining	45		

Benefit Plan

Benefit Plan	Effective Date	End Date
EBA: limited to OTC items	09/13/2008	09/25/2008

TPL

*** No rows found ***

Managed Care

Provider Name	Provider Phone	Plan Name	Effective Date	End Date
R-FIRST COAST ADVANTAGE	(866)270-2468	Provider Service Network Reform	09/13/2008	09/25/2008
R-FIRST COAST ADVANTAGE	(866)270-2468	Prepaid RPSN Tran Svcs	09/13/2008	09/25/2008

Lock-In

*** No rows found ***

UPDATE

Service Alert Notification

Subject: Florida Medicaid Timeline For NPI and 5010 Implementation

Date: August 9, 2010

Effective **January 1, 2011**, Florida Medicaid will require that all providers must obtain an NPI and include their NPI on all claims submitted to Medicaid including First Coast Advantage (FCA) claims. This will also include all claims whether submitted on paper or electronically. The Medicaid provider number will be allowed to accompany the NPI on claims; however, claims that do not contain the NPI will be denied.

The Health Insurance Portability and Affordability Act (HIPAA) of 1996 mandated the implementation of a National Provider Identifier (NPI). Most health care providers must register with the National Plan and Provider Enumeration System and receive a unique NPI. The intent of the HIPAA regulations was to require all health plans to convert their claims processing systems to use only the NPI for claims processing and reporting for providers required to obtain an NPI. Because of the complexities of this conversion by health care plans and providers, the use of the NPI has not yet been strictly enforced. However, Medicaid claims submitted on and after January 1, 2011, will have new requirements for the use of the NPI. Look for further instructions from Florida Medicaid in the near future for these new requirements.

Effective **April 1, 2011**, Florida Medicaid X12 transactions mandated by HIPAA are being modified with a new version, known as 5010. As Florida prepares to convert electronic transactions to the new version of HIPAA, further changes in the electronic claims are needed for the use of NPI for providers who must obtain an NPI.

The 5010 version of the claims transactions will no longer allow providers to include the Medicaid provider number as part of the transaction and will allow only the NPI. This affects only electronic claims. Consequently, in preparation for the 5010 implementation, Florida Medicaid will no longer accept X12 claim transactions that contain the Florida Medicaid provider number starting in April 2011. Electronic claims that contain the Medicaid provider number will be denied.

Florida Medicaid will provide further instructions in the near future on the 5010 implementation and associated changes that will be required later in 2011. If you have any questions, please contact your local Medicaid area office.

Florida Medicaid Timeline for NPI and 5010 Implementation

Timeline for NPI:

January 1, 2011

- NPI will be required on electronic transactions (837I, 837P and 837D) and paper claims for all providers who qualify for an NPI.
- The Provider Medicaid ID will still be accepted but claims without the presence of the NPI will be denied.

April 1, 2011

- Florida Medicaid will no longer accept the Provider Medicaid ID for providers who qualify for the NPI.
- Electronic claims transactions (837I, 837P and 387D) will be denied if the Provider Medicaid ID is present for providers who quality for an NPI
- Paper claims will not be affected.

Timeline for 5010:

July 1, 2011

- In order to provide a transition period to move from 4010 to 5010 electronic transactions (837I, 837P, 837D, 276/277, 277U, 270/271, 834, 820, 835); Florida Medicaid will allow both the X12 4010 and the X12 5010 versions.

- During the transition period, providers will received a 999 for 5010 claims submissions but will continue to receive a 997 response for 4010 claim submissions

January 1, 2012

- Mandated Implementation of X12 5010 version of electronic transactions.
- Florida Medicaid will no longer accept the 4010 versions.

Note: A timeline and requirements for encounter claim submissions are still in the planning stages and will be provided at a future date.

******** High Priority ********

Service Alert Notification

Subject: Effective March 1, 2010, First Coast Advantage (FCA) Paper Claims Submission Policy

Date: February 17, 2010

On January 22, 2010, The Agency for Healthcare Administration (AHCA) provided First Coast Advantage (FCA) with an Updated Paper Claims Submission Policy. This Policy includes Pricing By-Report Procedures, Medical-Surgical, Medical Necessity, and DME Procedure Code Pricing. This Paper Claims policy was being performed by EDS Medicaid's Fiscal Agent and effective March 1, 2010 this process will now be the responsibility of FCA. This process is ***not*** date of service driven. Any services that require Pre-authorization by FCA are still required. Any paper claims for inpatient or outpatient services that are submitted and fall under the below guidelines must have the appropriate documentation required for submission to FCA TPA (APEX Benefit Services).

The Paper Claims Submission Policy includes the following:

1. Paper Claims Submission Documentation Needed:
   - For items that are "By Report" or not priced, the claim submission must also include Medical-necessity documentation from Provider.
   - Provider's attainment cost and wholesale price information
   - Provider's invoice
   - FCA Provider By-Report Coding Form **(See Attachment I)**
   - Documentation stating that the item is the least costly alternative to meet the needs of the recipient or
   - Other documentation as specified in the appropriate Medicaid Handbook, as required for audit and control purposes.

2. Medical-Surgical and/or Medical Necessity Procedure Codes on the Medicaid Fee Schedule:
   - Procedure codes on the Medicaid fee schedule that do not have a price listed ($0) marked with a "B," "R," or "BR" (By Report) in the "SPEC" column of the Medicaid fee schedule require review for medical necessity and/or manual pricing.
   - HCPCS/CPT procedure codes that are identified by an "R" under the "SPEC" column of the fee schedules and/or CPT codes with modifiers 22, 24, or 59 must be reviewed for medical necessity and/or priced.
   - Once such a claim has been reviewed for medical necessity by FCA it will be submitted to the Fiscal Agent for payment.
   - ***Provider must submit the FCA Provider By-Report Coding Form (See Attachment I) for any procedure code that does not have a fee assigned. Provider also must supply a new procedure code and description with a fee assign that is most similar to the procedure being claimed for reimbursement.***
   - The fee for the procedure code that the provider has identified as the most similar to the procedure being service will be used to price the claim.
   - If a claim is denied for not meeting Medical Necessity, a denial letter will be sent to provider from FCA.

3. Durable Medical Equipment (DME) and Medical Supply Services:
   - Durable Medical Equipment (DME) and Medical Supply Services Coverage and Limitations Handbook (effective date 10-01-2008) discuss non-classified Medical Supply procedure codes and required pricing methodology.
     - The current process for DME procedure pricing does not change.
     - DME Providers need to continue to provide attainment cost and wholesale price information and any other required documentation for DME pricing.
     - Additional DME Procedure Codes that require prior authorization and/or pricing. **(See Attachment II)**

   - The following methodology will be used to price a **Medical Supply** with a **Non-Classified** procedure code and the provider will be reimburse for the lesser of the three methods:
     - The manufacturer's wholesale price plus fifteen percent (15%), includes fitting fee, freight, delivery, etc.
     - The provider's attainment cost (less manufacturer discounts, shipping and handling) plus fifteen percent (15%).
     - The provider's usual and customary fee.
     - For dates of service prior to 10/01/2008, the Medicaid pricing methodology reimbursed providers at the rate of ten percent (10%) above the provider's verified attainment cost.
     - Effective 10/01/2008, the Medicaid pricing methodology began reimbursing providers at the rate of fifteen percent (15%) above the provider's verified attainment cost.
     - Depending on the date of service for the service provided, FCA is responsible for pricing accordingly.
     - Enteral formulas that do not have prices listed on the DME fee schedule must be submitted to FCA TPA (APEX) to send directly to the Medicaid fiscal agent for pricing along with the invoice and documentation specified in the DME Coverage and Limitations Handbook.

If a provider fails to follow the outlined paper claims process for submission, By-Report Procedure, Medical Surgical and Medical Necessity procedure codes or DME pricing, the claim will be denied and the provider has the option of filing an appeal and providing the appropriate documentation outlined above.

FCA Appeals process can be found on the FCA Website at www.firstcoastadvantage.com under **Provider Information** / **Claims Information** and in the FCA Provider Manual under **Section 20 Claims**. This Service Alert is also posted on the FCA website under Service Alert. For question on this paper claims process call FCA Provider Services at 1-866-270-2468.

ATTACHMENT I
PROVIDER BY-REPORT CODING FORM

Form to be submitted by Provider for First Coast Advantage (FCA) Members where the CPT code requires pricing. Provider need to provide CPT/HCPC codes that is most similar to the procedure code being claim for reimbursement.

****

MEMBER INFORMATION

Date: _____

Member Last Name:_____ Member First Name:_____

Member Medicaid ID #:_____ Member Date of Birth:_____ / _____ /_____

REQUESTING PROVIDER INFORMATION

Provider Last Name: _____ Provider First Name: _____

Provider Medicaid ID #:_____ Provider NPI #: _____

Provider Location: _____

****

SERVICE INFORMATION

1st By-Report Procedure: _____
Diagnosis Code: _____Description: _____

CPT/HCPC Code: _____Description: _____

2nd By-Report Procedure: _____
Diagnosis Code: _____Description: _____

CPT/HCPC Code: _____Description: _____

****

CONTACT INFORMATION

FORM COMPLETED BY:
First Name: _____ Last Name: _____ Phone Number (____) _____

Title: _____

**********FOR OFFICE USE ONLY**********

FCA STAFF
First Name _____ Last Name: _____ Date: _____

Attachment II

PROCEDURE CODES THAT REQUIRE PRIOR AUTHORIZATION AND/ OR PRICING

Procedure Code	Description
A4421	OSTOMY SUPPLY; MISCELLANEOUS
A5507	FOR DIABETICS ONLY, NOT OTHERWISE SPECIFIED MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE, PER SHOE
A9900	MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT
E0485	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE
E1065	POWER ATTACHMENT (TO CONVERT ANY WHEELCHAIR TO MOTORIZED WHEELCHAIR, E.G., SOLO
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS
E1902	COMMUNICATION BOARD, NON-ELECTRONIC AUGMENTATIVE OR ALTERNATIVE COMMUNICATION DEVICE
E2500	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, LESS THAN OR EQUAL TO 8 MINUTES RECORDING TIME
E2502	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, GREATER THAN 8 MINUTES BUT LESS THAN OR EQUAL TO 20 MINUTES RECORDING TIME
E2504	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, GREATER THAN 20 MINUTES BUT LESS THAN OR EQUAL TO 40 MINUTES RECORDING TIME
E2506	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, GREATER THAN 40 MINUTES RECORDING TIME
E2508	SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, REQUIRING MESSAGE FORMULATION BY SPELLING AND ACCESS BY PHYSICAL CONTACT WITH DEVICE
E2510	SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, PERMITTING MULTIPLE METHODS OF MESSAGE FORMULATION AND MULTIPLE METHODS OF DEVICE ACCESS
E2511	SPEECH GENERATING SOFTWARE PROGRAM, FOR PERSONAL COMPUTER OR PERSONAL DIGITAL ASSISTANT
E2512	ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM
E2599	ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED
J7699	NOC DRUGS, INHALATION SOLUTION ADMINISTERED THROUGH DME
K0009	OTHER MANUAL WHEELCHAIR/BASE
K0014	OTHER MOTORIZED/POWER WHEELCHAIR BASE
K0108	WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED
L0999	ADDITION TO SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED
L1499	SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED
L2999	LOWER EXTREMITY ORTHOSES, NOT OTHERWISE SPECIFIED
L3257	ORTHOPEDIC FOOTWEAR, ADDITIONAL CHARGE FOR SPLIT SIZE
L3649	ORTHOPEDIC SHOE, MODIFICATION, ADDITION OR TRANSFER, NOT OTHERWISE SPECIFIED
L3999	UPPER LIMB ORTHOSIS, NOT OTHERWISE SPECIFIED
L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L5999	LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED
L6703	TERMINAL DEVICE, PASSIVE HAND/MITT, ANY MATERIAL, ANY SIZE
L6706	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED
L6707	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED
L6708	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE
L6709	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE
L6882	MICROPROCESSOR CONTROL FEATURE, ADDITION TO UPPER LIMB PROSTHETIC TERMINAL DEVICE
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT

L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT
L7499	UPPER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED
L7510	REPAIR OF PROSTHETIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L7520	REPAIR PROSTHETIC DEVICE, LABOR COMPONENT, PER 15 MINUTES
L8499	UNLISTED PROCEDURE FOR MISCELLANEOUS PROSTHETIC SERVICES
L8615	HEADSET / HEADPIECE FOR USE WITH COCHLEAR IMPLANT DEVICE
L8617	TRANSMITTER COIL FOR USE WITH COCHLEAR IMPLANT DEVICE
L8618	TRANSMITTER CABLE FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT
L8619	COCHLEAR IMPLANT EXTERNAL SPEECH PROCESSOR, REPLACEMENT
L8621	ZINC AIR BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT, EACH
L8623	LITHIUM ION BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE SPEECH PROCESSOR, OTHER THAN EAR LEVEL, REPLACEMENT, EACH
L8624	LITHIUM ION BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE SPEECH PROCESSOR, EAR LEVEL, REPLACEMENT, EACH
L8690	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS
L8691	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, REPLACEMENT
L8699	PROSTHETIC IMPLANT, NOT OTHERWISE SPECIFIED
S2411	FETOSCOPIC LASER THERAPY FOR TREATMENT OF TWIN-TO-TWIN TRANSFUSION SYNDROME
V2799	VISION SERVICE, MISCELLANEOUS
V5299	HEARING SERVICE, MISCELLANEOUS
V5336	REPAIR/MODIFICATION OF AUGMENTATIVE COMMUNICATIVE SYSTEM OR DEVICE (EXCLUDES ADAPTIVE HEARING AID)

Attachment II

PROCEDURE CODES THAT REQUIRE PRIOR AUTHORIZATION AND/ OR PRICING

Procedure Code	Description
A4421	OSTOMY SUPPLY; MISCELLANEOUS
A5507	FOR DIABETICS ONLY, NOT OTHERWISE SPECIFIED MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE, PER SHOE
A9900	MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT
E0485	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE
E1065	POWER ATTACHMENT (TO CONVERT ANY WHEELCHAIR TO MOTORIZED WHEELCHAIR, E.G., SOLO
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS
E1902	COMMUNICATION BOARD, NON-ELECTRONIC AUGMENTATIVE OR ALTERNATIVE COMMUNICATION DEVICE
E2500	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, LESS THAN OR EQUAL TO 8 MINUTES RECORDING TIME
E2502	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, GREATER THAN 8 MINUTES BUT LESS THAN OR EQUAL TO 20 MINUTES RECORDING TIME
E2504	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, GREATER THAN 20 MINUTES BUT LESS THAN OR EQUAL TO 40 MINUTES RECORDING TIME
E2506	SPEECH GENERATING DEVICE, DIGITIZED SPEECH, USING PRE-RECORDED MESSAGES, GREATER THAN 40 MINUTES RECORDING TIME
E2508	SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, REQUIRING MESSAGE FORMULATION BY SPELLING AND ACCESS BY PHYSICAL CONTACT WITH DEVICE
E2510	SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, PERMITTING MULTIPLE METHODS OF MESSAGE FORMULATION AND MULTIPLE METHODS OF DEVICE ACCESS
E2511	SPEECH GENERATING SOFTWARE PROGRAM, FOR PERSONAL COMPUTER OR PERSONAL DIGITAL ASSISTANT
E2512	ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM
E2599	ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED
J7699	NOC DRUGS, INHALATION SOLUTION ADMINISTERED THROUGH DME
K0009	OTHER MANUAL WHEELCHAIR/BASE
K0014	OTHER MOTORIZED/POWER WHEELCHAIR BASE
K0108	WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED
L0999	ADDITION TO SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED
L1499	SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED
L2999	LOWER EXTREMITY ORTHOSES, NOT OTHERWISE SPECIFIED
L3257	ORTHOPEDIC FOOTWEAR, ADDITIONAL CHARGE FOR SPLIT SIZE
L3649	ORTHOPEDIC SHOE, MODIFICATION, ADDITION OR TRANSFER, NOT OTHERWISE SPECIFIED
L3999	UPPER LIMB ORTHOSIS, NOT OTHERWISE SPECIFIED
L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L5999	LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED
L6703	TERMINAL DEVICE, PASSIVE HAND/MITT, ANY MATERIAL, ANY SIZE
L6706	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED
L6707	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED
L6708	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE
L6709	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE
L6882	MICROPROCESSOR CONTROL FEATURE, ADDITION TO UPPER LIMB PROSTHETIC TERMINAL DEVICE
L7007	ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, ADULT

L7009	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, ADULT
L7499	UPPER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED
L7510	REPAIR OF PROSTHETIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L7520	REPAIR PROSTHETIC DEVICE, LABOR COMPONENT, PER 15 MINUTES
L8499	UNLISTED PROCEDURE FOR MISCELLANEOUS PROSTHETIC SERVICES
L8615	HEADSET / HEADPIECE FOR USE WITH COCHLEAR IMPLANT DEVICE
L8617	TRANSMITTER COIL FOR USE WITH COCHLEAR IMPLANT DEVICE
L8618	TRANSMITTER CABLE FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT
L8619	COCHLEAR IMPLANT EXTERNAL SPEECH PROCESSOR, REPLACEMENT
L8621	ZINC AIR BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE, REPLACEMENT, EACH
L8623	LITHIUM ION BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE SPEECH PROCESSOR, OTHER THAN EAR LEVEL, REPLACEMENT, EACH
L8624	LITHIUM ION BATTERY FOR USE WITH COCHLEAR IMPLANT DEVICE SPEECH PROCESSOR, EAR LEVEL, REPLACEMENT, EACH
L8690	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS
L8691	AUDITORY OSSEOINTEGRATED DEVICE, EXTERNAL SOUND PROCESSOR, REPLACEMENT
L8699	PROSTHETIC IMPLANT, NOT OTHERWISE SPECIFIED
S2411	FETOSCOPIC LASER THERAPY FOR TREATMENT OF TWIN-TO-TWIN TRANSFUSION SYNDROME
V2799	VISION SERVICE, MISCELLANEOUS
V5299	HEARING SERVICE, MISCELLANEOUS
V5336	REPAIR/MODIFICATION OF AUGMENTATIVE COMMUNICATIVE SYSTEM OR DEVICE (EXCLUDES ADAPTIVE HEARING AID)