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Florida Medicaid Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION

Continuing Medical Education Web-Based Training in ICD-10 for Providers

Centers for Medicare and Medicaid Services Web-Based Training through Medscape Education

The ICD-10 implementation date has been finalized and it is important that providers learn ICD-10 documentation requirements. The Centers for Medicare and Medicaid Services (CMS) is offering Web-Based-Training (WBT) for physicians. Providers can also earn continuing medical education (CME) credits!

CMS, through Medscape Education, has released two ICD-10 video lectures and an expert article providing practical guidance for the ICD-10 transition.

The video lectures are specifically for physicians, while the article covers more general topics for all health care providers.

CME credits are available to physicians who complete the modules, and anyone who completes them can receive a certificate of completion.

The modules are free. If you are not a member of Medscape, you will first be prompted to fill out a brief registration form.

To sign up for the FREE CMS Medscape Education Modules:

1. Go to http://www.medscape.com/
2. Click on the link for "New Users: *FREE*Registration"
3. Complete the entire form, including 5 character password and security questions
4. Once registered, you can use the links to access the modules

What's in the Videos & Article?

The videos feature Daniel J. Duvall, MD, MBA, a medical officer with the Hospital and Ambulatory Policy Group at CMS.

Description:

- Global differences between ICD-9 and ICD-10
- How ICD-10 will have different impacts on practices of different sizes
- Basic transition planning steps and resources

In the article, Joseph Nichols, MD, of Health Data Consulting, covers documentation improvements, the coder-clinician relationship, training, working with vendors and payers, search tools, and resources.

Inside This Issue:

All Providers

DME/Medical Supplies, HCBS Waiver, Pharmacy

National Health Care Observances

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A Message from Secretary Elizabeth Dudek

Dear Medicaid Provider,

Since our last issue, the Agency received 99 submissions from 14 bidders responding to the 11 regional Statewide Medicaid Managed Care (SMMC) Long-term Care Invitations to Negotiate. We are very pleased with the number of responses we received and are looking forward to choosing the best plan to serve Floridians. The Agency is hopeful the upcoming ITN for the Managed Medical Assistance program generates as much interest as the Long-term Care program did. We believe healthy competition will result in the best programs for Floridians.

While the Agency is expending a lot of effort planning and implementing the SMMC program, there are many other "hot items" also happening in Medicaid and around the Agency. For one, the date for ICD-10 implementation has been finalized and it is important that as a Medicaid provider, you learn about the documentation requirements. The Centers for Medicare and Medicaid Services (CMS) is offering Web-Based Training (WBT) for physicians on this very topic, and in fact, physicians can also earn continuing medical education (CME) credits for participating. Medscape Education is offering two ICD-10 video lectures and an expert article providing practical guidance for the transition. I encourage you to read more about this on the cover page.

The Agency continues to recognize and celebrate national health observances designed to raise public awareness about important health topics. We are very thankful for the role you play in Florida's health care system, and we encourage you to use these opportunities to educate those recipients you engage with about the importance of staying committed to health and wellness.

As always, thank you for your commitment to serving the Medicaid population.

Sincerely,

Elizabeth Dudek
Secretary

Medicaid Compliance Corner
Reduce Your Risk for Non-compliance

In previous issues of the *Medicaid Compliance Corner* we have reminded providers of their obligation to ensure that claims submitted to the Medicaid program are correct and properly reimbursed. We have shared information about compliance-related and policy training that is available on our website. We have drawn attention to specific issues of non-compliance across many provider types and have encouraged providers to incorporate compliance efforts into their day-to-day business activities, asking providers to fix issues (void/adjust claims or conduct self-audits) before they become the subject of an Agency-initiated audit.

Some providers have accepted the offer to assist them in conducting routine and ongoing self-audits of their Medicaid compliance. Those providers can rest assured, knowing that the likelihood of an Agency-initiated audit revealing non-compliances is minimal. Yet, in comparison to the number of enrolled and actively-billing Medicaid providers, the number of providers who are incorporating compliance programs isn't as high as we would have expected.

The Agency is continuing to be proactive at managing areas of potential risk and focusing investigatory efforts where they are best directed. These improved efficiencies with regard to Agency processes will increase the possibility that a provider will be the subject of an Agency-initiated Medicaid review for non-compliance. A provider who would like to reduce their risk for non-compliance should institute a compliance program.

An effective compliance program utilizes the following seven (7) basic elements:

1. Written policies, procedures, and standards of conduct which articulate the organization's commitment to compliance and implement the compliance program.
2. Designation of a compliance officer and compliance committee.
3. Effective training and education, including training on compliance to all employees, and specialized training for individual employees involved in specific risk areas.
4. Effective lines of communication between the compliance officer and the organization's employees to provide a mechanism to report compliance issues.
5. Enforcement of standards by publicizing disciplinary guidelines, articulating expectations, identifying non-compliance and providing for timely, consistent and effective enforcement.
6. Internal monitoring and auditing to identify, prioritize, focus on, and report on compliance risks.
7. Prompt responses and corrective action for detected offenses or audit findings.

The Agency has prepared a presentation titled: *Medicaid Provider Compliance Program & Provider Self-Audits,* which is available on the Florida Medicaid Provider Training e-Library under the tab for "Previous Training Materials." This presentation is intended to assist providers in preparing a compliance program.

Providers are also welcome to contact Kelly Bennett, the Medicaid Director's liaison regarding compliance matters at Kelly.Bennett@ahca.myflorida.com.

Finally, we appreciate your continued efforts to assist us by reporting suspected fraud and abuse. The Agency's Bureau of Medicaid Program Integrity accepts referrals of suspected fraud, abuse, or overpayments in the Medicaid program at 1 (888) 419-3456 or electronically on the Agency's website (see link to form below). Suspected fraud can also be reported to the Office of the Attorney General toll-free at 1 (866) 966-7226.

Enhanced Benefits Account (EBA) Program

The Enhanced Benefits Account (EBA) Program (also known as the Enhanced Benefits Reward$ Program) is a component of the 1115 Research and Demonstration Waiver (also known as Reform) and is an innovative program designed as an incentive to promote and reward recipients for participating in healthy behaviors.

One of the major goals of the demonstration is to increase access to care and to improve health outcomes for Medicaid recipients. The EBA Program attempts to accomplish both of those goals by offering credits to recipients who engage in healthy behaviors such as well-baby check-ups and immunizations, age-appropriate health screenings, and participation in disease management programs. When recipients make the healthy decision to receive these necessary services, they earn credits which can be used to purchase over-the-counter (OTC) health related items such as vitamins, cold medicine and first-aid supplies. These products also can assist recipients in maintaining a healthy lifestyle and improving overall health outcomes. All Medicaid recipients who enroll in a Reform health plan are automatically eligible and enrolled in the EBA program. No separate application or process is required prior to participation.

Recipients enrolled in a Reform health plan may earn up to $125.00 of credit each year. Any earned credits may be used to purchase approved health related products and supplies at any Medicaid participating pharmacy. The credit dollars earned may be carried forward each year so the recipient does not lose unused credits at the end of the year; however, as of December 2011, once a recipient loses Medicaid eligibility for three consecutive years, any earned credits are removed. Also, as of January 2012, credits are removed when there is a loss of Medicaid eligibility for one year.

Some statistical information FY 2006 – 2012 are below:

Credits Earned by Date of Service	Recipient Count	Amounts
Credits Earned Totals	499,209	$53,810,936.16
Purchases by Date of Service	**Recipient Count**	**Amounts**
Purchase Totals	277,531	$29,512,502.90

It is very important for recipients to practice healthy behaviors, and this program incentivizes those behaviors. Over the past years, the list was modified to include healthy behaviors that were crucial to reward active preventive healthy behaviors, such as healthy start screenings during the 1st trimester. Some of the top healthy behaviors are below:

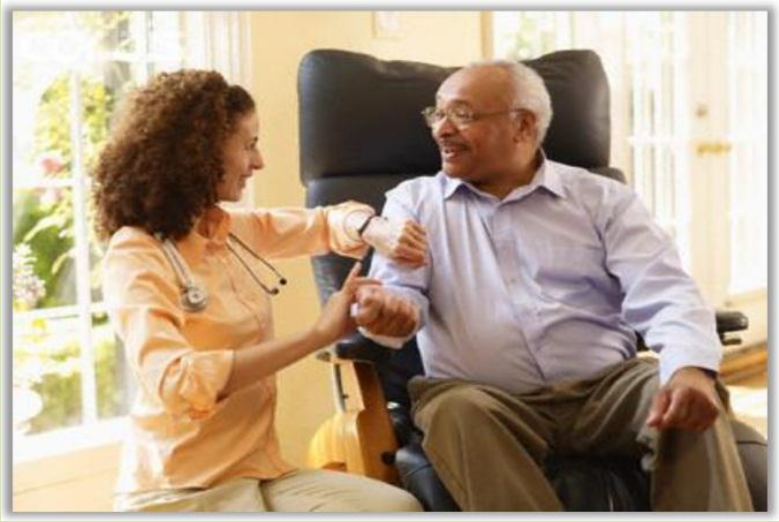
- Childhood preventive care
- Dental preventive services
- Compliance with prescribed medication
- Vision exams
- Pap smear

For more information, visit the Enhanced Benefits Reward$ Program website.

Telephonic Home Health Services Delivery Monitoring and Verification Project Expanded

The Agency for Health Care Administration expanded the *Telephonic Home Health Service Delivery Monitoring and Verification (DMV) Project* on October 1, 2012.

The purpose of the project is to ensure appropriate utilization and expenditures for Medicaid home health services, improve the quality of care for Medicaid recipients, and prevent Medicaid fraud and abuse. The DMV Project now includes monitoring of all home health services (i.e., home health visits, private duty nursing, and personal care services). The project was initially only operational in Miami-Dade County; however, during the 2012 legislative session, the Legislature directed the Agency to expand the DMV Project statewide.



The DMV Project telephonically verifies the delivery of home health services. The goals of the DMV Project are to track the time spent in the home by the nurse or home health aide providing the home health service, verify the home health services occurred as indicated on the recipient's plan of care and as prior authorized by the Agency's quality improvement organization (eQHealth Solutions, Inc.), and electronically submit claims on the provider's behalf for services that have been successfully verified. The Agency is currently contracted with Sandata Technologies, LLC to implement and manage the expansion of the DMV Project.

To learn more about the project, providers are encouraged to visit Sandata's DMV Project website at: http://www.sandatafl.com/. Providers may also contact Sandata Customer Service at (877) 818-7148.

National Health Care Observances – October

Tips to Increase Compliance with the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Policy

The Florida Medicaid program encourages all providers to review their handbooks, sign up for provider alerts, review and follow the information that is conveyed through the alerts, and take advantage of provider training opportunities. A recent training program was produced regarding the Top Findings from the Community Behavioral Health On-Site Reviews. More information about this, and other trainings, can be found at the Florida Medicaid Provider Training e-Library website.

Below you will find nine tips for Community Behavioral Health Services providers to assist them in increasing their compliance with Medicaid policy.

1. The treatment plan must contain measurable objectives.

   Try SMART Objectives that are specific, measurable, attainable, relevant and time-based.

2. The treatment plan must contain target dates.

   This is the anticipated date of completing a measurable objective. Follow policy stated on the *Florida Medicaid Community Behavioral Health Services Handbook,* page: 2-1-15.

3. The amount, frequency and duration of each service for the duration of the treatment plan are required.

   Do not combine services (e.g. individual/group therapy) when prescribing amount, frequency and duration. Also, it is not permissible to use the terms “as needed,” “prn,” or to use ranges such as “x to y times per week.”

4. Claims submitted to the Medicaid program need to be supported by a treatment plan.

   Avoid submitting claims not supported by a treatment plan due to the following:

   - not signed by treating practitioner;
   - signature not credentialed or dated; or
   - no brief assessment/evaluation by a licensed practitioner of the healing arts or a psychiatrist prior to completion of the treatment plan.

5. Services must be rendered as prescribed in the treatment plan and authorized in writing by the treating practitioner.

   When it is medically necessary, Behavioral Health Overlay Service (BHOS) and Therapeutic Group Care Service (TGCS) providers need to include therapeutic home visits in treatment plans. TGCS must identify the clinician responsible for individual and group therapy.

6. Signature of the recipient’s parent, guardian, or legal custodian (if the recipient is under the age of 18) is a required component of the treatment plan.

   If the recipient’s age or clinical condition precludes participation in the plan review and signing, a written explanation and justification of why the recipient is unable to participate must be provided in the clinical record.

Tips to Increase Compliance with the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Policy (continued)

7. Treatment demonstrates progress related to goals and objectives.

   Service documentation must contain updates regarding the recipient's progress toward meeting goals and objectives identified in the treatment plan.

8. Keep an eye on documentation requirements.

   Follow the documentation requirements stated in the *Community Behavioral Health Services Handbook,* page: 2-1-2.

9. Treating practitioners need to be linked or enrolled in Medicaid

   A group must have at least one (1) provider type 25 or 26 linked to your group in order to be a Community Behavioral Health Provider. Only provider types 25, 26, and 07 are allowed to be linked to a provider type 05 group.

Description	Provider Type
Treating physicians	25 or 26
Treating licensed practitioners of the healing arts (LPHA)	07
Licensed Practitioners of the Healing Arts (LPHA) **must also be affiliated with a group provider** (provider type 05) to be reimbursed as an individual provider type 07.	

If you have questions regarding Florida Medicaid Community Behavioral Health Services Coverage and Limitations policy, please contact your local Medicaid Area Office.

If you have any questions about Medicaid training sessions, please contact Yolanda Sacipa at Yolanda.Sacipa@ahca.myflorida.com.

Provider information and resources, including training materials to assist with compliance efforts, are available on the Agency's Medicaid website. Providers are also welcome to contact Kelly Bennett, the Medicaid Director's liaison regarding compliance matters at Kelly.Bennett@ahca.myflorida.com.

National Health Care Observances – November

New Web Portal Security Feature

In an effort to prevent scripting, BOTS, or other non-humans from accessing the secure Web Portal, a new security feature has been added when providers and agents log on to the secure Web Portal. After users log on to the secure Web Portal, before the Provider Home/Switch Provider page is displayed, a User Access Confirmation page appears requiring the user to enter the randomly generated value that is displayed. The following is a sample of the User Access Confirmation page:

The user must enter the correct text in the **Response** field in order to proceed to the secure Provider Home page or Switch Provider page, depending on how the account is setup. If the correct text is not entered, the following error message appears:

> "The response did not match the characters shown in the image. A new image has been generated."

The user can attempt to enter the text of the new (second) image. If the user enters the new text incorrectly, three more attempts may be made (for a total of five attempts). On the fifth attempt, if the text entered does not match the displayed text, the following final message appears:

> "The response did not match the characters shown in the image. No more attempts are allowed."

After the fifth failed attempt, the user must close the browser, return to the Florida Medicaid Home web page, select the Florida Web Portal link, and try again to successfully enter the correct text on the User Access Confirmation page.

The ICD-10 Planning Checklist from CMS

With the ICD-10 transition deadline set for **October 1, 2014**, providers, payers, and vendors need to focus on planning their ICD-10 transitions. Below is a checklist of essential planning activities.

The ICD-10 Planning Checklist

Whether you've already started or are just beginning your ICD-10 transition, you will need to thoughtfully plan for the transition and then communicate those strategies to internal staff and external partners. Below are a few steps to help guide your planning process:

- **Seek Resources on the ICD-10 transition.** CMS and professional and membership organizations have developed information and resources to guide you through ICD-10 implementation.
- **Establish an ICD-10 Project Team.** This team will be responsible for overseeing the ICD-10 transition, and will vary based on the size of your organization. Larger practices should have a team with representatives from different departments (e.g., executive leadership, physicians, and IT). Smaller practices may only have one or two individuals responsible for helping the practice make the switch to ICD-10.
- **Develop an ICD-10 Communication and Awareness Plan.** This plan will map out how your organization will communicate with internal staff and external partners about ICD-10 throughout the transition.
- **Revisit and Revise Your Implementation Timeline.** Since the ICD-10 compliance deadline is now October 1, 2014, your timeline for ICD-10 implementation activities will need to be updated.
- **Share Your Implementation Plans and Timelines.** Discuss the new ICD-10 compliance deadline and share your revised implementation plans and timelines with internal staff and external partners to ensure transition activities are coordinated.

Share Best Practices and Lessons Learned

Communication and collaboration will help organizations as they transition to ICD-10. As you continue planning, share lessons learned and best practices with others in your area. You can do this through organization newsletters and social media, as well as at conferences, workshops, and other educational events. Remember, ICD-10 will affect everyone currently using ICD-9 codes!

Keep Up to Date on ICD-10.

Please visit the ICD-10 website for the latest news and resources to help you prepare.

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October 4, 2012

Agency's Contractor Now Performs Utilization Management of Durable Medical Equipment (DME) and Medical Supplies

Last year, the Agency for Health Care Administration entered into a contract with a quality improvement organization (QIO), eQHealth Solutions, Inc., for utilization management of several fee-for-service Medicaid services.

On October 1, 2012, eQHealth began prior authorization of durable medical equipment (DME) and medical supplies. Providers use eQHealth's web-based system, eQSuite, to request authorization to provide services. Using the assigned eQSuite login, providers may submit requests and modification requests, access real time reports, and submit inquiries and complaints. Authorization requests must be accompanied by submission of all required documentation necessary for eQHealth to process the request and make a determination of medical necessity (as defined in Chapter 59G-1.010 (166), Florida Administrative Code).

Claims for services that require prior authorization must be submitted to the Medicaid fiscal agent with a valid authorization number that is inclusive of the date(s) of service for which reimbursement is being requested, or the claim will be denied. The DME and Medical Supply Services fee schedules indicate which services require prior authorization; the fee schedules are published on the FMMIS Web portal. Providers can help expedite the authorization review process by fully complying with the authorization process.

Please visit the eQHealth Solutions website or call eQHealth Customer Service at (855) 444-3747 for more information on the prior authorization requirements.

National Health Care Observances – December