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Florida Medicaid

Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION

International Classification of Diseases (ICD-10) Effective October 1, 2014

Health care entities are required by Federal regulations to use a standard code set to indicate diagnosis and procedure codes on claim transactions. For diagnoses, the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code set is used. For inpatient hospital procedures, the ICD-9 procedure code set (PCS) is used. **Effective October 1, 2014**, the standard code set that is required for diagnosis codes is changing to require the **ICD-10-CM** format and the standard code set that is required for inpatient hospital procedures is changing to the **ICD-10-PCS** format. The effective date for the ICD-10 conversion, published by CMS, is October 1, 2014. Other procedure code sets known as Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) used in other claims transactions are not changing.

The new ICD-10 codes will be used in clinical, administrative process, and health care systems, which necessitate changes for health care payment and reporting. Reasons for making these code set changes are numerous. For example, the practice of medicine has changed dramatically in the last several decades. Many new conditions have been discovered, treatments developed, and types of medical devices are available to patients. The ICD-9 code set does not allow for enhancements to add new diagnosis codes or to capture new and emerging health concerns. The ICD-10 code set enables more precise description of the current practice of medicine and offers the flexibility to adapt as medical practice changes. See the example below that shows how a current ICD-9 diagnosis can translate to multiple ICD-10 diagnoses:

ICD-9 Code	ICD-9 Description	ICD-10 Codes	ICD-10 Description
174.5	Malignant neoplasm of lower-outer quadrant of female breast	C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
		C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
		C50.519	Malignant neoplasm of lower-outer quadrant of unspecified female breast

Please visit the [Medicaid Provider Portal](#) for helpful information.

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For more information visit:

healthfinder.gov
Live well. Learn how.

A Message from Secretary Elizabeth Dudek

Dear Medicaid Provider,

I was fortunate to travel to many parts of the state this summer and have been very impressed by the providers I have interacted with and the facilities I have visited. Repeatedly, I was welcomed by hard-working people who are proud of what they do and the role they play in the communities they serve. I will continue to travel periodically and welcome invitations to visit your place of business to see firsthand the innovations you have enacted to create jobs, grow our economy and enhance our health care system for Floridians.

Implementation of the Long-term Care program has been in full swing since August 1, 2013. Staff from headquarters continue to travel the state to host information sessions for partners and specific provider groups that are essential to the success of this program. There has been overwhelming participation in these meetings as well as in our other provider education efforts, including the webinar series. If you are not able to attend a live webinar, I encourage you to review the presentation, which is posted on our [Statewide Medicaid Managed Care](#) website and on [Slideshare](#) or watch a recording of the webinar via our [YouTube Channel](#). Responses to the questions asked during the live webinars are also added to the (often-updated) Frequently Asked Questions document, which is also available on the [Statewide Medicaid Managed Care](#) website.

I wish each of you an enjoyable fall season; may you take the time to pause, reflect and be thankful. I am thankful for a provider community that is so dedicated to serving the Medicaid population.

Sincerely,



Elizabeth Dudek
Secretary



Medicaid Compliance Corner

Each quarter the Medicaid Director's Fraud Prevention and Compliance Unit prepares an article intended to assist providers with increasing compliance with Medicaid program rules. This article will provide you with helpful tips and information/resources to aid you in those efforts and provide general compliance awareness to Medicaid providers.

The Agency's on-going review of Medicaid providers around the state suggests a need for additional reminders to encourage providers to develop a compliance program to ensure that they are taking responsibility for compliance with all required regulations. Providers may seek guidance from the compliance recommendations issued by the Department of Health and Human Services, Office of Inspector General (HHS/OIG). The [HHS/OIG](#) website describes the seven basic elements of an effective compliance program. Also, the Agency's website (at the Medicaid fraud and abuse [quick-link](#)) includes several compliance training materials, including a video to aid providers in these efforts. Some examples of issues that providers can readily improve upon relate to compliance with record requests, ensuring provider enrollment information is up-to-date, ensuring that treating providers are eligible to participate in Medicaid, and conducting routine self-audits.

Medicaid providers are required to furnish copies of records to the Agency, the Attorney General, the Federal Government, and the authorized agents of each of these entities, as requested and as specified in governing regulations. The Agency may request records from a provider for purposes of an audit or review; the failure to furnish those records as requested will result in an administrative sanction, in accordance with the Agency's sanction rule (Rule 59G-9.070, Florida Administrative Code), which is available electronically on the [Florida Department of State, Florida Administrative Register](#) searchable website. The sanction for a first offense is a \$2,500 fine and suspension from the Medicaid program -- the fine increases if the violation continues; and if the violation continues for 30 days, the provider will be terminated from participation in Medicaid. Suspension and termination preclude participation in the Medicaid program.

Record-keeping issues continue to be a major point of provider non-compliance (from failing to document services all-together, to failing to document all of the necessary elements as required by policy); however, other issues that providers should be mindful of include whether:

- Required licenses for the goods or services being provided, as required by the state or local government, have been obtained and are readily available and properly displayed when so required;
- Records are maintained in a systematic and orderly manner and are readily available for inspection;
- If there has been a change in the provider's federal employer identification number or taxpayer identification number, or a change in the ownership, shares, membership, or controlling interest, as well as any changes of ownership as defined in the provider's licensure statute, the appropriate notice and documentation has been furnished to the Agency; a new provider enrollment application is required to be submitted at least 60 days before a change of ownership occurs;
- If a change of ownership has occurred, the records that relate to the sale or transfer of the business interest are maintained and readily available for inspection;
- Any required insurance or surety bonds are current (have not expired);
- Changes of address or telephone numbers were reported to Medicaid as soon as they occurred (note, however, that when an active Medicaid provider opens a new location, it is not necessary to fill out a new application; only a new location request form is necessary);
- Member affiliation within a group practice are current/accurate (and for individuals, whether their membership with groups is current/accurate) – providers are required to notify Medicaid when associated practitioners leave the group (group affiliation does not require an enrollment application to simply affiliate an active provider to an existing group);
- Both record-keeping and services are rendered in accordance with Medicaid policy - familiarize yourself with the Medicaid provider handbook applicable for your practice (and, keep in mind policy may be different between Medicare and Medicaid);
- Treating providers or other service providers have been involuntarily terminated from the Florida Medicaid program. Section 409.913(25)(b), Florida Statutes, provides that the Agency may not pay for goods or services that were furnished by, supervised by, or caused to be furnished by (e.g., prescribed, ordered, authorized) a person who has been suspended or terminated from the Medicaid program or Medicare program by the Federal government or any state. If the Agency does reimburse a provider for goods or services that were furnished, supervised, ordered, authorized, or prescribed by a terminated or suspended person, the reimbursements are subject to recoupment. Providers may find information about Medicaid sanctioned providers, including providers who were sanctioned with suspension or termination, by a simple search on the Agency's website at the public record's [link](#).

Finally, Medicaid providers have an obligation to ensure that claims submitted to the Medicaid program are correct and properly reimbursed. When a provider determines that reimbursements were in excess of the amount due from the Medicaid program, the provider is obligated to return the improper amounts to the State. Providers should return the improper amounts to the Agency along with supporting information that will allow the Agency to validate the overpayment amount. The Agency refers to these self-disclosures as "self-audits." Additional information about self-audits is available at the Medicaid fraud and abuse [quick-link](#), and includes the [MPI self-audit guide](#) and a provider [self-audit example](#).

Online Provider Enrollment

Effective July 1, 2013, the Agency requires applicants seeking enrollment as a provider in Florida Medicaid to submit their application via the online Provider Enrollment Wizard. Paper applications are no longer accepted from most in-state applicants as well as those Alabama and Georgia applicants seeking enrollment in Florida Medicaid. Out-of-state providers of emergency transportation and emergency services, in-state hospitals undergoing a change of ownership, and, enrolled providers seeking to add new types of services or additional service addresses to their existing record will continue to submit paper applications until further notice.

In-state and border applicants seeking to enroll in Florida Medicaid must apply online using the [enrollment wizard](#) located on the Medicaid public portal. The wizard provides interactive guidance to the applicant which ensures an accurately completed application. This reduces processing time by limiting the chances the application will reject as incomplete. To access the wizard, applicants can go to the [Medicaid public portal](#) and select **Public Information for Providers**, then **Enrollment**.



National Health Observances - October



Provider Enrollment Screening Requirement

An applicant seeking to participate as a provider in the Medicaid program must submit a complete set of fingerprints for each person declared on an initial or renewal application, for the purpose of conducting a "Level 2" criminal history record check. This includes an FDLE (state) and FBI (national) screening. Applicants are encouraged to submit their fingerprints electronically via a LiveScan vendor. To locate a LiveScan vendor, please visit the [HQA Background Screening](#) page.

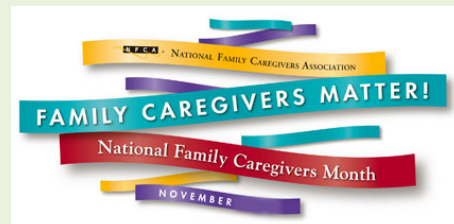
To ensure the results of the provider enrollment screening are delivered to Florida Medicaid, and not to the Agency's Division of Health Quality Assurance, be sure the LiveScan vendor uses the correct account number, or ORI, assigned to Florida Medicaid. The ORI which must be used for Medicaid provider enrollment is **FL922013Z**. Screenings submitted under any other ORI may not meet the screening requirement for Medicaid providers or may cause delays in processing.

NOTE: Persons screened for AHCA licensure after January 1, 2013, who had their picture taken at the time they submitted their fingerprints, may request the screening be reprocessed for Medicaid provider enrollment purposes on the clearinghouse website.

For more information about the background screening process for Medicaid provider enrollment, please visit the [Medicaid background screening](#) web page.



National Health Observances - November



Payment Error Rate Measurement Project (2014)

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

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

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

Consequences of Non-Response

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

Medical Record Requests

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

The collection and review of protected health information contained in individual-level medical records is permissible for payment review purposes via the Health Information Portability and Accountability Act of 1996 (HIPAA), as stated in 45 Code of Federal Regulations, parts 160 and 164:

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

Payment Error Rate Measurement Project (2014) (continued)

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

Look for additional details in upcoming Provider Bulletins regarding the 2014 PERM cycle, which has just begun for Federal fiscal year 2013-2014. Medical reviews by A+ Government Solutions will begin in the fall of 2014. We will continue to send out specific information that pertains to medical record requests by A+ Government Solutions as the information becomes available. If your claim has been selected as part of the sample, the billing and treating provider offices on the claim will be notified by a letter from the Agency. You will then need to provide medical records as requested by A+ Government Solutions.

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

Please note, if you have changed your address or telephone number and have not updated your information with the Agency, this is a good opportunity to do so, as you are required to report any changes per the Provider General Handbook (Chapter 2, Page 49):

“Providers must promptly notify Medicaid of any change of address by calling the Medicaid fiscal agent’s Provider Services Contact Center at 1-800-289-7799 and selecting Option 4.

The following four addresses may be housed on the provider file: service address, pay-to-address, mail-to or correspondence address, and home or corporate office address. To ensure accurate communication, including prompt payment for services rendered, providers must report address changes.”

Please continually check the [Web Portal](#) for Provider General Rule and Handbook updates for upcoming changes on how to report a change of address.

If you have updated or need to assign a delegated custodian of records, this is a perfect time to make note of this change as well. Please notify the Medicaid fiscal agent of any changes when updating your address change information. If closing out a former custodian, list the individual’s name and the date they departed. If adding a new custodian, list the individual’s name, home address, date of birth, SSN, whether they are the financial or medical custodian, and the date they started. Background screening is required. Please view the Background Screening page under Enrollment on the Medicaid Public [Web Portal](#) for more information.

If you would like more information related to PERM and your role in this process, please visit the [CMS PERM](#) website. All documentation specific to 2014 participating states will be located under **Cycle 3**. General state provider information will be located under **Providers**.

We appreciate your continued cooperation with the Florida Medicaid program. If you have any questions, please contact Jason Ottinger, Office of Medicaid Performance, Evaluation, and Research by telephone at (850) 412-4695 or via email at Jason.Ottinger@ahca.myflorida.com.

Are You Signed Up for Florida Medicaid Health Care Alerts?

We are making it easier for you to keep up-to-date with changes in Medicaid by signing up to receive Medicaid Health Care Alerts.

Once signed up, you will receive updates on policy, billing, and news for the provider type(s) and geographic areas you select. You will control what you wish to receive and will be able to easily update your email address and preferences.

Here's how you sign up:

Go to the [Agency for Health Care website](#).

Click on **Sign Up for Medicaid Health Care Alerts** located at the bottom of the page.

On the Florida Medicaid Health Care Alerts page complete the form with your email address (required), first name and last name (optional). You can then choose to receive all areas and all messages/provider types, or as many individual provider types and areas as you wish. Once you have completed the form, click **Submit**.

*Email
First Name
Last Name

*Area
 All Areas
 Area 1
 Area 2
 Area 3
 Area 4
 Area 5

*Provider Type
 00 - All Messages/Provider Types
 01 - General Hospital
 04 - State Mental Hospital
 05 - Community Behavioral Health Services
 06 - Ambulatory Surgical Center
 07 - Mental Health Practitioner
 08 - District Schools
 09 - Skilled Nursing Unit
 10 - Skilled Nursing Facility/Nursing Home
 11 - State ICF/IDD Facility
 12 - Private ICF/IDD Facility
 13 - Swing Bed Facility

- = Required Field
Submit

A confirmation email will be sent to your mailbox to avoid fraudulent subscription requests. You must click on the link **Confirm to list: Medicaid Alerts** in the confirmation email to complete your subscription. If you do not wish to be added, do not click on the link.

You can unsubscribe or add/change email addresses at any time by clicking on the **Manage Your Subscription** link located at the bottom of any health care alert email you receive.

If you have any questions on subscribing or unsubscribing to health care alerts, please contact Medicaid_Alert@ahca.myflorida.com.

To see previous health care alerts please visit the [Provider Message Archive](#) page and follow the instructions on how to search for an alert.

National Health Observances - December

