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Florida Medicaid

Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION

ICD-10 Transition Plans

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

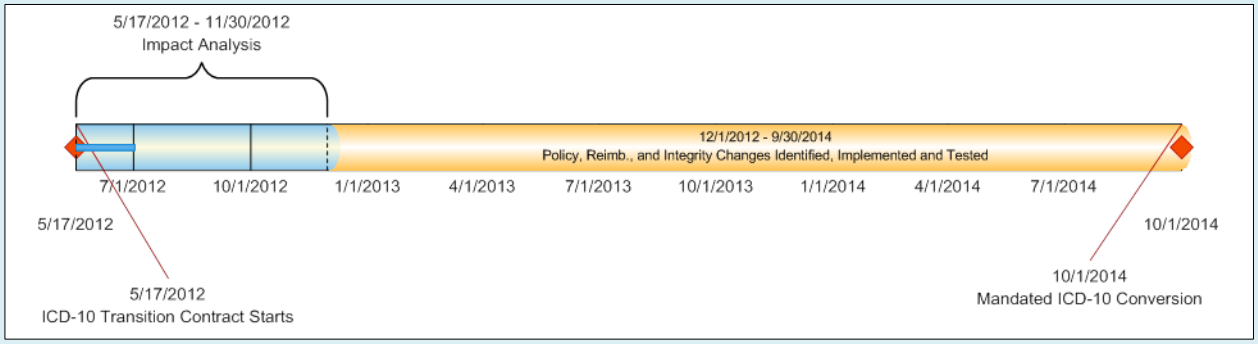
These codes are used in almost every clinical and administrative process and system, which will necessitate changes and adjustments in many areas of health care payment and reporting. Reasons for making these code set changes are irrefutable. The practice of medicine has changed dramatically in the last several decades. Many new conditions have been discovered, many new treatments developed, and many new types of medical devices have been made available to patients. The ICD-9 code set is not capable of being enhanced to add codes or to capture new and emerging health concerns. The ICD-10 code set will enable a much better description of the current practice of medicine and has the flexibility to adapt as medicine changes.

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

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

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

The plans that are being made now will follow the timeline below. CSG Government Solutions has been chosen to assist the Agency in completing the tasks and activities required for a successful transition.



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

Inside This Issue:

A Message From Secretary Elizabeth Dudek

Dear Medicaid Provider,

We are happy to inform you that the Agency is on the path toward implementing the Statewide Medicaid Managed Care program (SMMC). On June 29, 2012, our Procurement Office issued 11 Invitations to Negotiate (ITN) for Long-term Care (LTC) Managed Care services via the Department of Management Services' Vendor Bid System (VBS). This procurement process will result in the Agency selecting managed care plans to provide Long-term Care Managed Care services to Medicaid recipients in both capitated and fee-for-service structures in every region of the state. Now that the LTC procurements are moving forward, the Agency has more time to focus on the Managed Medical Assistance component.

In addition to the SMMC updates, the Agency is beginning the activities needed to prepare Florida Medicaid for the changes to the International Classification of Diseases diagnosis code set. Effective October 1, 2014, the standard code set that is required for diagnosis codes is changing from the ICD-9 to the ICD-10, which will necessitate changes and adjustments in many areas of health care payment and reporting. Read more about the ICD-10 transition on the front page.

The Agency is also preparing to expand the Comprehensive Care Management (CCM) Project and Telephonic Home Health Service Delivery Monitoring and Verification (DMV) Project that are currently implemented in Miami-Dade County. In October, both projects will be expanded statewide to counties deemed cost effective and will include all home health services (i.e., home health visits, private duty nursing, and personal care services).

We look forward to your support and input as we make these and many other positive changes to our Medicaid program. Thank you for your commitment to serving the Medicaid population.

Sincerely,

Elizabeth Dudek
Secretary

Medicaid Compliance Corner

In this edition, we want to share with you a training opportunity offered by the Florida Medicaid program on ***"Verifying Medicaid Recipient Eligibility."***

So far, we have trained over 2,500 providers and continue our efforts to reach most of our Medicaid providers in order to avoid mistakes that can lead to overpayments. We want to encourage providers not to solely rely on the Florida Medicaid Management Information System (FMMIS) to deny a claim when processing the payment for a recipient who is not eligible on the date of service. A provider must verify a recipient's eligibility for the date of service prior to rendering the service. Providers run the risk of having the payment recouped by the Florida Medicaid program if they have been overpaid.

Verifying Medicaid Recipient Eligibility is a basic training for every Medicaid provider. Attending this training will increase your understanding of the different Medicaid benefit categories and the importance of verifying Medicaid recipient eligibility each time you render services to a Medicaid recipient. The training presentation will be divided into six sections: Determination of Eligibility, Medicaid Reimbursement, Ways to Access Recipient Information, Benefit Plans and Program Codes (also known as Aid Categories), Steps Taken in Order to Verify Eligibility and Summary and Resources. Medicaid offers monthly training sessions and will communicate future training dates to providers via Florida Medicaid Health Care Alerts. If you have not already done so, please visit the Florida Medicaid Health Care Alerts web page and sign-up to receive alerts in your mail box.

The training will follow a PowerPoint presentation found at the Florida Medicaid Provider Training e-Library website. To download the presentation to view during the teleconference, please click on the **Upcoming Training and Schedules** tab. Right click on the hyperlink for the training presentation and choose **Save Target As…** and save a copy of the presentation to your computer. You may also click on the hyperlink for the training presentation and view it online. Please have a copy of the PowerPoint presentation available before the teleconference so you can follow along.

If you have any questions about the teleconferences, please contact Yolanda Sacipa at Yolanda.Sacipa@ahca.myflorida.com. If you have questions regarding Medicaid eligibility, please contact your local Medicaid area office. You can find your local Medicaid area office by visiting the Public Provider Web Portal.

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

Attesting for Meaningful Use

Providers now have the ability to attest for Meaningful Use through the Medicaid Electronic Health Record (EHR) Incentive Program. The application, which launched in June 2012, allows eligible professionals the ability to attest to the 15 core measures, the selected five menu measures and a total of six clinical quality measures. As of June 6, 2012, 3,258 eligible professionals had received payments through the EHR Program for adopting, implementing, or upgrading to certified technology. The next step, Meaningful Use, is a provider's demonstration that EHR technology is being used in a meaningful way. The American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
- The use of certified EHR technology to submit clinical quality and other measures.

Simply put, "meaningful use" means providers need to show they are using certified EHR technology in ways that can be measured significantly in both quality and quantity. By putting into action and meaningfully using an EHR system, providers will reap benefits beyond financial incentives – such as reduction in errors, availability of records and data, reminders and alerts, clinical decision support and e-prescribing/refill automation.

Upcoming Meaningful Use Events:

Event Type	Date	Time
West Palm Beach Provider Workshop	July 24, 2012	9:30 am – 11:30 am (eastern)
Miami Provider Workshop	July 25, 2012	9:30 am – 11:30 am (eastern)
Ft. Lauderdale Provider Workshop	July 26, 2012	9:30 am – 11:30 am (eastern)
Webinar	July 27, 2012	10 am – 12 noon (eastern)
Ft. Myers Provider Workshop	July 31, 2012	9:30 am – 11:30 am (eastern)
Tampa Provider Workshop	August 1, 2012	9:30 am – 11:30 am (eastern)

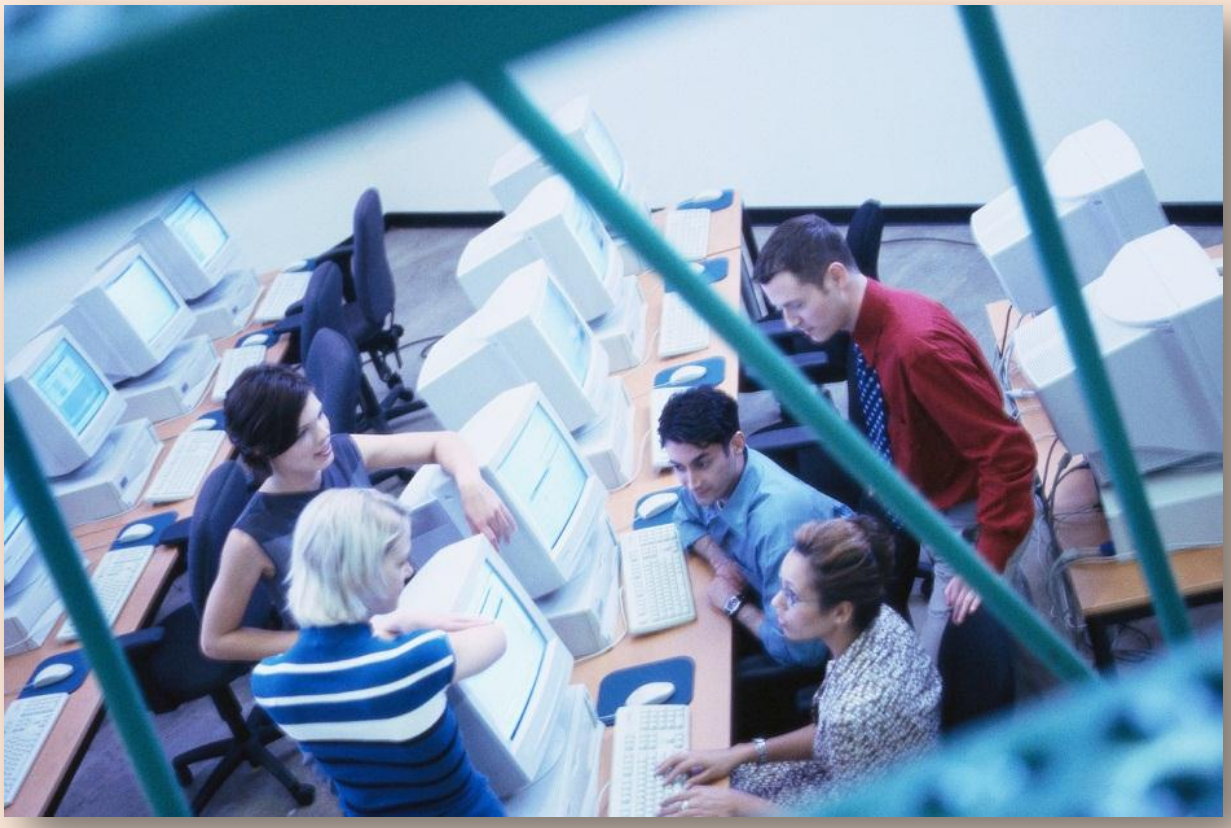
Accessing Training in the Web Portal

Confused? We can help! HP has many training resources, including opportunities to attend in-person workshops with our Provider Field Services Representatives. Training workshops are offered regularly around the state. To locate the current training schedule for your area, go to the Public Provider Web Portal and navigate to the individual page for your area office.

Can't make it to an in-person training session? HP also offers online resources providing instruction on navigating the secure Web Portal, completing and submitting claims electronically or on paper and much more. To access the online training resources, navigate to the Provider Support link on the Web Portal and click on "Training." On this page, you can download copies of the same training materials that are provided at in-person workshops.

For those who like a more hands-on approach, the Training page also contains Computer Based Training (CBT) courses which are interactive, self-paced courses that provide a walkthrough of the different types of electronic claims submission offered by HP. CBT courses are available on submitting Provider Electronic Solutions (PES) claims and submitting direct-data-entry (DDE) claims in the Web Portal.

No matter what your learning style or level of comfort with the Web Portal, you can find just the right training to make you an efficient portal user! If you need to speak to someone in person, please call our Provider Services Contact Center at 1 (800) 289-7799, Option 7.



Reminders of Critical Billing Requirements for Reimbursement of Nursing Facilities Services

Eligibility

On or after July 1, 2012, nursing facility claims will be denied with EOB 2107 when the long-term care benefit plan is not on the recipient's file for the date(s) of service billed.

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

Please note that DCF must determine ICP Medicaid eligibility even for individuals who receive Supplemental Security Income (SSI) or those who have already been determined eligible for other Medicaid benefits. The only exception to this policy is that a nursing facility may bill Medicaid for Medicare Part A coinsurances (level of care "X" claims) and Medicare B Crossover claims when the recipient is not eligible for ICP Medicaid but is eligible for Qualified Medicare Beneficiary (QMB), with or without other Medicaid coverage. Someone who is SSI and has Medicare is automatically considered to be QMB eligible.

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

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

Hospice Patients Living in Nursing Facilities Who Revoke Hospice

The Department of Children and Families must terminate eligibility for hospice services and determine eligibility for long-term care services before Medicaid may pay for nursing facility claims. On or after July 1, 2012, nursing facility claims will be denied with EOB 2107 when the long-term care benefit plan is not on the recipient's file for the date(s) of service billed.

Hospice providers must notify the Department of Children and Families within two days of a recipient revoking hospice by forwarding the original copies of the following two signed and dated forms to the local DCF Hospice Coordinator:

- Florida Medicaid Hospice Care Services Revocation or Change Statement, AHCA 5000-22; and
- AHCA 5000-23, Notice of Change in Recipient's Hospice Status.

Pre-Admission Screening and Resident Review (PASRR)

Prior to billing Medicaid, the Pre-Admission Screening and Resident Review (PASRR) process must be completed in a timely and accurate manner. Per 42 CFR 483.122(b), a nursing facility is only eligible for Medicaid reimbursement after completion of the Pre-Admission Screening (PAS) or the Resident Review (RR), as required. In addition to recoupment of payment for services, the Agency for Health Care Administration is entitled to recover investigative, legal and expert witness costs and will apply sanctions, which may include a fine, suspension or termination from the Medicaid program for violations of federal and state laws, or Medicaid policy.

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

Pre-Admission Screening (PAS) is required once in a lifetime, regardless of payor, and is typically done by hospital discharge planners as a step in the process of transferring an individual from a hospital to a nursing facility. Subsequent to the PAS, a Resident Review (RR) must be performed any time there is a significant change in the resident's condition or subsequent to the patient continuing to reside in the facility in excess of the PAS exemption period. PASRR paperwork must be maintained in the nursing facility's files, even after the recipient is discharged from the nursing facility.

Reminders of Critical Billing Requirements for Reimbursement of Nursing Facilities Services (cont.)

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

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

Patient Responsibility (PR)

Prior to billing Medicaid, the amount of patient responsibility must be documented with either a recent DCF Notice of Case Action or a print screen from the 'Provider View' feature on the Medicaid Web Portal. Click on **Secure Information for Providers** and sign in. Click on **My Account History** and then select **My Account History**. If used to document the amount of PR billed, the 'My Account History' screen must be printed within at least 6 months of the month of service. For instance, a 'My Account History' print screen for services rendered from January 1st through January 21st must be printed sometime between January 1st and July 21st. Also, periodically providers should double check the 'My Account History' screen for retroactive adjustments to the PR and adjust paid claims accordingly.

Please note that there is no patient responsibility for Medicare coinsurance claims if the recipient is a Qualified Medicare Beneficiary (QMB) with or without other Medicaid coverage. SSI recipients with Medicare are automatically considered to be QMB with other Medicaid, although you may not see QMB on FMMIS.

Where to Go for Help

Department of Children and Families (DCF)

Please work with the recipient and DCF to resolve any issues with Medicaid ICP eligibility or the amount of a recipient's patient responsibility. Nursing home providers may contact DCF by calling 1 (866) 762-2237 or emailing the facility's DCF Customer Call Center:

- Jacksonville: NFCCC_CCC@dcf.state.fl.us
- Tampa: sr_call_center@dcf.state.fl.us
- Miami: D11_SFL_CallCenter@dcf.state.fl.us

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

Please contact the CARES program for information about nursing home level of care determinations and the PASRR process. The Department of Elder Affairs website provides contact information for local CARES offices, as well as information about the PASRR.

Medicaid Area Office

The local Medicaid area offices provide information about Medicaid reimbursement policy and claims submission. You may access contact information for your local Medicaid area office on the Public Provider Web Portal.

Medicaid Fiscal Agent

Please contact the HP Call Center at 1 (800) 289-7799 for technical questions related to billing Medicaid. Information and training materials about billing Medicaid electronically are available under Electronic Data Interchange (EDI) on the Public Provider Web Portal.

Email Alerts

Florida Medicaid has an e-mail alert system to notify registered providers or interested parties of "late-breaking" health care information. You may subscribe to the automated alert system on the Florida Medicaid Health Care Alerts web page.

Training Materials

You may access training materials for billing Medicaid, Medicaid Provider Bulletins, Provider Notices, and Provider Alerts under Provider Support on the Public Provider Web Portal.

Provider Handbooks

The Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook, the Florida Medicaid Provider General Handbook, and the Florida Medicaid Provider Reimbursement Handbook UB-04 can be found under Provider Handbooks on the Public Provider Web Portal.

Licensure and Certification

Information about nursing facility licensure and Medicare certification are accessible on the Health Quality Assurance website. Click on **Licensing and Regulation**, then **Long Term Care Unit**, then **Nursing Homes**, and then select the appropriate topic. You may also contact the Bureau of Long Term Care Services for more information at (850) 412-4303.

Home Health Pilot Projects Expanding

The Agency for Health Care Administration (Agency) is preparing to expand the *Comprehensive Care Management (CCM) Project* and *Telephonic Home Health Service Delivery Monitoring and Verification (DMV) Project* that are currently implemented in Miami-Dade County.

During the 2012 legislative session, the Legislature directed the Agency to expand the CCM and DMV Pilot Projects on a statewide basis, or in counties determined to be cost-effective by the Agency. Effective October 1, 2012, both projects will be expanded statewide to counties deemed cost effective and will include all home health services (i.e., home health visits, private duty nursing and personal care services).

The purpose of the expansion 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 CCM Project will include face-to-face (recipient) assessments by a nurse licensed pursuant to Chapter 464, F.S., consultation with ordering physicians to substantiate medical necessity for services, and on-site or desk reviews of recipients' medical records. The Agency is currently contracted with eQHealth Solutions, Inc., to implement and manage the expansion of the CCM Project.

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 indicted on the recipient's plan of care and as prior authorized by the Agency's peer review contractor, 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 facilitate an efficient and smooth transition, outreach and training sessions will be scheduled prior to implementation. The Agency will continue to provide periodic updates throughout the implementation process via Health Care Provider Alerts and letters.

Child Health Check-Up (CHCUP)

Early Periodic Screening, Diagnosis and Treatment AND…….

As licensed health care professionals, you understand the importance of preventive care. The Child Health Check-Up (CHCUP) program includes comprehensive physical exams, developmental assessments and anticipatory guidance. You can find more information about this program in the Child Health Check-Up Coverage and Limitations Handbook.

Fluoride Varnish

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

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

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

Dental Referrals

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

Blood Lead Testing

Performing a blood test for lead is a federal requirement at specific intervals during the CHCUP. This note is to remind you how important it is to document the blood tests you are performing. Failure to provide documentation can lead to a federal audit and the requirement to repay Medicaid for fees received. The federal regulation as referenced in the Child Health Check-Up Coverage and Limitations Handbook, October 2003, pages 2-13 and 2-14, and 3-6, requires that all Medicaid children receive a screening blood lead test at the ages of 12 months and 24 months, and between the ages of 36 months and 72 months if they have not been previously screened for lead poisoning. The procedure code for blood lead testing is 83655. You can find more information about this program in the Child Health Check-Up Coverage and Limitations Handbook.