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# Florida Medicaid

# Provider Bulletin

AGENCY FOR HEALTH CARE ADMINISTRATION

## A Message from Secretary Justin M. Senior

Dear Medicaid Provider:

I am honored to announce that since our last bulletin, Governor Scott has asked me to remove my interim label and continue as Secretary of the Agency. I am also excited to announce that Beth Kidder will be staying on as Florida Medicaid Director. Beth has incredible knowledge of the Medicaid program, and we both are looking forward to working with everyone involved in ensuring quality health care for all Floridians.

As you know, since transitioning to our Statewide Medicaid Managed Care program (SMMC), Floridians have enjoyed an increasingly higher quality of health care and are more satisfied with the services that they receive. The Agency is now entering into the re-procurement process for the program for the first time since it began in 2013. As we move through the process, the Agency's goal is to be as transparent as possible by making information publicly available and engaging with stakeholders. I am excited for the future of the SMMC program as we strive to continue to provide terrific health care for Floridians.

As always, thank you for your continued commitment to serving Florida's Medicaid population.



Justin M. Senior  
Secretary

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## AHCA's New Office of Fair Hearings

Beginning March 1, 2017, most Medicaid Fair Hearing requests must be filed with the Agency for Health Care Administration (AHCA or Agency). When requesting a Medicaid Fair Hearing the notice of hearing rights provides important instructions specifying whether AHCA or the Department of Children and Families (DCF) is responsible for providing a Medicaid Fair Hearing

Notices of Medicaid Fair Hearing rights issued prior to March 1, 2017, identify DCF as the Agency responsible for providing a Medicaid Fair Hearing.

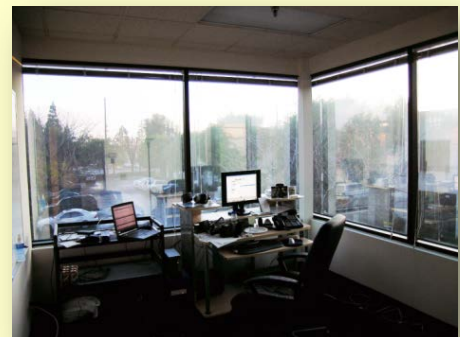
Notices of Medicaid Fair Hearing rights issued on or after March 1, 2017, identify AHCA as the agency responsible for providing a Medicaid Fair Hearing. The DCF will have limited Medicaid Fair Hearing responsibilities after March 1, 2017.

Pursuant to Section 409.285(2), F.S., Medicaid fair hearings related to Medicaid programs directly administered by the AHCA, including Medicaid fair hearings related to Florida's Statewide Medicaid Managed Care program and associated federal waivers will be heard by AHCA's Office of Fair Hearings. DCF will continue to conduct fair hearings regarding Medicaid financial eligibility, hearings pertaining to the iBudget Waiver administered by the Florida Agency for Persons with Disabilities, hearings arising from the Pre-Admission Screening and Resident Review, as mandated by the Section 1917(e)(7) of the Social Security Act and Title 42, CFR, Sections 483.100 through 483.138, Subpart C., and hearings resulting from resident transfers or discharges as those terms are defined in Section 400.0255, F.S.

### **Requesting a Medicaid Fair Hearing from AHCA:**

Requesting a Medicaid Fair Hearing from AHCA will utilize AHCA's new fair hearing **intake process**. A Medicaid Fair Hearing may be requested from AHCA's Medicaid Hearing Unit by contacting:

Agency for Health Care Administration  
Medicaid Hearing Unit  
P.O. Box 60127  
Ft. Myers, FL 33906  
Telephone: (877) 254-1055 (toll-free)  
Fax: (239) 338-2642  
E-mail: [MedicaidHearingUnit@ahca.myflorida.com](mailto:MedicaidHearingUnit@ahca.myflorida.com)



### **Obtaining Information from AHCA Regarding a Medicaid Fair Hearing Request:**

AHCA's Office of Fair Hearings (OFH or Office), is responsible for acknowledging Medicaid Fair Hearing requests filed with AHCA. The Office will assign a Hearing Officer who will schedule a hearing, or take other appropriate action, on the hearing request pursuant to Rule 59G-1.100, F.A.C. Contact information for the AHCA Office of Fair Hearings is:

Agency of Health Care Administration  
Office of Fair Hearings  
2727 Mahan Drive, MS #11  
Tallahassee, Florida 32308  
E-mail: [OfficeOfFairHearings@ahca.myflorida.com](mailto:OfficeOfFairHearings@ahca.myflorida.com)

# Medicaid Provider Enrollment Guidance

## Legal Name & Tax Identification Number (TIN) Requirements

Providers are required to submit their legal name and TIN when enrolling with Florida Medicaid.

Providers who are unsure of the legal name and TIN to enter on their Medicaid provider enrollment application should check their most recent Internal Revenue Service (IRS) tax return. The legal name and TIN entered on the application must match the legal name and TIN on the IRS tax return.

Florida Medicaid compares provider names and TINs to IRS records and is required to withhold payments from those providers when the IRS notifies the program of mismatches between provider names and TINs and IRS records.

Providers should review the name and TIN on their provider enrollment record periodically and submit change requests to update the information as needed.

Name and TIN change requests require submission of an IRS Form W-9 to Florida Medicaid. When completing the form, enter the Medicaid Provider ID as the Account Number on Line 7. FAX the completed form to Medicaid Provider Enrollment at 866-270-1497.

If you have any questions regarding provider applications or file updates, please call the Provider Enrollment Call Center at 1-800-289-7799, Option 4.

Federal regulatory provisions regarding disclosure of ownership and control interests, including TINs, to Florida Medicaid are at Part 455, Subpart B (§§ 455.100 through 455.106).

In addition, the Privacy Act of 1974 requires the Agency for Health Care Administration inform providers and other entities of the following information.

### **Privacy Act Notice**

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.



## AHCA Announces Start of Re-Procurement Process for Statewide Medicaid Managed Care Program

The Agency is in the process of developing the invitation to negotiate to re-procure health plans for the Statewide Medicaid Managed Care (SMMC) program. This will be the first re-procurement since the program began in 2013, and the Agency's goal is to be as transparent as possible by making information publicly available and engaging with stakeholders, including Medicaid providers.

Information about the re-procurement will be distributed through multiple platforms including posting information on the SMMC website which can be accessed through the following link:

[http://ahca.myflorida.com/Medicaid/statewide\\_mc/index.shtml](http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml)

Interested parties can also sign up to receive SMMC related alerts through our website:

[http://ahca.myflorida.com/medicaid/statewide\\_mc/signupform.html](http://ahca.myflorida.com/medicaid/statewide_mc/signupform.html)



# Medicaid Grievance and Appeal Process

All Statewide Medicaid Managed Care (SMMC) health plans must have a grievance and appeal system for handling enrollee complaints, grievances, and appeals. In 2016, the Centers for Medicare & Medicaid Services published a final rule on Medicaid managed care that changed some of the requirements around the grievance and appeal system. Also in 2016, the Florida Legislature passed a law to designate responsibility to the Agency for Health Care Administration (Agency) for conducting Medicaid fair hearings for services administered by the Agency. This article will briefly describe important changes to the grievance, appeals, and fair hearings process for health plan enrollees.

Beginning on or after **March 1, 2017**, requests for a Medicaid fair hearing must be sent to:

- The Agency's Medicaid Hearing Unit for Medicaid services covered by the health plan or directly administered by the Agency.
- The Department of Children and Families, Office of Fair Hearings for iBudget waiver services, Medicaid financial eligibility determinations made by DCF, fair hearings arising out of the Pre-admission Screening and Resident Review (PASRR), all fair hearings resulting from resident transfers or discharges from nursing facilities or related health care facilities.

Other aspects of the grievance and appeal process are also changing. Here are some key concepts.

When an enrollee tells the health plan verbally or in writing that he or she is dissatisfied about any matter (other than a service denial, suspension, reduction, or termination), this is called a **complaint**. The health plan must resolve a complaint within one business day, or the complaint becomes a **grievance**.

If a grievance is not resolved within 90 days, the grievance becomes an adverse benefit determination. An **adverse benefit determination** also occurs when the health plan has denied, reduced, suspended, or terminated a service. The health plan must send the enrollee a letter, called a **notice of adverse benefit determination**, to tell the enrollee what the health plan decided and why. The letter must give directions on how the enrollee may ask for a plan appeal.

When an enrollee asks for a **plan appeal**, he or she is disagreeing with the health plan's adverse benefit determination. The enrollee has 60 days after the plan's adverse benefit determination to ask for a plan appeal. The health plan then has 30 days from the date of the enrollee's request to make a final decision. Sometimes, waiting for 30 days may be harmful to the enrollee. In such cases, the enrollee can ask for a "fast" appeal, called an **expedited plan appeal**. The health plan has 72 hours to respond to the enrollee's request for an expedited plan appeal.

When the health plan reviews a plan appeal, a different person at the health plan has to review the information and make a decision. The health plan must send a letter to the enrollee what the health plan decided about the plan appeal and why. The letter is called a **notice of plan appeal resolution**. If the plan upholds any part of its decision, the enrollee may ask for a Medicaid Fair Hearing within 120 days.

***The enrollee must complete the plan appeal process before asking for a Medicaid fair hearing.*** When the enrollee asks for a **Medicaid Fair Hearing**, an Agency hearing officer will have a hearing where both the enrollee and the health plan can talk about the health plan's decision. The enrollee may tell why they disagree with the health plan, and the health plan may tell the Agency hearing officer why they made their decision. The Agency hearing officer make a final decision on the enrollee's fair hearing in approximately 90 days.

While the plan appeal and the Medicaid Fair Hearing are occurring, the enrollee can ask to have his or her services continue. This is called **continuation of benefits**. The enrollee may have to pay for the services later if the outcome is not in his or her favor.

This article highlights only some of the changes to the grievance and appeals process. You can find more information about this process by reviewing your contracted health plan's updated Provider Handbook. Enrollees will also receive an updated Member Handbook with the new information.

# Behavior Analysis Service and Prior Authorization Implementation Dates

Behavior Analysis (BA) service is ready for implementation. Adherence to the below rule, enrollment, and prior authorization information will contribute to a smooth transition and continuity of care.

## Background

The Agency for Health Care Administration (Agency) has developed the Behavior Analysis (BA) service for Medicaid recipients under 21 years of age (herein referred to as “children”). The new service will be delivered by a specific provider type created for BA services (Provider Type 39). This new service will replace coverage of Applied Behavior Analysis (ABA) services that is currently reimbursed under the following policies: Community Behavioral Health, Early Intervention Services, and the Individual Budgeting Home and Community-Based Services Waiver. To review a copy of the Behavior Analysis coverage policy, please visit the <http://ahca.myflorida.com/medicaid/review/index.shtml>.

## Enrollment Requirements

Medicaid providers who have been furnishing ABA services to children will need to re-enroll with Florida Medicaid as a Provider Type 39 if they wish to continue to provide services. Providers who do not complete the Provider Type 39 application process prior to March 1, 2017, will not be able to be reimbursed for BA services until their application is complete. Online provider enrollment application information is located at <http://portal.flmmis.com/flpublic/default.aspx>. The enrollment presentation materials can be found on at this link: [http://portal.flmmis.com/FLPublic/Provider\\_ProviderServices/Provider\\_Training/Provider\\_Training\\_Presentations/tabId/84/Default.aspx](http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_Training/Provider_Training_Presentations/tabId/84/Default.aspx)

## Prior Authorization Requirement

In addition, Behavior Analysis services will require prior authorization through a vendor contracted with the Agency, Beacon Health Options. The Agency will activate the prior authorization requirement for Behavior Analysis assessments and services on April 3, 2017. All BA assessments and services provided on or after April 3, 2017, will require prior authorization in order to be reimbursed.



## Behavior Analysis Service and Prior Authorization Implementation Dates (continued)

While providers will not need a prior authorization number to bill for services provided between February 1, 2017, and April 3, 2017, providers will be required to submit requests for prior authorization beginning February 1, 2017. The purpose of this requirement is to enable providers to receive technical assistance from Beacon regarding the prior authorization process, ensure prior authorization requests are processed by April 3, 2017, and to ensure continuity of care.

Provider training on the prior authorization process via webinar is posted on <http://fl.beaconhealthoptions.com/provider/prv-training.html>. For information regarding the prior authorization process and webinar-based provider training contact Beacon customer service at 1-866-827-7737. Hours of Operation: 8 a.m. – 5 p.m. ET, Monday through Friday.

### Summary of Key Dates:

February 2017: Provider training on the prior authorization process for Behavior Analysis (BA) services is available by webinar on <http://fl.beaconhealthoptions.com/provider/prv-training.html>.

March 1, 2017: Applied Behavior Analysis (ABA) services will end and BA services will begin. Providers must be enrolled as Provider Type 39 with Florida Medicaid to bill for dates of service starting March 1 and providers must use the new BA billing procedure codes.

April 3, 2017: Provider Type 39 must have an approved prior authorization for dates of service starting April 3, 2017.



## Well-Child Visit and Sick Visit on the Same Date of Service

The Agency for Health Care Administration has updated its Medicaid policies to allow reimbursement for a well-child visit (Child Health Check-Up) and a sick visit on the same day, in accordance with the guidelines published in the American Medical Association Current Procedural Terminology (CPT) code book. For further information on this policy, please review the Evaluation and Management Coverage Policy on our website at <http://ahca.myflorida.com/medicaid/review/Promulgated.shtml>.

