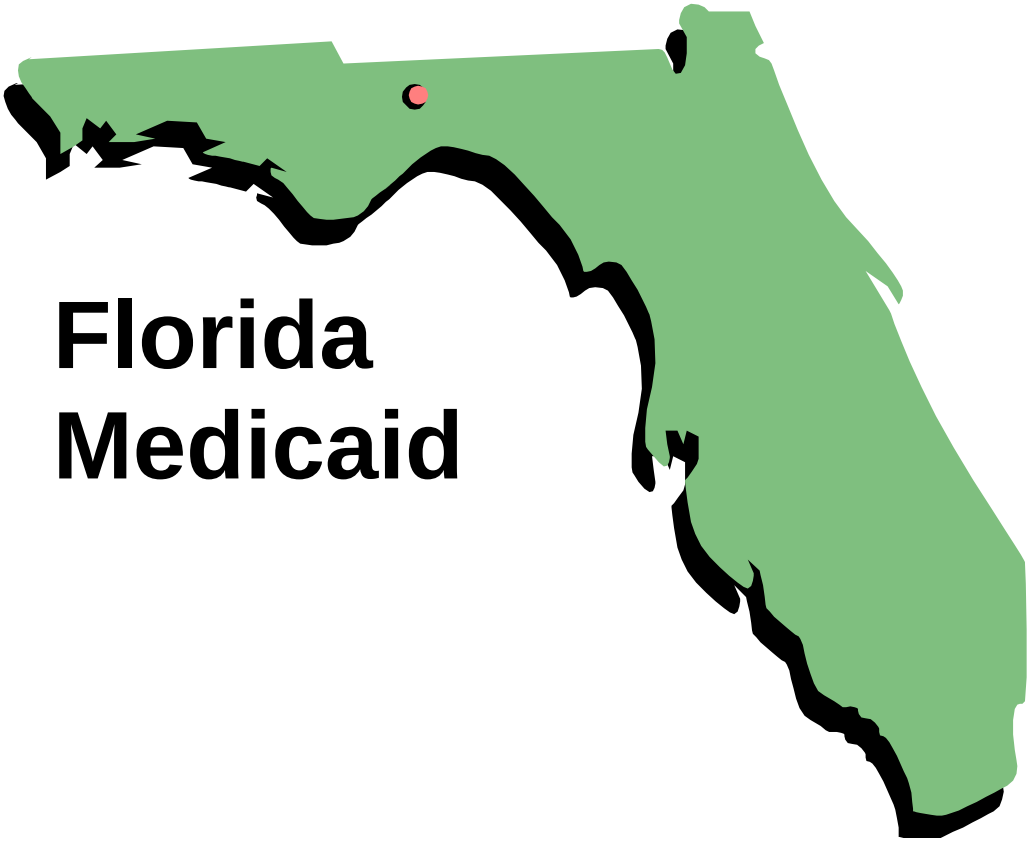

Florida Medicaid

PROVIDER GENERAL HANDBOOK

Agency for Health Care Administration

July 2012

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

UPDATE LOG
FLORIDA MEDICAID PROVIDER GENERAL HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material and if he maintains a paper copy, file it in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update describes the change that was made.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 800-289-7799.

UPDATE	EFFECTIVE DATE
New Handbook	October 2003
Replacement Page	January 2004
Revised Handbook	January 2007
Revised Handbook	July 2008
Revised Handbook	July 2012

Florida Medicaid Provider General Handbook

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Chapter 4 - Medicare Crossover Policy

Chapter 5 - Medicaid Abuse and Fraud

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- *Provider General Handbook* describes the Florida Medicaid Program.
- *Coverage and Limitations Handbooks* explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- *Reimbursement Handbooks* describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act;
- Title 42 of the Code of Federal Regulations;
- Chapter 409, Florida Statutes;
- Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	The term “recipient” is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Note	Note is used most frequently to refer the user to important material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update” and the “Effective Date.”
How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may be: 1. Replacement handbook - Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy. 2. Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.

Handbook Updates, continued

Effective Date of New Material	The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.
New Label and New Information Block	A new label and a new information block will be identified with yellow highlight to the entire section.
New Material in an Existing Information Block or Paragraph	New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence and/or paragraph affected by the change.

CHAPTER 1
THE FLORIDA MEDICAID PROGRAM

Overview

Introduction

This chapter describes the Florida Medicaid Program organization and administration; gives an overview of managed care programs; describes fee-for-service, cost-based and capitation reimbursement; gives general obligations and requirements regarding the delivery of Medicaid services; and reviews recipient copayment responsibility, third party resources, and third party liability.

Background

Medicaid is a federal and state government program that pays for medical care for people who meet specific technical, income and asset criteria. The federal government sets guidelines for services and pays part of the cost. Each state designs and operates its own Medicaid program based on federal and state guidelines.

Legal Authority

The Medicaid program is authorized by Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations. The Florida Medicaid Program is authorized by Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code, F.A.C.

The federal regulations, Florida Statutes, and the Florida Administrative Code that deal with the purpose, implementation and administration of each Medicaid service are referenced in that service's Coverage and Limitations Handbook. The Coverage and Limitations Handbooks are incorporated by reference in the Medicaid Services Rules in Chapter 59G-4, 59G-8, and 59G-13, F.A.C. They are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

In This Chapter

This chapter contains:

Overview, continued

In This Chapter, continue

Organization and Administration

State Administration

The Medicaid Program is administered in Florida by the Agency for Health Care Administration (AHCA).

The Department of Children and Families (DCF) and the Social Security Administration (SSA) determine recipient eligibility for Medicaid.

Medicaid Funding

The Florida Legislature appropriates funds to pay for Medicaid services; and by legislative authority Medicaid sets the reimbursement, coverage and limitations policies. The policies that govern Medicaid allow for the payment of a variety of medical services.

Who Pays Medicaid Claims

Medicaid contracts with a private company to pay claims. This company is called the "Medicaid fiscal agent." The fiscal agent also performs a variety of other functions for Medicaid including enrollment of providers and management of the recipient eligibility system.

Who is Eligible to Receive Services

Low income families and children and aged and disabled adults who meet specific eligibility requirements such as citizenship or resident alien status, Florida residency, and income and asset criteria can be eligible for Medicaid. All individuals who receive Supplemental Security Income (SSI) are automatically eligible for Medicaid.

Note: See Chapter 3 of this handbook for information about Medicaid recipient eligibility.

Who Can Provide Services

Only health care providers that meet the conditions of participation and eligibility requirements and are enrolled in Medicaid may provide and be reimbursed for rendering Medicaid-covered services.

Organization and Administration, continued

Free Choice of Providers

Per Title 42 of the Federal Code of Regulations Part 431.51, recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.

The exceptions to a recipient's freedom of choice of providers are as follows:

- The allowable restrictions that are specified in section 1915(a) of the Social Security Act.
- If the recipient is enrolled in a Medicaid managed care program. An exception is freedom of choice of providers for family planning services, which may not be restricted. Managed care plans are responsible for paying for family planning for their members regardless of whether the family planning provider is a plan subcontractor.

Note: See Medicaid Managed Care Programs in this chapter for additional information on choice of providers within a managed care program.

Types of Reimbursement

Fee-For-Service

Fee-for-service is a method of payment where the provider is paid a fee for each procedure performed and billed within the Medicaid policy limitations.

Global Reimbursement

Global reimbursement is a method of payment where the provider is paid one fee for a service that consists of multiple procedure codes that are rendered on the same date of service or over a span of time rather than paid individually for each procedure code.

Providers that bill for several individual procedure codes that are covered under a global procedure code, a practice called "unbundling," are subject to audit of billings and recoupment of inappropriate payments.

Cost-Based Reimbursement

Cost-based reimbursement, which is sometimes referred to as a per diem rate or an encounter rate, is based on the provider's actual costs for rendering services to Medicaid recipients. Providers who are reimbursed on a cost basis are: hospitals, county health department clinics, federally qualified health centers, hospices, intermediate care facilities for the developmentally disabled, nursing facilities, rural health clinics, and state mental hospitals.

Types of Reimbursement, continued

Capitation Reimbursement

Health maintenance organizations (HMOs) and certain other managed care providers are prepaid a fixed amount each month for each recipient (per capita) who is enrolled to receive services from that HMO or managed care provider.

Note: See Medicaid Managed Care Programs in this chapter and Managed Care Enrollment Verification in Chapter 3 for information on recipient managed care coverage.

Payment for Services

Direct Payment to Providers

Medicaid provides an eligible recipient with access to Medicaid services by direct payment to the Medicaid provider upon submission of a payable claim to the Medicaid fiscal agent. Payments for Medicaid services must be made by direct payment to the provider, except in the following circumstances:

- Payment may be made in accordance with a reassignment from the provider to a government agency or reassignment by court order.
- Payment may be made in the name of the provider to the provider's Medicaid-enrolled billing agent's address.

Note: See Billing Agent in Chapter 2 in this handbook for additional information on billing agents.

Pay-To-Provider

Pay-to-provider is a term used in the Medicaid program to refer to the enrolled Medicaid provider who receives payment from Medicaid for covered services provided to eligible recipients. The pay-to-provider can be the provider who has provided treatment to a Medicaid recipient or the provider group to which the treating provider belongs.

Note: See Chapter 2 of this handbook for more information regarding group providers.

What the Provider May Charge for Services

The provider's charges for services billed to Medicaid must not exceed the provider's lowest charge to any other third party source for the same or equivalent medical and allied care, goods, or services provided to individuals who are not Medicaid recipients.

Payment for Services, continued

Reimbursement for Services	Medicaid reimbursement for services is the lesser of the Medicaid fee or the provider's usual and customary charge, except for cost-based or capitation reimbursed providers.
Free Health Care	Medicaid will not reimburse services for Medicaid recipients if non-Medicaid recipients are provided the same services free of charge. Exceptions are: • Services provided by agencies that receive federal funds from Title V (Maternal and Child Health) of the Social Security Act; • Services provided by agencies that receive federal funds from Part B or C of the Individuals with Disabilities Education Act; or • Services provided in the primary office (or non pro bono office or service) of a provider that participates in a valid pro bono program. Examples of agencies that receive federal funds are the Department of Health, County Health Departments, and Children's Medical Services. Examples of valid pro bono programs are We Care, Volunteer Health Care Provider Program, and Project Dentists Care.
Billing for Missed Appointments	Providers may not bill recipients for missed appointments. Medicaid considers a missed appointment to be part of the provider's overall cost of doing business.
Billing for Administrative Costs	Medicaid does not reimburse providers for time spent completing and submitting claims for payment or time spent responding to an audit. Medicaid considers time spent billing or responding to an audit to be part of the provider's overall cost of doing business.
National Correct Coding Initiative	Florida Medicaid is fully compliant with the National Correct Coding Initiative mandated by Section 1903(r) of the Social Security Act, SEC. 6507, effective October 1, 2010. This promotes correct coding and helps control inappropriate payments. This mandate is enforced through the Florida Medicaid Management Information System limits that change as directed by the federal government.

Payment for Services, continued

Medicaid Payment Is Payment In Full

A provider who bills Medicaid for reimbursement of a Medicaid-covered service must accept payment from Medicaid as payment in full. This does not include Medicaid copayments and Medicaid coinsurance.

An exception is if a third party liability payment or Medicare payment exceeds the Medicaid payment so that no Medicaid payment is made, then the Medicaid copayment or coinsurance cannot be deducted. If the provider has collected the Medicaid copayment or coinsurance, he must reimburse it to the recipient.

A provider who fails to bill Medicaid correctly and in a timely manner may not bill the recipient.

A provider who bills Medicaid for reimbursement of a Medicaid-covered service may not:

- File a lien against the recipient or the recipient's parent, legal guardian or estate;
- Apply any money received from any non-Medicaid source to charges related to a claim paid by Medicaid. (This restriction is commonly referred to as the prohibition against "balance billing.");
- Bill the recipient, the recipient's relatives or any person or persons acting as the recipient's designated representative; or
- Turn a recipient's overdue account over to a collection agency, except in the situations described on the next page.

Payment for Services, continued

Billing the Recipient

After verifying that a patient is eligible for Medicaid and prior to rendering a service, a provider must inform the recipient of his responsibility for the payment of any services received that are not covered by Medicaid. The provider must discuss this with the recipient for each service and must document this discussion in writing in the recipient's medical record. Only those procedures that are not listed on the provider's Medicaid fee schedule (procedure code table) are non-covered services.

Certain Medicaid eligibility categories do not cover all Medicaid services. See Limited Coverage Categories in Chapter 3 for information on these categories. Prior to rendering a service, a recipient whose eligibility does not cover a particular service must be informed that the service will not be covered by Medicaid. Recipients who are enrolled in the Medically Needy Program must meet their share of cost and the Department of Children and Families must determine if the recipient is eligible for Medicaid on the provider's service date. See the Medically Needy Program in Chapter 3 for additional information.

Other than Medicaid copayments and Medicaid coinsurance, the provider cannot seek payment from a recipient for a compensable service for which a claim has been submitted, regardless of whether the claim has been approved, partially approved or denied except under the following circumstances:

- The recipient is not eligible to receive Medicaid services on the date of service;
- The service the recipient receives is not covered by Medicaid;
- The provider has verified that the recipient has exceeded the Medicaid coverage limitations or frequency cap. The provider must inform the recipient that he has exceeded the frequency cap for the specific service to be rendered. (An exception is for prenatal visits. Payment for prenatal care is based on a total amount for complete care. Reimbursement for the 10 or 14 visits is the maximum reimbursement for the full course of prenatal care. If additional visits are provided, payment is considered already made in full. The provider may not bill the additional visits to Medicaid or the recipient.);
- The recipient is enrolled in a Medicaid managed care program or Medipass and has been informed that the particular service has not been authorized by the recipient's managed care plan or primary care provider;
- The recipient is enrolled in managed care program and has been informed that the treating provider is not a member of the recipient's managed care network; and
- The provider has informed the recipient in advance that he does not accept Medicaid payment for the specific service to be rendered. The provider must document in the recipient's medical record that the recipient was informed and agrees to the service.

Payment for Services, continued

Contributions to a Facility

For any contribution made to a facility on behalf of a specific recipient, the facility must treat the contribution as a third party payment and deduct the contribution from Medicaid payment for the cost of the recipient's care.

If a contribution is made to a facility that is not for a specific recipient, but for the benefit of all residents, the facility does not have to report the contribution to Medicaid.

Note: See the Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook, which is incorporated by reference in 59G-4.200, F.A.C; the Florida Medicaid State Mental Health Hospital Services Coverage and Limitations Handbook, which is incorporated by reference in 59G-4.300, F.A.C.; and the Florida Medicaid ICF/DD Coverage and Limitations Handbook, which is incorporated by reference in 59G-4.170, F.A.C for additional information on contributions to a facility. The handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Non-Covered Services

The provider may bill a recipient for a service that the recipient requested and that is not reimbursable by Medicaid if it is the provider's standard policy to bill all patients for the specified service. Before rendering the service, the provider must notify the recipient that he will be billed for the service.

Copying or Transferring Records

The provider may bill the recipient for copying medical records at the recipient's request if it is the provider's standard policy to bill all patients for copying medical records, and the recipient was notified of the copying charge before the records were copied.

The provider may not bill the recipient or AHCA for copying records requested by AHCA or any other state or federal agency.

The provider may not bill a MediPass recipient, AHCA, or the new primary care provider for the transfer of the recipient's medical records to a new primary care provider, if the recipient requested and authorized the transfer in writing.

Medicaid Copayment and Coinsurance

Introduction	For certain Medicaid services, the recipient is responsible for a set copayment or coinsurance that is to be paid directly to the provider.
Copayment	A copayment is a predetermined amount of money, specified by Medicaid, that the recipient pays to a provider.
Coinsurance	A coinsurance is a predetermined percent of the Medicaid payment that the recipient pays to a provider.
Deduction Of Copayment and Coinsurance	Medicaid reimburses the provider the difference between the established Medicaid payment and the Medicaid copayment or coinsurance amount. The provider is not required to bill or collect the copayment or coinsurance; however, Medicaid deducts the copayment or coinsurance amount from the provider's Medicaid reimbursement regardless of whether or not it was paid.
Medicare Crossovers	A dually-eligible Medicare and Medicaid recipient is required to pay Medicaid copayments and coinsurance, unless the recipient is otherwise exempt. The Medicaid copayment and coinsurance applies to services that will be billed first to Medicare and then crossover to Medicaid for payment of the Medicare deductibles and coinsurances. An exception is if the Medicare payment or other third party payment exceeds the Medicaid payment so that no Medicaid payment is made, then the Medicaid copayment or coinsurance cannot be deducted. If the provider has collected the Medicaid copayment or coinsurance, he must reimburse it to the recipient. Note: See Chapter 4 in this handbook for information on Medicare crossover claims.
When Third Party Liability (TPL) or Medicare Exceeds the Medicaid Payment	When the third party liability (TPL) payment or Medicare payment exceeds the Medicaid payment so that no Medicaid payment is made, the Medicaid copayment or coinsurance cannot be deducted. If the provider has collected the Medicaid copayment or coinsurance, he must reimburse it to the recipient.
Services that Require a Copayment	The following chart lists the services that require a copayment and the copayment amounts.

Medicaid Copayment and Coinsurance, continued

Copayment Chart

SERVICES WITH COPAYMENTS	FEES
• Birth Center, per provider, per day for gynecological services	$2.00
• Chiropractor services, per provider or group provider, per day	$1.00
• Community behavioral health services, per provider, per day	$2.00
• Home health services, per provider, per day	$2.00
• Hospital inpatient admission to a hospital	$3.00
• Hospital outpatient department or clinic visit for elective or scheduled admissions, per day. (See below for the coinsurance for emergency room services.)	$3.00
• Federally qualified health center visit, per clinic, per day	$3.00
• Independent laboratory services, per provider, per day	$1.00
• Nurse practitioner services, per provider or group provider, per day	$2.00
• Optometrist services, per provider or group provider, per day	$2.00
• Physician services, per provider or group provider, per day	$2.00
• Physician assistant services, per provider or group provider, per day	$2.00
• Podiatrist services, per provider or group provider, per day	$2.00
• Portable x-ray services, per provider, per day	$1.00
• Registered Nurse First Assistant, per provider or group provider, per day	$2.00
• Rural health clinic visit, per clinic, per day	$3.00
• Non-Emergency Transportation services, each one-way trip	$1.00

Hospital Coinsurance for Emergency Room Services

Medicaid recipients using the hospital emergency room for non-emergency services are responsible for a five percent coinsurance on the first $300 of the Medicaid payment. There is zero coinsurance on the amount in excess of the first $300. All the recipient exemptions listed on the next page are applicable to the coinsurance assessment.

The five percent coinsurance is not applicable to elective or scheduled admissions to the hospital outpatient department. Recipients are responsible for a $3.00 copayment for these outpatient services.

Medicaid Copayment and Coinsurance, continued

Dental Coinsurance

Medicaid recipients are responsible for paying the provider a five percent coinsurance charge for certain specified denture services for adults.

Note: See the Florida Medicaid Dental Coverage and Limitations Handbook for the procedures that require coinsurance. The handbook is incorporated by reference in 59G-4.060, F.A.C. and is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Categories of Recipients Exempt From Copayment and Coinsurance

The following categories of recipients are not required to pay a copayment or coinsurance:

- Recipients under 21 years of age;
- Pregnant women when the services relate to the pregnancy or to any other medical condition that may complicate the pregnancy or conditions or complications of the pregnancy extending through the end of the month in which the 60-day period following termination of pregnancy ends;
- Recipients who are eligible under the Medicaid Institutional Care Program (ICP). To be exempt, ICP recipients must meet the Medicaid income and asset requirements, and be inpatients in long-term care facilities, hospitals, or other medical institutions where, as a condition of receiving services, they are required to spend all of their income for medical care costs, except for a minimum amount that is exempted for personal needs;
- Recipients who require emergency services after the sudden onset of a medical condition which if left untreated would place the recipient's health in serious jeopardy;
- Recipients receiving services or supplies related to family planning;
- Recipients who are enrolled in Medicaid health maintenance organizations (HMOs) or capitated Provider Service Networks (PSNs);
- Recipients enrolled in a Medicaid Prepaid Mental Health Plan when receiving a mental health service; and
- Recipients participating in a hospice program.

Recipients Unable To Pay

A provider cannot deny service to a recipient based solely on the recipient's inability to pay a Medicaid copayment or coinsurance amount. If the recipient is unable to pay at the time services are rendered, the provider may bill the recipient for the unpaid charge.

Note: See Provider Rights and Responsibilities in Chapter 2 for additional information on a provider's right to refuse services.

Third Party Liability

Description

Third Party Liability (TPL) is the obligation of any entity other than Medicaid or the recipient to pay all or part of the cost of the recipient's medical care. If the recipient has other coverage through a TPL source, the provider must bill the TPL source prior to billing Medicaid.

Availability of Third Party Liability (TPL) Resource Information

Providers must verify recipient eligibility prior to serving the recipient and verify third party sources prior to billing Medicaid. TPL information for each recipient is available to a provider whenever the provider verifies recipient eligibility.

Note: See Chapter 3 of this handbook for information about verifying recipient eligibility.

Note: The third party source listing is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then TPL.

Refusal of Services to Recipients

Florida Medicaid and Title 42, Code of Federal Regulations, Part, 447.20 (b), prohibit a provider from refusing to furnish a covered Medicaid service to a Medicaid recipient solely because of the presence of other insurance, including Medicare. Although providers can choose which Medicaid recipients they will serve, they cannot refuse services to recipients solely due to third party coverage.

Note: See Chapter 2, Provider Rights and Responsibilities, for information on the right to refuse service and federal anti-discrimination laws.

Responsibility For Exhausting TPL Sources

Medicaid is the payer of last resort. If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, the provider must bill the primary insurer prior to billing Medicaid.

If the amount of the third party payment meets or exceeds the Medicaid fee for the service, Medicaid will not reimburse for the service. If the third party payment amount is less than the Medicaid fee, Medicaid will reimburse the difference between the Medicaid fee and the third party payment minus any Medicaid copayment or coinsurance.

If a third party source, such as an insurance company, pays a provider who has already been paid by Medicaid, the provider must adjust or void the claim to debit the Medicaid payment.

Note: See the Medicaid Provider Reimbursement Handbook for instructions on completing claim forms that involve a TPL payment.

Note: See Chapter 4 in this handbook for information about filing Medicare crossover claims.

Third Party Liability, continued

Third Party Liability Copayments

Per 409.907, F.S., the provider must accept Medicaid payment as payment in full, and not bill or collect from the recipient any additional amount except, and only to the extent that AHCA permits or requires, copayments, coinsurance, or deductibles to be paid by the recipient for the services or goods provided.

Exceptions to Medicaid Being Payer of Last Resort

The exceptions to Medicaid being payer of last resort are as follows:

- Federal funds from the Individuals with Disabilities Education Act (I.D.E.A.), Part B or C;
- Victim's Compensation;
- Indian Health, 1905(b) of the Social Security Act; and
- Programs funded through state and county funds such as:
  - Children's Medical Services,
  - AIDS Drug Assistance program,
  - Department of Health indigent drug programs,
  - County Health Departments,
  - Substance abuse, mental health and developmental disabilities programs funded by the Department of Children and Families and Agency for Persons with Disabilities; and
  - Vocational Rehabilitation programs.

Funds from these programs may be accessed after Medicaid. A provider may bill Medicaid for a service prior to billing these programs.

TPL Prior Authorization

The provider must inquire if a service to be rendered needs approval from a third party source and obtain approval if needed. Failure to obtain required third party prior approval is not sufficient cause for Medicaid to pay the provider's claim.

Benefits Under Discounted Contracts

When the provider enters into a plan with a third party in which the provider agrees to accept as full payment an amount less than its customary charges, Medicaid will reimburse the claim only to the extent that there remains a third party patient liability under the plan, such as a copayment or deductible. The third party payment plus the Medicaid payment minus any Medicaid copayment or coinsurance cannot exceed the Medicaid maximum fee for the service.

Third Party Liability, continued

Procedures for Billing Medicaid When there is a Discount Contract

If the discount contract's allowable fee is less than Medicaid's maximum allowable fee and there remains a patient liability under the plan, use the following procedures to obtain Medicaid reimbursement:

- Compute the amount of patient responsibility (deductible, coinsurance, etc.).
- Deduct this amount from the Medicaid rate.
- Show the resulting amount as the third party payment on the claim.

If the Explanation of Benefits (EOB) from the insurance company is not itemized, prorate the discount contract's allowable, third party liability payment and the patient responsibility for each line item.

Note: See the Medicaid Provider Reimbursement Handbook for the provider's specific claim type for additional information on completing a claim when there is a Discount Contract.

Billing the Recipient for a Denied Claim

Providers may not bill a recipient when a Medicaid claim is denied due to third party liability.

TPL Denied Claims

If the third party insurer does not reimburse the provider for the service, the provider must attach to the Medicaid paper claim, a copy of the third party's explanation of benefits (EOB) that indicates the reason for the denial and submit it for processing.

Note: See the Medicaid Provider Reimbursement Handbook for instructions on completing claim forms that involve a TPL payment.

Canceled or Expired Third Party Coverage

If the provider contacts the third party insurer by phone to confirm coverage and finds that the coverage has expired or is not applicable, even though the Medicaid computer system shows the recipient is insured, the provider must request that the third party insurer send proof that the recipient's insurance has been terminated, does not exist, or does not cover the procedure. The provider must attach this proof to the Medicaid paper claim and submit it for processing to the Medicaid fiscal agent.

Third Party Liability, continued

If Proof is Not Available

If the provider has billed the third party insurer and the third party insurer refuses to send the provider an explanation of benefits (EOB) or proof that the coverage has been terminated or the service is not covered, the provider must attach a letter on official letterhead stationery to the Medicaid paper claim that details his attempts to obtain information. The provider must submit the claim with the letter attached for processing.

The letter must include:

- Recipient's name, Medicaid number, and date of service;
- Date of telephone conversation or letter to the third party;
- Name of person(s) contacted;
- Telephone number, if available, for the third party insurer;
- Patient's policy number;
- Any pertinent information obtained from the third party insurer; and
- A detailed explanation of the attempts made to obtain an EOB from the third party source.

Requesting Help

Providers who have questions concerning third party insurance can contact the Medicaid third party contractor by telephone at 877-357-3268 (FL-RECOV), fax at 866-443-5559, Web site at http://www.FLMedicaidTPLRecovery.com, email at FLMedicaidTPLRecovery@acs-inc.com, or in writing to:

ACS
Florida TPL Recovery Unit
2308 Killearn Center Blvd., Bldg A1
Tallahassee, Florida 32309

Types of Third Party Resources

TPL of A Non-custodial Absent Parent

Claims for services provided to Medicaid recipients who are covered by insurance policies maintained by a non-custodial absent parent must be billed to the applicable insurance company. If after 30 days, the provider has not received either a payment or a denial from the third party for the absent parent maintained policy, the provider should attach a written explanation certifying the above facts and submit that statement to the fiscal agent along with the claim.

Private or Public Health Insurance

Recent or present employment of the recipient, the recipient's parent, absent parent or spouse could indicate the presence of group health coverage through an employer. Even if employment has been terminated, the provider should check to see if insurance coverage continuation has been obtained.

Types of Third Party Resources, continued

Union Benefits

Recipients may be eligible for benefits provided by a union through the vested rights of the individual even though employment or membership has been terminated. Past or present membership in a union by a recipient, a recipient's parent, absent parent or spouse could indicate potential health benefits.

Veterans Administration Benefits

Military service of the recipient, the recipient's parent, absent parent, or spouse indicates the possibility of Veterans Administration (VA) benefits. VA benefits are available through TRICARE, which is a regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors.

TRICARE offers eligible beneficiaries three choices for their health care:

- TRICARE Prime - where Military Treatment Facilities (MTFs) are the principal source of health care.
- TRICARE Extra - a preferred provider option.
- TRICARE Standard - a fee-for-service option.
- TRICARE Pharmacy - a replacement policy for Medicare Part D recipients. Recipients are responsible for TRICARE Pharmacy copayments.

Medicare

Recipients who are 65 years or older and recipients who are not yet 65 years old, but receive Social Security Disability benefits and have received those benefits for 24 months or longer can have full major medical coverage through Medicare.

Recipients who are on renal dialysis for three months or longer or who have received a kidney transplant can have limited Medicare coverage because they qualify for special medical benefits.

Dually-eligible recipients (eligible for Medicaid and Medicare) may receive Medicare services from a Medicare Advantage Plan (Medicare HMO). A Medicare Advantage Plan is considered to be a TPL source. Medicaid reimburses copayments, coinsurance, or deductibles for services provided under Medicare Advantage Plans.

Dually-eligible recipients are not eligible to receive full Medicaid prescribed drug services, because they are eligible to enroll in a Medicare Part D plan to cover their prescriptions.

Note: See Chapter 4 in this handbook for information about Medicare crossover claims.

Types of Third Party Resources, continued

Organizational Benefits

National organizations often offer health and accident benefits to their members such as:

- The National Rifle Association (NRA) offers accident coverage for gun related accidents.
- The Shriners offer long-term care for certain members.
- The National Association of Foresters provides several types of benefits to its members and their families.

Auto Insurance

Florida law requires that owners of automobiles registered in Florida maintain at least Personal Injury Protection (PIP or no-fault insurance). PIP provides for basic medical coverage with additional coverage provided if a recipient has an expanded coverage policy.

If a recipient is being treated for injuries resulting from an auto accident, Medicaid will consider payment of claims related to those injuries only after the associated claim(s) has been evaluated and paid or denied by the auto insurance company.

Uninsured Motorist

This coverage applies to the insured recipient if he is injured by an uninsured motorist. If the insured's Personal Injury Protection (PIP) or expanded coverage is depleted, there are certain circumstances under which the uninsured motorist coverage will pay for medical benefits that should have been paid by the other party's insurance had there been other insurance. The recipient will need to pursue this coverage and provide proof of disposition prior to any provider submitting claims for Medicaid reimbursement.

Types of Third Party Resources, continued

Codes For Coverage Types

Insurance coverage types are assigned a numeric code for purposes of claim processing. A provider should determine if the insurance on the Medicaid file is applicable to the services being provided. The Medicaid computer system will match the coverage type to the claim and will not deny payment if the insurance would not cover the claim.

Whenever a provider verifies a recipient's Medicaid eligibility, third party liability (TPL) information will also be given to the provider in the eligibility verification response.

Note: See Chapter 3 in this handbook for information on verifying recipient eligibility.

The following is a listing of the identifying two-digit numeric code for each associated insurance coverage type:

03	BASIC SURGICAL
04	BASIC HOSPITAL/MEDICAL/SURGICAL
05	PHARMACY ADMINISTRATOR (TPA)
06	MAJOR MEDICAL
07	ACCIDENT ONLY (NON AUTO)
08	VEHICLE ALL INCLUSIVE
09	MAJOR MEDICAL WITH TPA OR NO PHARMACY
10	CANCER
11	MEDICARE SPECIAL NEED PLAN
12	MEDICARE SUPPLEMENT
13	NURSING HOME SUPPLEMENT
14	HEALTH MAINTENANCE ORGANIZATION
15	DENTAL
16	TRICARE
17	HMO WITHOUT PHARMACY
18	CONTINUOUS CARE/LIFE CARE
19	MEDICARE HMO UNLIMITED PHARMACY
20	MEDICARE HMO LIMITED PHARMACY
21	PHARMACY CARD SERVICE
22	HOSPITAL ROOM – BOARD/INDEMNITY
23	BASIC MEDICAL

Medicaid Managed Care Programs

Introduction

Most Medicaid recipients are required to obtain services through managed care. Recipients who are not required to enroll in managed care obtain services through the Medicaid providers of their choice on a "fee-for-service" basis.

Medicaid Options

Medicaid contracts with a private company, Medicaid Options, to help Medicaid recipients enroll or disenroll in the following Medicaid managed care programs:

- Medicaid Provider Access System (MediPass),
- Minority Physician Networks,
- Pediatric Emergency Room Diversion Program,
- Medicaid Health Maintenance Organizations (HMOs),
- Prepaid Dental Health Plan,
- Prepaid Mental Health Plan,
- Provider Service Networks (PSNs), and
- Children's Medical Services (CMS) Network for children with special health care needs.

Recipients who wish to receive information regarding their managed care options may call the Medicaid Options toll-free help line at 888-367-6554.

Managed Care Mandatory Assignment

Section 409.9122, F.S. mandates that Medicaid recipients must enroll with a managed care provider unless they:

- Have Medicare or other major medical third party coverage;
- Reside in a long term care facility, such as a nursing facility or ICF/DD;
- Are enrolled in hospice;
- Are enrolled in a Medicaid program with limited benefits, such as the Medically Needy Program or Family Planning Waiver Program;
- Are foster care children per 42 USC 1396u-2](a)(2)(A)(iv)-(v) of the Social Security Act; or
- Are children in subsidized adoption arrangements children per 42 USC 1396u-2(a)(2)(A)(iv)-(v) of the Social Security Act.

Eligible recipients are given 30 days from the date that Medicaid eligibility begins to select a managed care option. If recipients do not select an option within 30 days, they are automatically assigned to a managed care plan.

Medicaid Managed Care Programs, continued

12-Month Enrollment Period

Recipients who become eligible for Medicaid and enroll with a managed care plan will begin a 12-month enrollment period during which they have 90 days to try the plan. After the initial 90 days, they will remain with their plan for the next nine months, as long as they do not lose Medicaid eligibility. Only plan changes "for cause" will be allowed during these nine months. Each year thereafter, recipients will receive notification of their open enrollment period during which they can change plans for the following year.

Recipients may change primary care providers within their current plans. To change their primary care providers, recipients must contact the program in which they are enrolled (their managed care organization's member services office or their Medicaid area office, respectively).

Recipients who wish to receive information regarding their managed care options may call the Medicaid Options toll-free help line at 888-367-6554.

Exceptions to the 12-Month Enrollment Period

The following recipients are not bound to the 12-month enrollment period and are allowed to change their managed care plans at any time:

- SSI recipients under age 19;
- Foster care children;
- Children in subsidized adoption arrangements;
- Children enrolled with Children's Medical Services;
- Dually-eligible individuals (eligible for both Medicare and Medicaid); and
- American Indians.

Exclusions from Managed Care Eligibility

The following Medicaid recipients are NOT eligible to enroll in a Medicaid managed care plan:

- Recipients who reside in an intermediate care facility for the developmentally disabled (ICF/DD), nursing facility, state mental hospital, or state-operated residential program;
- Recipients who are under the age of 21 and are enrolled in Children's Medical Services;
- Recipients under 18 who are in a Statewide Inpatient Psychiatric Program (SIPP);
- Recipients who receive hospice;
- Recipients who are enrolled in a Medicare or private HMO or other health care insurance such as TRICARE; and
- Recipients who are only eligible for limited Medicaid under such programs as the Family Planning waiver, Medically Needy or Qualified Medicare Beneficiary (QMB).

MediPass

Description	The Medicaid Provider Access System (MediPass) is a primary care case management program that is available statewide. MediPass primary care providers are responsible for providing or arranging for the recipient's primary care and for referring the recipient for other necessary medical services on a 24-hour basis. Recipients select the primary care provider of their choice from those participating in MediPass.
MediPass Coverage	When a provider verifies a recipient's eligibility for Medicaid, he must also verify whether the recipient is enrolled in MediPass or another managed care program. Note: See Chapter 3 in this handbook for information on verifying recipient eligibility and MediPass enrollment.
Institutional Care Program Recipients	Recipients who are eligible for Medicaid under the Institutional Care Program (ICP) cannot enroll in MediPass. If an ICP recipient receives Medicaid under another program (such as SSI) and is enrolled in MediPass, he will automatically be disenrolled when he becomes eligible for ICP. Note: See Chapter 3 in this handbook for information on verifying recipient eligibility and MediPass enrollment.
Choosing a MediPass Primary Care Provider	Recipients choose a single primary care provider or health care clinic to be their MediPass provider. The MediPass provider becomes the recipient's case manager and receives a monthly management fee for each enrolled recipient. The MediPass provider is responsible for providing primary care services and for providing referrals for necessary specialty services.
Hours Available	MediPass providers must provide 24-hour, seven-days-a-week access to care for MediPass enrolled recipients.
MediPass Primary Care Provider Reimbursement	MediPass primary care providers are paid a management fee each month for each MediPass patient assigned to them. In addition, MediPass providers receive Medicaid fee-for-service reimbursement for services that they render.
Hospital-Affiliated MediPass Providers	Hospital-affiliated providers may not bill outpatient charges for office visits and related procedures on an UB-04 claim and be paid a per diem rate. They must bill for office visits and related procedures on a CMS-1500 claim and be paid the physician fee-for-service rate.

MediPass, continued

Exclusion from MediPass Eligibility	Recipients who are eligible for Medicaid and Medicare cannot enroll in MediPass.
MediPass Covered Services	MediPass providers must provide or approve the following services for enrollees: • Advanced registered nurse practitioner (ARNP) services; • Ambulatory surgical center services; • Birth center services; • Child Health Check-Up; • Chiropractic services (first ten visits per calendar year do not need MediPass authorization); • County health department clinic services (except dental services); • Durable medical equipment and medical supplies; • Federally qualified health center services (except dental services); • Home health agency services; • Hospital inpatient services, except for behavioral health inpatient services; • Hospital outpatient services, except emergency room, emergency room screening services, and behavioral health outpatient services; • Laboratory services (independent laboratories do not need MediPass authorization); • Licensed midwife services; • Physician services; • Physician assistant services; • Podiatry services (first four visits per calendar year do not need MediPass authorization); • Prescribed drugs; • Rural health clinic services; • Therapy services (occupational, physical, respiratory, and speech); and • X-ray services, including portable x-rays. Note: See Exempt Services in this section for a list of services that do not require MediPass authorization.
MediPass Referrals	When a MediPass recipient is referred for covered services, the treating provider must get prior approval from the MediPass primary care provider.

MediPass, continued

Exemption from MediPass Referral: Public Providers

Public providers funded under the Public Health Services Act, s. 329 or s. 330, such as county health departments or federally qualified health centers, are not required to obtain prior approval from the MediPass provider before rendering the following services:

- Diagnosis and treatment of sexually transmitted infections and other communicable diseases such as tuberculosis and HIV;
- Immunizations; and
- Services rendered on an urgent basis.

Public health providers must still obtain post approval for the above services.

Note: See Appendix B, Glossary, in this handbook for the definition of urgent services.

Exemption from MediPass Referral: Emergency Services

Emergency services and care provided to a patient experiencing an emergency medical condition may be rendered without authorization from the MediPass provider, per section 409.9128, F.S. Emergency providers must still notify the MediPass provider about the services rendered to the MediPass recipient and must forward medical reports to the MediPass provider.

To receive reimbursement, the provider must indicate that the service was an emergency by entering an emergency indicator on the claim.

Note: See Appendix B, Glossary, in this handbook for the definition of an emergency medical condition.

Exemption from MediPass Referral: Services

The following services do not require prior approval or a referral by the MediPass provider:

- Dental (except in Medicaid areas with the Prepaid Dental Plan);
- Family planning;
- Early intervention;
- Dialysis services;
- Independent laboratory;
- Hearing;
- Vision;
- Mental health;
- Transportation; or
- Any other Medicaid service not listed under “MediPass Covered Services.”

Recipients may obtain Medicaid services not listed under “MediPass Covered Services” from any Medicaid enrolled provider.

MediPass, continued

Prior Authorization

If a service requires prior authorization in addition to the MediPass referral, the treating provider is responsible for obtaining that authorization or payment for the claim will be denied. This includes prior authorization for out-of-state services.

Inpatient hospital psychiatric or substance abuse admissions must be authorized by Magellan Medicaid Administration at 800-770-3084.

Prepaid Mental Health Program (PMHP) services do not require MediPass authorization, but do require the PMHP's authorization.

Note: See the Medicaid Provider Reimbursement Handbook for information on prior authorization. See the Hospital Coverage and Limitations Handbook for information on authorization for psychiatric and substance abuse admissions.

Billing for MediPass Covered Services

When billing Medicaid for a MediPass covered service, the treating provider must include the MediPass authorization number on the claim.

A MediPass authorization number is not required on an inpatient hospital claim billed for payment of medical, surgical, or rehabilitation services, except on claims for children in the Children's Medical Services (CMS) Network, unless the CMS Network child's admission was an emergency.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for instructions on entering the MediPass number on the claim. The handbook is incorporated by reference in 59G-4.001, F.A.C. and is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

MediPass Disease Management

Introduction

The Florida Legislature authorized the Disease Management Initiative and directed AHCA to "select methods for implementing the program that included best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools."

AHCA has contracted with disease management organizations (DMOs) to provide disease management services to Medicaid recipients enrolled in MediPass who have been identified as eligible for certain chronic disease state programs.

Note: For information on the Disease Management Initiative, visit the AHCA Web site at www.ahca.myflorida.com. Select Medicaid then Site Menu, then Disease Management.

MediPass Disease Management, continued

Purpose and Objectives

The Disease Management Initiative has been designed to promote and measure: health outcomes, improved care, reduced inpatient hospitalization, reduced emergency room visits, reduced costs, and better educated providers and patients. It is also expected that the disease management programs will bring an enhanced connection between the patient and the provider, making a significant impact on health outcomes and improved quality of life for patients with chronic diseases.

Ultimately the disease management program should prove to be beneficial to the patient, the provider, and to Medicaid. The expected benefits of this program are improved health and well-being of MediPass patients, additional resources to MediPass providers, and reduced costs associated with patients who have a chronic disease.

Who is Eligible

The Medicaid disease management programs are available only to Medicaid recipients who are enrolled in MediPass and have a chronic disease covered by the program. MediPass recipients identified as eligible are automatically enrolled in a disease management program. Recipients can dis-enroll at any time.

An exception is the Hemophilia Disease Management Program. The Hemophilia Disease Management Program is mandatory for all recipients who have hemophilia, unless the recipient is enrolled in an HMO, receives Medicaid through the Medically Needy Program, has third party liability, or is in a nursing facility. Recipients in the Hemophilia Disease Management Program have a choice among existing vendors. They may not disenroll from the program, but may change vendors at any time.

Disease Management Enrollment Process

AHCA identifies potential MediPass disease management recipients through paid claims. Prospective recipients are notified by AHCA and the appropriate disease management organization (DMO) that they are eligible for participation in the program. Recipients are advised of the additional care management benefits that are a part of the disease management program.

Providers do not need to obtain prior authorization from the disease management organization.

MediPass Disease Management, continued

Provider Involvement

The Disease Management Program notifies the MediPass primary care providers of the recipients in their MediPass patient caseloads who meet the criteria for disease management services. Providers may also refer their MediPass patients who are not already enrolled and who may benefit from a program to the DMO. The disease management care managers become an extension of the physician's services by helping enrolled patients better understand their diseases and make necessary life style changes with the goal of self-management. Providers are informed of their enrolled patients' progress through ongoing reports. In addition, clinical practice guidelines developed by leading experts in the treatment of each disease state are disseminated to providers by the DMOs.

Children's Medical Services (CMS) Network

CMS Network

Medicaid-eligible children with special health care needs have the option of enrolling with the Children's Medical Services (CMS) Network. The CMS Network is administered by the Florida Department of Health. The CMS Network provides a family centered, managed system of care for children with special health care needs. CMS Network enrollees are also enrolled in MediPass.

Children with special health care needs are those children under age 21 whose serious or chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children.

CMS offers a full range of care, which includes prevention and early intervention services; primary and specialty care; as well as long-term care for medically complex, fragile children.

Most services are provided at or coordinated through CMS offices in local communities throughout the state. When necessary, children are referred to CMS-affiliated medical centers. These centers provide many specialty programs with follow-up care provided at local CMS offices.

Note: For more information, see Children's Medical Services Web site at www.cms-kids.com.

Health Maintenance Organizations (HMOs)

Description

Medicaid contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

Medicaid pays each HMO a monthly capitation fee for managing and providing care to each enrolled recipient. In accordance with certain contractual agreements with Medicaid, the HMO provides a specified, comprehensive package of medical services for this monthly Medicaid fee.

Medicaid HMOs are also required to provide quality and benefit enhancements and can provide other expanded benefits as described in this section.

Note: A list of Medicaid HMOs is available on the AHCA Web site at www.ahca.myflorida.com. Select Managed Care (HMOs), and then Medicaid HMOs.

HMO Coverage

When a provider verifies a recipient's eligibility for Medicaid, he must also verify whether the recipient is enrolled in an HMO. If a recipient is an HMO member, the provider must seek authorization from the HMO in which the recipient is currently enrolled prior to providing services covered by the HMO, unless it is an emergency.

If the recipient is in an HMO, Medicaid will not pay a provider for any HMO-covered services. Providers must seek authorization and reimbursement from the HMO for services the HMO covers for its members.

Note: See Chapter 3 in this handbook for information on verifying recipient eligibility and HMO enrollment.

Institutional Care Program Recipients

Medicaid HMOs are responsible for payment for short-term institutional care (30 days or less). Medicaid HMOs are not responsible for long-term care.

If a recipient is enrolled in a Medicaid HMO, he will be automatically disenrolled from the HMO if he becomes eligible for the Medicaid Institutional Care Program. The nursing facility may then bill Medicaid and receive reimbursement for care, if the recipient meets the eligibility criteria for the institutional care program defined in the Institutional Care Program section in Chapter 3 of this handbook.

Health Maintenance Organizations (HMOs), continued

HMO Covered Services

The services provided under contract with each HMO are negotiated with each HMO contractor. However, every HMO plan must include the following basic services up to the limits required by fee-for-service Medicaid:

- Child Health Check-Up;
- Community mental health services;
- Dialysis treatment in freestanding centers;
- Durable medical equipment and medical supplies;
- Family planning services;
- Hearing services;
- Home health services;
- Hospital services (inpatient, outpatient and emergency services);
- Laboratory services, including independent laboratory services;
- Prescribed drug services;
- Physician services (as described below);
- Mental health targeted case management;
- Therapy services;
- Vision services; and
- X-ray services.

Physician Services

Physician services include services rendered by a licensed physician and services rendered by:

- Advanced registered nurse practitioners;
- Ambulatory surgery centers;
- Birthing centers;
- Chiropractors;
- County health department clinics;
- Federal qualified health centers;
- Physician assistants;
- Podiatrists; and
- Rural health clinics.

Health Maintenance Organizations (HMOs), continued

Inpatient Hospital Days Exhausted for Recipients Under 21

Medicaid inpatient coverage is available for recipients under the age of 21 who have exhausted their HMO inpatient hospital benefits. If a Medicaid HMO denies an inpatient hospital claim for a recipient under the age of 21 at the time of service, the provider may send the claim and the HMO denial to the Medicaid area office to override the denial edit for payment.

Additional HMO Services

In addition, plans are required to provide the following quality and benefit enhancements:

- Smoking Cessation: Regularly scheduled smoking-cessation programs must be conducted by the plan as an option for all plan members. Members must also have access to smoking-cessation counseling. The plan must provide primary care physicians with the Quick Reference Guide for Smoking Cessation Specialists, published by the U.S. Department of Health and Human Services, to assist in identifying tobacco users and supporting and delivering effective smoking-cessation interventions;
- Substance Abuse: The plan must have primary care physicians screen enrollees for signs of substance abuse as part of prevention evaluation. Targeted enrollees must be asked to attend community or plan-sponsored substance abuse programs. The plan must provide substance-abuse screening training to its providers on a regular basis;
- Domestic Violence: The plan must have primary care physicians screen enrollees for signs of domestic violence and must provide referral services to applicable domestic-violence prevention community agencies. The plan must provide domestic-violence screening training to its providers on a regular basis;
- Pregnancy Prevention: Regularly scheduled pregnancy-prevention programs must be conducted by the plan or the plan must make a good faith effort to involve members in existing community pregnancy-prevention programs. The workshops must be targeted toward teen members, but must be open to all enrollees;
- Prenatal and Postpartum Pregnancy Programs: The plan must provide regular home visits conducted by a home health nurse or aide, counseling and educational materials to pregnant members and postpartum members who are not in compliance with the plan's prenatal and postpartum programs. The plan must coordinate with Healthy Start Care Coordinators to prevent duplication of services; and
- Children's Programs: The plan must provide regular general wellness programs targeted specifically toward plan members from birth to the age of five or the plan must make a good faith effort to involve members in existing community children's programs. Programs must promote increased utilization of prevention and early intervention services for at-risk families with children in the target population. The plan must provide training for providers that promotes immunizations, Child Health Check-Ups (wellness and prevention), and early intervention services.

Health Maintenance Organizations (HMOs), continued

Family Planning	Plans are responsible for paying for family planning services for their members, regardless of whether the service provider is a plan subcontractor.
Optional Services	Other services that plans may provide include dental services, transportation, nursing facility and home and community-based services. Plans may also provide services under their contracts that Medicaid does not cover, such as over-the-counter drugs.
HMO Limitations	An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service.
Exemptions from HMO Authorization	All services may be prior authorized by the HMO plan except for the following: • Emergency services; • Family planning services regardless of whether the provider is a plan provider; • The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments; • OB/GYN services for one annual visit and the medically-necessary follow up care for a condition(s) detected at that visit (the recipient must use a plan provider for these services); • Chiropractic, podiatry, and some dermatology services (the recipient must use a plan provider for these services); and • Immunizations by county health departments.

Health Maintenance Organizations (HMOs), continued

Recipients Who Are Ineligible to Enroll in HMOs

The following Medicaid recipients are not eligible to be enrolled in HMOs:

- Recipients who reside in an intermediate care facility for the developmentally disabled (ICF/DD), nursing facility, state mental hospital, or state-operated residential program;
- Recipients who are under the age of 21 and are enrolled in Children's Medical Services;
- Recipients enrolled in hospice;
- Recipients who receive Assisted Living Home and Community-Based Waiver Services;
- Recipients who are enrolled in a Medicare HMO or private HMO, or other major medical insurance such as TRICARE;
- Recipients who are eligible for Medicaid under the Family Planning Services Waiver, Medically Needy or Qualified Medicare Beneficiary (QMB) coverage groups;
- Pregnant women who have not enrolled in Medicaid prior to the effective date of their SOBRA eligibility;
- Women eligible for Medicaid due to breast and/or cervical cancer;
- Individuals enrolled in the Nursing Home Diversion Program or the Program of All Inclusive Care for the Elderly (PACE);
- For non-Reform populations, individuals enrolled in the PAC Waiver; and
- Medicaid recipients who are members of the Florida Assertive Community Treatment Team (FACT team) unless they disenroll from the FACT team.

Newborn Enrollment

A newborn whose mother is enrolled in a Medicaid HMO is covered by the HMO for the first 90 days of life. The HMO must create an unborn record and the HMO, Department of Children and Families, hospital, or any other provider must activate the unborn record by completing an activation form and faxing it to the Medicaid fiscal agent.

Note: Please see Presumptively Eligible Newborns in Chapter 3 for additional information and the Unborn Activation Form.

HMO Member Handbook

The HMO provides its members an HMO member handbook that informs its members of the services it provides and how to obtain those services. The HMO sends the member handbook to all new members immediately upon enrollment.

HMO Reimbursement

HMO contractors are prepaid a fixed monthly capitation rate per member in each of the various eligibility categories, by age group, to provide all the covered services required by each member during the month. The rate is based on actual fee-for-service Medicaid claims experience for each eligibility category in the plan's operating area.

Prepaid Mental Health Plan

Prepaid Mental Health Plan

Recipients who are enrolled in MediPass will be enrolled in the Prepaid Mental Health Plan (PMHP) for the provision of their mental health services unless they are otherwise excluded from managed care or there is not a PMHP in the area where the recipient resides.

The PMHP covers inpatient and outpatient hospital services, psychiatric and physician services, community mental health services, and targeted case management services.

Recipients receive physical health care services from their primary care provider and mental health care services from the prepaid mental health plan contractor. The primary care provider and the prepaid mental health plan contractor should coordinate the recipient's health care needs to ensure that medical and mental health services are provided collaboratively for continuity of care.

Prepaid Dental Health Plan

Description

The Prepaid Dental Health Plan (PDHP) is a Medicaid managed dental care option available to Medicaid recipients in Miami-Dade county under the age of 21 who are not enrolled in an HMO that provides dental services.

PDHP Services

The following services are managed by the PDHP:

- Diagnostic examinations;
- Radiographs;
- Preventive services;
- Restorations;
- Endodontics and periodontal treatment;
- Surgical procedures and extractions;
- Dentures, complete and partial; and
- Orthodontic.

Exclusions from PDHP Eligibility

The following Medicaid recipients are not eligible to enroll in PDHP:

- Recipients 21 years of age or older;
- Recipients who reside in an intermediate care facility for the developmentally disabled (ICF/DD) or state hospitals;
- Recipients who are eligible for Medicaid under the Medically Needy Program;
- Recipients who are members of a Medicaid HMO that provides dental services; and
- Recipients who are in the Statewide Inpatient Psychiatric Program (SIPP).

Provider Service Networks (PSNs)

Provider Service Network (PSN)

A Provider Service Network (PSN) is an integrated health care delivery system owned and operated by Florida hospitals or other providers. The PSN is a Medicaid managed-care option for Medicaid recipients in many Florida counties (Reform and non-Reform), in addition to HMOs, MediPass, and the CMS Network.

PSNs may be capitated health plans, like HMOs, or may be fee-for-service (FFS) health plans. Capitated PSNs pay authorized claims directly. In FFS health plans, claims for services approved by the plan are generally submitted by providers to the plan for authorization. FFS health plan-approved claims are forwarded by the plan to the Medicaid fiscal agent for payment directly to the provider.

Fee-for-Service PSNs

The fee-for-service PSNs are a shared-risk model in which PSN authorizes provider claims and submits approved claims to the Medicaid fiscal agent for processing and transmission of payment to the provider. Medicaid pays each fee-for-service PSN a monthly administrative allocation and primary care case management fee for arranging and managing the care provided to each enrolled recipient. The fee-for-service PSN is at risk for a portion of the payment Medicaid provides to it.

Capitated PSNs

Medicaid pays each capitated PSN a monthly capitation fee for managing and providing care to each enrolled recipient. Capitated PSNs are prepaid a fixed monthly capitation rate per member in each of the various eligibility categories, by age group, to provide all the covered services required by each member during the month. The rate is based on actual fee-for-service Medicaid claims experience for each eligibility category in the plan's operating area.

Provider Service Networks (PSNs), continued

PSN Coverage

When a provider verifies a recipient's eligibility for Medicaid, he must also verify whether the recipient is enrolled in a PSN. If a recipient is a PSN member, the provider must seek authorization from the PSN in which the recipient is currently enrolled prior to providing services, unless it is an emergency or the Medicaid services are not covered in the PSN's contract with Medicaid.

If the recipient is enrolled in a fee-for-service PSN, providers must contact the fee-for-service PSN to determine its protocols for claims submission. Fee-for-service Medicaid will not pay a provider for any fee-for-service PSN-covered services unless:

- The PSN is a fee-for-service PSN and the services were authorized by the PSN; or
- The fee-for-service PSN has authorized the provider to bill Medicaid directly.

If the recipient is enrolled in a capitated PSN, providers must seek authorization and reimbursement from the capitated PSN for services the PSN covers for its members.

PSN Eligibility

The following categories of recipients are eligible to enroll in a PSN:

- Low Income Families and Children;
- Sixth Omnibus Budget Reconciliation Act (SOBRA) children;
- Children in Foster Care;
- Children in Subsidized Adoptions; and
- Supplemental Security Income (SSI) recipients who do not receive Medicare.

Provider Service Networks (PSNs), continued

Recipients Who Are Ineligible to Enroll in PSNs

The following Medicaid recipients are not eligible to be enrolled in PSNs:

- Recipients who reside in an intermediate care facility for the developmentally disabled (ICF/DD), nursing facility, state mental hospital, or state-operated residential program;
- Recipients who are under the age of 21 and are enrolled in Children's Medical Services;
- Recipients who receive hospice services;
- Recipients who receive Assisted Living Home and Community-Based Waiver Services;
- Recipients who are eligible for Medicaid under the Institutional Care Program;
- Recipients who are dually eligible for Medicare and Medicaid;
- Recipients who are enrolled in a Medicare Advantage Plan (Medicare HMO) or private HMO, or other major medical insurance such as TRICARE;
- Recipients who are eligible for Medicaid under the Family Planning Services Waiver, Medically Needy, or Qualified Medicare Beneficiary (QMB) coverage groups;
- Pregnant women who have not enrolled in Medicaid prior to the effective date of their SOBRA eligibility;
- Women eligible for Medicaid due to breast and/or cervical cancer;
- Individuals enrolled in the Nursing Home Diversion Program or the Program of All Inclusive Care for the Elderly (PACE);
- For non-Reform populations, individuals enrolled in the PAC Waiver; and
- Medicaid recipients who are members of the Florida Assertive Community Treatment team (FACT team) unless they disenroll from the FACT team.

Provider Service Networks (PSNs), continued

PSN Managed Services

The following services are managed by the PSN:

- Advanced registered nurse practitioner services;
- Ambulatory surgical center services;
- Birth center services;
- Child Health Check-Up;
- Chiropractic services;
- County health department services;
- Dermatology services;
- Dialysis services;
- Durable medical equipment and medical supply services;
- Family planning services;
- Federally qualified health center (FQHC) services;
- Hearing services;
- Home health services;
- Hospital inpatient services;
- Hospital outpatient services;
- Laboratory services, including independent laboratories;
- Licensed midwife services;
- Optometric services;
- Prescribed drug services;
- Physician services;
- Physician assistant services;
- Podiatry services ;
- Rural health clinic services;
- Therapy services;
- Vision services; and
- X-ray services including portable x-rays.

PSN enrollees may self-refer for family planning, FQHC, chiropractic (ten visits per calendar year), podiatry (five visits per calendar year), and dermatology services. However, claims for these services must be submitted through the PSN.

Provider Service Networks (PSNs), continued

Exceptions to Using a PSN Provider

The enrollee must use a PSN provider for all PSN-covered services with the following exemptions:

- The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments;
- OB/GYN services for one annual visit and the medically-necessary follow up care for a condition(s) detected at that visit (the recipient must use a plan provider for these follow-up services);
- Immunizations by county health departments; and
- Prescribed drug services. However, fee-for-service PSNs may use Medicaid's pharmacy system as its pharmacy benefits manager. Pharmacy providers should contact the fee-for-service PSN to determine if it uses the Medicaid pharmacy system or if it has its own pharmacy benefits manager.

Institutional Care Program Recipients

PSNs are responsible for authorization for short-term institutional care (30 days or less). PSNs are not responsible for long-term care.

If a recipient is enrolled in a PSN, he will be automatically disenrolled from the PSN if he becomes eligible for the Medicaid Institutional Care Program. The nursing facility may then bill Medicaid and receive reimbursement for care provided.

Inpatient Hospital Days Exhausted for Recipients Under 21

Medicaid inpatient coverage is available for recipients under the age of 21 who have exhausted their PSN inpatient hospital benefits. If a PSN denies an inpatient hospital claim for a recipient under the age of 21 at the time of service due to the patient having exhausted their inpatient days, the provider may send the claim and the PSN denial to the Medicaid area office to override the denial edit for payment.

Note: See Appendix A for the addresses and telephone numbers of the area Medicaid offices. The area Medicaid offices' telephone numbers are also available on the Agency for Health Care Administration's Web site at www.ahca.myflorida.com. Select Medicaid, and then Area Offices.

Provider Service Networks (PSNs), continued

Additional PSN Services

PSNs are required to provide the following quality and benefit enhancements:

- Smoking Cessation: Regularly scheduled smoking-cessation programs must be conducted by the plan as an option for all plan members. Members must also have access to smoking-cessation counseling;
- Substance Abuse: The plan must have primary care physicians screen enrollees for signs of substance abuse as part of prevention evaluation. Targeted enrollees must be asked to attend community or plan-sponsored substance abuse programs. The plan must provide substance-abuse screening training to its providers on a regular basis;
- Domestic Violence: The plan must have primary care physicians screen enrollees for signs of domestic violence and must provide referral services to applicable, domestic-violence prevention community agencies. The plan must provide domestic-violence screening training to its providers on a regular basis;
- Pregnancy Prevention: Regularly scheduled pregnancy-prevention programs must be conducted by the plan or the plan must make a good faith effort to involve members in existing community pregnancy-prevention programs. The workshops must be targeted toward teen members, but must be open to all enrollees;
- Prenatal and Postpartum Pregnancy Programs: The plan must provide regular home visits conducted by a home health nurse or aide, and counseling and educational materials to pregnant members and postpartum members who are not in compliance with the plan's prenatal and postpartum programs. The plan must coordinate with Healthy Start Care Coordinators to prevent duplication of services; and
- Children's Programs: The plan must provide regular general wellness programs targeted specifically toward plan members from birth to the age of five or the plan must make a good faith effort to involve members in existing community children's programs. Programs must promote increased utilization of prevention and early intervention services for at-risk families with children in the target population. The plan must provide training for providers that promotes immunizations, Child Health Check-Ups (wellness and prevention), and early intervention services.

Provider Service Networks (PSNs), continued

Family Planning	PSNs are responsible for paying for family planning services for their members, regardless of whether the service provider is a plan subcontractor.
Optional Services	PSNs may provide other services that Medicaid covers but are not PSN managed services, such as dental services. PSNs may also provide services under the contract that Medicaid does not cover, such as over-the-counter drugs.
Services Not Managed by the PSN	The PSN does not manage the following services: • Dental services (optional); • Early intervention services; • Home and community-based waiver services; • Hospice services; • Medical foster care; • Nursing facility services; • Prescribed pediatric extended care services (Exception – CMS Specialty Plan for Children with Chronic Conditions); • School-based services; and • Transportation services (Exception – Reform Health Plans). Providers can submit claims for non-PSN managed services directly to the Medicaid fiscal agent for processing.
PSN Limitations	A PSN's services cannot be more restrictive than those provided under Medicaid fee-for-service.

Home and Community-Based Services (HCBS)

Description

The Social Security Act allows states to obtain waivers to provide home and community-based services (HCBS) to target groups of recipients.

These services are designed to help the recipient avoid placement in an institutional setting. To receive waiver services, a recipient must be enrolled in the specific waiver program.

HCBS Provider Enrollment

In order for a provider to be reimbursed for rendering a home and community-based service (HCBS) to an eligible recipient, the provider must be enrolled as a waiver-specific HCBS provider. All waiver home and community-based services must be prior approved by a waiver case manager or waiver support coordinator.

Florida HCBS Programs

Florida has the following HCBS waiver programs:

- Adult Cystic Fibrosis Waiver;
- Aged and Disabled Adult Waiver;
- Assisted Living Waiver;
- Channeling Waiver;
- Developmental Disabilities Waivers (Tiers 1-4);
- Individual Budget Waiver;
- Familial Dysautonomia (FD);
- Model Waiver;
- Nursing Home Diversion Waiver;
- Project AIDS Care (PAC) Waiver; and
- Traumatic Brain and Spinal Cord Injury Waiver.

Adult Cystic Fibrosis Waiver

The Adult Cystic Fibrosis Waiver serves adults with cystic fibrosis who are at risk of hospitalization.

Aged and Disabled Adult Waiver

The Aged and Disabled Adult Waiver serves frail elderly and adults with disabilities who are at risk of placement in a nursing facility.

Assisted Living Waiver

The Assisted Living Waiver serves adults with disabilities and frail elders who reside in specially licensed adult assisted living facilities and who are at risk of placement in a nursing facility.

Home and Community-Based Services (HCBS), continued

Channeling Waiver	The Channeling Waiver serves frail elderly individuals in Dade and Broward counties. It is intended to delay or prevent nursing home placement.
Developmental Disabilities Waivers (Tiers 1-4)	The Developmental Disabilities Waivers serve people age 3 or older who are at risk of placement in an intermediate care facility for the developmentally disabled (ICF/DD).
Familial Dysautonomia Waiver	The Familial Dysautonomia (FD) Waiver provides needed services to individuals diagnosed with Familial Dysautonomia. The waiver is operated statewide.
Individual Budget Waiver (iBudget)	The iBudget Waiver provides services to qualified individuals with developmental disabilities age 3 or older as an alternative to placement in an Intermediate Care Facility for the developmentally disabled (ICF/DD).
Model Waiver	The Model Waiver serves children with degenerative spinocerebellar diseases who would be hospitalized without the services offered through the waiver.
Nursing Home Diversion Waiver	The Nursing Home Diversion Waiver serves frail elderly individuals 65 and older who are dually eligible for Medicare and Medicaid and who are at risk of nursing home placement.
Project AIDS Care Waiver	Project AIDS Care Waiver serves disabled people with AIDS who are at risk of hospitalization or meet the criteria for nursing facility care.
Traumatic Brain and Spinal Cord Injury Waiver	The Traumatic Brain and Spinal Cord Injury Waiver services adults with traumatic brain and spinal cord injuries who are at risk of placement in a nursing facility.

Medicaid Special Services for Children

Introduction

Florida Medicaid provides all medically necessary services to eligible children under 21 years of age, to correct or ameliorate a defect, a condition, or a physical or mental illness, even if the services are not covered for adults. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1905(a) of the Social Security Act, codified at 42 USC 1396d(a).

Prior authorization is required in order to receive reimbursement for special services that meet one or more of the following conditions:

- The service is not listed in the service-specific Medicaid Coverage and Limitations Handbook as a covered service;
- The service is not included in the applicable fee schedule;
- The service is described in the service-specific handbook as an
- "excluded service";
- The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the fee schedule.

Providers seeking prior authorization for special services should first refer to the service-specific handbook for a description of the prior-authorization process. For example, if the provider is seeking additional units of occupational therapy which exceed the service limits, the provider should refer to the Medicaid Therapy Services Coverage and Limitations Handbook for instructions on prior authorization.

If the service is not listed in the service-specific handbook, or if there are not any instructions for requesting additional services, the provider can submit a request for prior authorization to their local Medicaid area office. An optional form for requesting prior authorization for special services is available online at ahca.myflorida.com/CHCUP.

Medicaid Special Services for Children, continued

Prior Authorization Requirements

The following information must be included in the request for prior authorization:

- Recipient's name, date of birth, and Medicaid ID number;
- Requesting provider information;
- Rendering provider information (if different from requesting provider);
- Rendering provider type and specialty;
- The type of service (for example: diagnostic service, treatment, equipment, supplies, or procedure);
- CPT or HCPCS Code for the service or, if unavailable, then a detailed narrative description of the service;
- Expected amount, frequency, and duration of the service;
- Whether the service is experimental or investigational - attach supporting information;
- Whether the service is considered safe - attach supporting information;
- Whether the service is proven effective - attach supporting information;
- Whether the service is intended primarily for the convenience of the recipient or caregiver;
- A description of how the service will correct or ameliorate the recipient's condition.
- Medical records or other information related to the recipient and the requested service.

Medicaid will review the information submitted and will determine if the service is medically necessary, if it is covered under one of the categories listed in the Social Security Act under 1905(a), and if it will correct or ameliorate recipient's condition.

If the service is approved, the provider will be notified and informed of the specific requirements for reimbursement by Medicaid. If the service is denied, the provider and the recipient will be sent written notification of the denial, which will include an explanation of appeal rights, as specified at 42 CFR 431.210.

CHAPTER 2
THE FLORIDA MEDICAID PROVIDER

Overview

Introduction

This chapter describes Medicaid provider requirements, enrollment, maintaining provider qualifications, provider terminations, provider rights and responsibilities, record keeping requirements, and billing agent requirements.

In This Chapter

This chapter contains:

Provider Requirements

Who Must Enroll

To receive Medicaid reimbursement, a provider must be enrolled in Medicaid and meet all provider requirements at the time the service is rendered. Any entity that bills Medicaid for Medicaid-compensable services provided to Medicaid recipients or that provides billing services of any kind to Medicaid providers must enroll as a Medicaid provider.

Enrollment Qualifications

Applicants must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers. This chapter contains general requirements that apply to most provider types. Specific qualifications for each provider type are listed in service-specific Coverage and Limitations Handbooks.

Note: The Florida Medicaid Coverage and Limitations Handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The handbooks are incorporated by reference in the Medicaid Services Rule Chapter 59G-4, F.A.C.

Accuracy of Information

All enrollment statements or documents submitted to the Agency for Health Care Administration (AHCA) or the Medicaid fiscal agent by the provider must be true and accurate. Filing of false information is sufficient cause for denial of an enrollment application or termination from Medicaid participation.

Tax ID Number

The applicant must enter his tax identification (ID) number on the Enrollment Application and attach a signed W-9 form, proof of federal tax identification number, or a copy of his Social Security Number.

An individual provider's tax ID number is either his Social Security Number or federal tax ID if he is incorporated. An individual cannot enroll using the group's tax ID number as his individual tax number.

A group provider or facility's tax identification number is the federal tax ID number that the Internal Revenue Service (IRS) assigned to the group, entity or corporation.

IRS requires Medicaid to generate IRS 1099 forms for all providers to whom reimbursement is issued. (Tax-exempt providers do not receive 1099 forms.) The provider's tax ID number must be correct on the Medicaid computer system for the IRS 1099 form to be correctly generated.

Provider Requirements, continued

Ongoing Eligibility

Providers must continue to meet all the provider qualifications to remain enrolled in Medicaid. Medicaid will terminate any provider's enrollment who no longer meets a provider qualification.

If a provider continues to receive payment for services rendered after no longer meeting the provider qualifications, the payments will be subject to recoupment; and, if applicable, the provider will be referred to the Attorney General, Medicaid Fraud Control Unit.

Note: See Chapter 5 in this handbook for additional information on recoupment and fraud referrals.

Suspension from Medicare or Medicaid

Medicaid will immediately terminate providers who are suspended, excluded or terminated from Medicare or any other state's Medicaid program. The effective date of the termination will be the date that the provider was suspended, excluded or terminated from the Medicaid or Medicare program.

Medicaid will terminate a provider for a period no less than that imposed by the Federal Government or any other state, and will not enroll such provider in this state's Florida Medicaid program while such foreign suspension or termination remains in effect.

Licensure and Certification

Professional Licenses

Health care practitioners must be actively licensed to practice as required in the applicable Coverage and Limitations Handbook to enroll as Medicaid providers and to remain enrolled.

The Department of Health, Division of Medical Quality Assurance, Licensing Boards issue health care practitioner licenses. Providers must renew their professional licenses when the Department of Health, Licensing Board requires renewal. Medicaid will terminate providers who fail to maintain professional licensure effective the date that the license was terminated.

If a provider continues to receive payment for services rendered after his license has expired, the payments will be subject to recoupment; and, if applicable, the provider will be referred to the Attorney General, Medicaid Fraud Control Unit.

Note: See Chapter 5 in this handbook for additional information on recoupment and fraud referrals.

Licensure and Certification, continued

Facility Licensure

The following health care facilities must be actively licensed as required in the applicable Coverage and Limitations Handbook to enroll as Medicaid providers and to remain enrolled:

- Adult Family Care Homes;
- Ambulatory Surgical Centers;
- Assisted Living Facilities;
- Birth Centers;
- Home Health Agencies;
- Home Medical Equipment Companies (Durable Medical Equipment and Medical Supply Agencies);
- Hospices;
- Hospitals;
- Hospital Based Skilled Nursing Units (notated on the hospital's license);
- Inpatient Psychiatric Hospitals;
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
- Independent Laboratories;
- Prescribed Pediatric Extended Care Centers;
- Residential Treatment Centers;
- Skilled Nursing Facilities;
- State Mental Health Hospitals; and
- Swing Beds in a Hospital.

The Agency for Health Care Administration, Division of Health Quality Assurance (HQA), Health Facility Regulation, licenses health care facilities.

If a provider continues to receive payment for services rendered after its license has expired, the payments are subject to recoupment; and if applicable, the provider will be referred to the Attorney General, Medicaid Fraud Control Unit.

Note: See Chapter 5 in this handbook for additional information on recoupment and fraud referrals.

License Match

The Medicaid fiscal agent periodically compares the provider license file to the DOH health care practitioner license files and to the HQA facility license files. If information is missing or does not match an active number on the DOH or HQA file, Medicaid will send a termination letter to the provider giving the provider thirty (30) days to present documentation to correct the error. If the documentation is not received or is inadequate, Medicaid will terminate the provider's enrollment.

Licensure and Certification, continued

Medicare Certification

The following providers must be Medicare certified to enroll as Medicaid providers and to remain enrolled:

- Ambulatory Surgical Centers;
- Freestanding Dialysis Centers;
- Hospices;
- Hospitals;
- Rural Health Clinics;
- Portable X-ray Providers; and
- Skilled Nursing Facilities.

Home health agencies must be either certified or meet the standards for certification.

HQA conducts the survey to determine if the facility is in compliance with the Medicare certification standards. Medicaid regularly receives certification information from HQA. Medicaid will terminate providers who fail to maintain standards of certification, effective the date of the Medicare termination.

If a provider continues to receive payment for services rendered after it is no longer in compliance with the Medicare certification standards, the payments are subject to recoupment; and, if applicable, the provider will be referred to the Attorney General, Medicaid Fraud Control Unit.

Note: See Chapter 5 in this handbook for additional information on recoupment and fraud referrals.

CLIA Certification

To enroll as Medicaid providers and to remain enrolled, providers with laboratories must be certified under the Clinical Laboratory Improvement Act (CLIA) for the tests that they perform.

Medicaid regularly receives CLIA certification information from HQA. Medicaid will terminate providers who fail to maintain appropriate CLIA certification.

It is the responsibility of the laboratory provider to notify the Medicaid fiscal agent within 60 days of any changes to the facility's CLIA certification status and the test specialties that may be performed. CLIA certification is effective for a maximum of two years.

If a provider continues to receive payment for services rendered after it is no longer in compliance with the CLIA certification standards, the payments are subject to recoupment; and, if applicable, the provider will be referred to the Attorney General, Medicaid Fraud Control Unit.

Note: See Chapter 5 in this handbook for additional information on recoupment and fraud referrals.

Non-Institutional Provider Enrollment

Institutional and Non-Institutional Providers

Medicaid classifies providers as institutional or non-institutional. The enrollment procedures in this section apply to non-institutional providers.

Note: See Institutional Provider Enrollment in this chapter for the institutional provider enrollment procedures.

Note: See the service-specific Coverage and Limitations Handbook for additional enrollment information that is specific to the type of provider who is enrolling.

Non-Institutional Provider List

Medicaid defines non-institutional providers as the following provider types:

- Advanced Registered Nurse Practitioner;
- Aging and Adult Services Waiver;
- Air Ambulance;
- Ambulance;
- Audiologist;
- Billing Agent;
- Birth Center;
- Bureau of Blind Services;
- Case Management Agency;
- Case Manager or Social Worker;
- Children's Medical Services;
- Chiropractor;
- Community Mental Health Center;
- County Health Department;
- Dentist;
- Division of Vocational Rehabilitation;
- Durable Medical Equipment;
- Early Intervention Professional;
- Early Intervention Paraprofessional;
- Federally Qualified Health Center;
- Freestanding Dialysis Center;
- Hearing Aid Specialist;
- Home and Community-Based Waiver Services;
- Home Health Agency;
- Independent Laboratory;
- Licensed Midwife;
- Medical Foster Care or Personal Care;
- Optician;
- Optometrist;
- Pharmacy;
- Physician Assistant.

Non-Institutional Provider Enrollment, continued

Non-Institutional Provider List, continued

- Physician M.D. & D.O.;
- Podiatrist;
- Portable X-ray;
- Prescribed Pediatric Extended Care Center;
- Registered Nurse;
- Registered Nurse First Assistants;
- Rural Health Clinic;
- School District;
- Therapeutic Services for Children;
- Therapist;
- Transportation Non-Profit;
- Transportation Multi-load Private;
- Transportation-Non-Emergency; and
- Transportation-Private.

Note: If your provider type is not on this list, see Institutional Provider Enrollment in this chapter.

Required Enrollment Forms and Documentation

To enroll in Medicaid, non-institutional applicants must submit the following forms and documentation.

- Florida Medicaid Provider Enrollment Application, AHCA Form 2200-0003;
- Non-Institutional Medicaid Provider Agreement;
- Fingerprint Card or appropriate fingerprinting exemption (See Criminal History Check in this chapter for the specific fingerprinting exemption procedures);
- Electronic Data Interchange Agreement (included in AHCA Form 2200-0003);
- Medicaid Provider Surety Bond form (included in AHCA Form 2200-0003), if applicable;
- Physician Group Certification of Ownership Form (included in AHCA Form 2200-0003), if applicable; and
- Any other information that is requested in the enrollment package such as copies of required licenses, certifications, and other required documentation.

The applicant must keep a copy of the application form and attachments for his own records. Legible photocopies of the application forms or printed forms from the Internet with original signatures are acceptable.

Note: The Medicaid enrollment forms are incorporated by reference in 59G-5.010, F.A.C. They are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment.

Non-Institutional Provider Enrollment, continued

Enrollment on the Medicaid Fiscal Agent's Web site

Individuals may also apply to be a Medicaid provider using the provider enrollment wizard on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment.

How to Obtain Enrollment Forms

Enrollment forms can be obtained from the Medicaid fiscal agent by calling 800-289-7799 and selecting Option 4 or writing to:

Florida Medicaid
Provider Enrollment
P. O. Box 7070
Tallahassee, Florida 32314-7070

The enrollment forms, except for fingerprint cards, may also be downloaded from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment. Fingerprint cards must be obtained from the fiscal agent or the area Medicaid office.

Note: See Appendix A for the area Medicaid offices phone numbers and addresses.

Where to Submit the Enrollment Package

The Provider Enrollment application contains the addresses for specific provider types to submit the completed enrollment package and required documentation.

Institutional Provider Enrollment

Introduction

The enrollment procedures in this section apply to institutional providers.

Note: See Non-Institutional Provider Enrollment in this chapter for the non-institutional provider enrollment procedures.

Note: See the service-specific Coverage and Limitations Handbook for additional enrollment information that is specific to the type of provider who is enrolling.

Institutional Provider Types

The following institutional providers enroll using the procedures in this section:

- Adult Family Care Homes (AFCH);
- Ambulatory Surgical Centers (ASC);
- Assisted Living Facilities (ALF);
- Hospices;
- Hospitals;
- Hospital-Based Skilled Nursing Units;
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
- Residential Treatment Facilities (RTF);
- Skilled Nursing Facilities;
- State Mental Hospitals;
- Statewide Inpatient Psychiatric Program (SIPP) Providers; and
- Swing Beds.

Institutional Enrollment Process

An application for licensure or Medicare certification will prompt HQA to conduct a survey. After HQA surveys an institution for licensure and Medicare, HQA sends a certification and transmittal to Medicaid Provider Enrollment certifying that the institution has applied to become a Medicaid provider and that the institution has been surveyed, indicating an effective date.

Medicaid Provider Enrollment sends an Institutional Provider Agreement and a letter with instructions to the institution.

The following institutions are reimbursed on a cost basis: hospitals, county health department clinics, federally qualified health centers, hospices, intermediate care facilities for the developmentally disabled, nursing facilities, rural health clinics, and state mental hospitals. When an institution applies to enroll in Medicaid, it must submit a cost report to Medicaid Program Analysis, Cost Reimbursement Unit. The Cost Reimbursement Unit computes the institution's reimbursement rate and notifies Medicaid Provider Enrollment.

Institutional Provider Enrollment, continued

Required Enrollment Forms and Documentation

To enroll in Medicaid, institutional applicants must submit the following forms and documentation:

- Medicaid Provider Enrollment Application, AHCA Form 2200-0003;
- Institutional Medicaid Provider Agreement;
- Electronic Data Interchange Agreement (included in AHCA Form 2200-0003);
- Copies of required licenses, certifications, and other required documentation; and
- Any other information that is requested in the enrollment package.

The applicant must keep a copy of the application form and attachments for its records. Legible photocopies of the application forms or printed forms from the Internet with original signature are acceptable.

Note: The Medicaid enrollment forms are incorporated by reference in 59G-5.010, F.A.C. They are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment.

How to Obtain Enrollment Forms

Enrollment forms can be obtained from the Medicaid fiscal agent by calling 800-289-7799 and selecting Option 4 or writing to:

Florida Medicaid
Provider Enrollment
P. O. Box 7070
Tallahassee, Florida 32314-7070

The enrollment forms can also be obtained from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment.

Effective Date of Enrollment

Effective Date of Enrollment

Per s. 409.907(9), F.S., upon approval of a fully completed application, Medicaid will enroll the applicant as a Medicaid provider. The enrollment effective date for a new provider shall be the date that AHCA or the Medicaid fiscal agent received the provider application except for the following situations:

- With respect to a provider that requires a Medicare certification survey, the enrollment effective date is the date the certification is awarded;
- With respect to a provider that completes a change of ownership, the effective date is the date the agency received the application, the date the change of ownership was complete, or the date the applicant became eligible to provide services under Medicaid, whichever date is later; and
- With respect to a provider of emergency medical services transportation or emergency services and care, the effective date is the date the services were rendered.

Payment for any claims for services provided to Medicaid recipients between the date of receipt of the enrollment application and the date of approval is contingent on applying any and all applicable audits and edits contained in Medicaid's claims adjudication and payment processing systems.

An applicant should not bill Medicaid until the applicant receives confirmation from Medicaid that it is enrolled in Medicaid and has received its Medicaid provider ID number and confirmation of the effective date of the enrollment.

Approved Application

An approved application is an accurately and fully completed application that meets all the enrollment requirements, including criminal history checks and onsite inspections, and is approved by Medicaid.

Provider Agreement

Provider Agreement	Each Medicaid applicant, in state and out-of-state, must sign a Medicaid Provider Agreement that affirms that the applicant will comply with all laws and rules governing the delivery and reimbursement of services or goods to Medicaid recipients. Non-institutional applicants must sign the Non-Institutional Medicaid Provider Agreement, and institutional applicants must sign the Institutional Medicaid Provider Agreement. The agreement is a legal contract between the applicant and AHCA. The applicant is responsible for its employees and contractees maintaining compliance with the terms of the agreement. If approved into the Medicaid program, the provider must maintain compliance with the terms of the agreement and be responsible for timely renewal of the agreement.
Provider Agreement Signature	The Medicaid Provider Agreement must contain an original signature and date. Copies and signature stamps are not acceptable. The agreement must be signed by the provider or by the provider's registered agent. Registered agents are those individuals authorized to transact business on behalf of the provider in the provider's Articles of Incorporation filed with the Florida Department of State. If a registered agent signs the agreement, the organization and its owners will be held accountable for the contents of the agreement just as if they had signed it themselves. A Chief Executive Officer or president of an organization may sign the agreement in lieu of all owners, principals, partners, and financial custodians. If a registered agent signs the agreement, a copy of the Articles of Incorporation must be included with the Agreement to document the registered agent's status. Authorized agents who are not designated as "registered" agents in the Articles of Incorporation may sign the Enrollment Application but not the provider agreement. Authorized agents must be designated in writing by the organization to transact business on its behalf.
Provider Agreement Submission	Provider Agreements must be submitted with the provider's enrollment package to the address on the Medicaid Enrollment Application for the specific provider type.

Provider Agreement, continued

Duration of Provider Agreement	All Non-Institutional Medicaid Provider Agreements are effective for ten years from the effective date of the provider's eligibility unless it is otherwise terminated. All Institutional Medicaid Provider Agreements are effective for three years, except for an agreement with an intermediate care facility for the developmentally disabled (ICF/DD), which is effective for one year.
Renewing Provider Agreement	Institutional and Non-Institutional Medicaid Provider Agreements, except Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Provider Agreements, are renewed through the re-enrollment process. (See Provider Re-enrollment in this chapter for details.) Renewal agreements are mailed to: Florida Medicaid Provider Enrollment P. O. Box 13800 Tallahassee, Florida 32317-3800 Renewals for Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Provider Agreements are mailed to: Medicaid Contract Management Facilities Analyst 2562 Executive Center Circle East Suite 100 Tallahassee, FL 32399

Provider Identification Numbers, Suffix Codes, and Specialty Codes

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the use of a standard unique identifier for covered health care providers. The National Provider Identifier (NPI) is the standard unique health identifier.

The NPI is a 10-digit number. The NPI number does not indicate any information about the health care provider, such as the state in which he lives or his medical specialty.

NPI Requirements

All HIPAA-covered health care providers, whether they are individuals or organizations, must obtain an NPI to use to identify themselves in the HIPAA standard transactions.

Once an NPI is assigned to a provider, whether an individual or an entity, it will not change. The NPI remains with the provider regardless of job or location changes.

Note: To obtain an NPI or for further information regarding NPI, see the National Plan and Provider Enumeration System (NPPES) Web site at https://nppes.cms.hhs.gov.

Covered Health Care Providers

The HIPAA definition of a covered health care provider is a health care provider that electronically transmits any of the HIPAA standard transactions such as claims or eligibility verification.

A health care provider is any person or organization that furnishes, bills, and is paid for health care in the normal course of business.

Examples of health care providers included in this definition are physicians and other practitioners; hospitals and other institutional providers; suppliers of durable medical equipment, supplies related to health care, prosthetics, and orthotics; pharmacies (including on-line pharmacies) and pharmacists; and group practices. Managed care organizations are considered to be health care providers if they also provide health care.

Provider Identification Numbers, Suffix Codes, and Specialty Codes, continued

Non-Covered Health Care Providers

Some Medicaid providers are not considered covered health care providers according to HIPAA and are not eligible for an NPI. These include:

- Individuals or organizations that furnish nontraditional services that are only indirectly health care related, such as a taxi, home and vehicle modifications, habilitation, and respite services; and
- Other individuals or organizations that only bill or receive payment for, but do not furnish, health care services or supplies, such as billing services, clearinghouses, and value-added networks such as Medicaid eligibility vendors. This may include Exclusive Provider Organizations (EPOs) and Provider Service Networks (PSNs) if they do not provide health care.

NPI Subparts

Subparts are subdivisions of a health care organization, such as a home health agency or ambulance service that is part of a large multi-servicing entity (i.e. a hospital). Covered health care organizations are required to obtain NPIs for subparts of their organizations if the subpart otherwise meets the definition of a covered health care provider.

For example, a subpart may qualify for assignment of its own NPI based on a certification or licensure that is separate from the organizational health care provider. Entities (providers) who believe they meet the guidelines for obtaining subpart numbers, which will allow them to uniquely identify various components of operations within a large multi-servicing entity such as a hospital, may apply for subpart (NPI) number(s) through the NPPES at https://nppes.cms.hhs.gov.

Medicaid Provider Identifier

When providers are enrolled in Florida Medicaid they are assigned a unique nine-digit number that identifies the provider to Medicaid. The provider identification (ID) number consists of a seven-digit base number followed by a two-digit suffix in the format #######-##. The suffix is used to identify additional types of services that a provider has enrolled to provide or for additional service addresses.

Transfer of Medicaid Provider Identification (ID) Numbers

The Medicaid provider ID number is assigned to the individual or entity that signed the agreement and cannot be transferred to or used by any other individual or entity.

Additional Medicaid Provider Identification (ID) Numbers

An individual or entity provider can be assigned only one Medicaid provider seven-digit base identifier per tax ID. Additional suffixes may be assigned for additional types of service, or for additional service addresses.

Provider Identification Numbers, Suffix Codes, and Specialty Codes, continued

Services Provided at Multiple Locations	Individual and entity providers may provide services at multiple locations. Unique Medicaid provider identification suffix numbers may be required based on the type of license or certification held by the provider.
Notifying Medicaid of Multiple Service Locations	Individual and entity providers are required to report when they have multiple addresses where services are rendered. The requirements for this vary by provider type and whether or not a unique license or certification is issued for each address as described below.
Multiple Service Locations under a Single License or Certification	Individual or group providers who render services at more than one service address under a single license or certification are required to submit an Application for New Location Code to identify each separate physical address where services are provided. This is required for each type of service for which the provider is enrolled. The Application for New Location Code is an attachment to the Florida Medicaid Provider Enrollment Application, AHCA Form 2200-0003, F.A.C. Note: An Application for New Location Code may be obtained from the Medicaid fiscal agent by calling Provider Enrollment at 800-289-7799 and selecting Option 4 or from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment.
Multiple Service Locations under Multiple Licenses or Certifications	Individual or group providers who provide only one type of service but are uniquely licensed or certified for each location are required to submit a separate Florida Medicaid Provider Enrollment Application to obtain a unique Medicaid identification suffix for each location.
Linking NPI to a Single Medicaid Provider Identifier	When a provider enrolls in Medicaid, he must include his NPI on the Medicaid provider enrollment application if he is a covered health care provider. The Medicaid fiscal agent will cross reference the provider's NPI to his Medicaid provider ID number in the Medicaid computer system.

Provider Identification Numbers, Suffix Codes, and Specialty Codes, continued

Linking NPI to Multiple Medicaid Provider Identifiers

Providers who have multiple Medicaid identification numbers must be able to create a unique cross-reference between their NPI and each Medicaid identification number to create a one-to-one relationship. This may be accomplished through the use of a unique subpart NPI for each Medicaid identification number, the NPI plus taxonomy, the NPI plus ZIP+4, or any combination of these items.

Example: A hospital that also provides pharmacy and home health services will be required to obtain unique Medicaid identification numbers for each type of service since the pharmacy and home health agency are both licensed separately from the hospital license. It may apply for NPIs for each subpart, the pharmacy and the home health agency, because they are uniquely licensed. The subpart identification numbers would allow them to be cross-reference one-to-one with the appropriate Medicaid provider identifier.

Should a provider be ineligible to request NPI identifiers for their subparts or choose not to request subparts, he must be able to cross-reference his one NPI to multiple Medicaid identification numbers through the use of taxonomy, ZIP+4, or a combination of these.

Note: For additional information on taxonomy and the taxonomy codes, see www.wpc-edi.com/codes/taxonomy.

Billing Medicaid with NPI

Providers must identify themselves in standard HIPAA transactions exactly as they registered their NPI with Medicaid.

Example: If a provider used a combination of NPI and taxonomy or Zip+4 to identify himself when he registered his NPI with Medicaid, then that same combination must be reflected on all transactions to properly cross reference to the correct Medicaid identification number.

Provider Identification Numbers, Suffix Codes, and Specialty Codes, continued

Specialty Codes

For payment purposes, physicians, advanced registered nurse practitioners (ARNP), dentists, home and community-based services waiver providers, and therapists must have their specialties listed on the Medicaid computer system.

When enrolling in Medicaid, the provider must specify its specialty on the Provider Enrollment Application and complete the self-attestation to document the successful completion of post-graduate training in the specialty field requested. Some specialties require a copy of the specialty certification from the issuing board.

Enrolled providers add a specialty by sending a letter to the Medicaid fiscal agent to request the addition of a specialty. The letter must contain an original signature (faxed or copied letters will not be accepted) and the verification as described.

Florida Medicaid
Provider Enrollment
P. O. Box 7070
Tallahassee, Florida 32314-7070

Note: See the service-specific Coverage and Limitations Handbooks for the specialty codes and required documentation for each provider type.

Group Providers

Group Enrollment

When two or more providers bill Medicaid using the same tax identification number, they must enroll in Medicaid as a group. Each member in the group who bills Medicaid must also enroll as an individual Medicaid provider. The providers are not required to practice at the same location to enroll as a group. However, if the group providers practice at different locations, the group must report the locations to Medicaid.

The group number is used for billing and tax identification purposes only.

Note: See Notifying Medicaid of Multiple Service Locations for information on reporting multiple locations.

Enrollment Process for Individual Membership in a Group

When a group provider enrolls in Medicaid, the group must submit a Group Membership Authorization with its Medicaid Enrollment Application. The Group Membership Authorization is an attachment to the Florida Medicaid Provider Enrollment Application, AHCA Form 2200-0003, F.A.C.

The group provider must add new members by submitting a Group Membership Authorization to the Medicaid fiscal agent at:

Florida Medicaid
Provider Enrollment
P. O. Box 7070
Tallahassee, Florida 32314-7070

Note: A Group Membership Authorization may be obtained from the Medicaid fiscal agent by calling Provider Enrollment at 800-289-7799 and selecting Option 4 or from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment.

Who Enrolls as Group Providers

Health care practitioners may enroll as group providers. County public health units, rural health clinics, and community mental health providers must enroll as group providers.

Note: See the service-specific Coverage and Limitations Handbooks for information on enrolling as a group provider.

Group Providers, continued

Removing a Group Affiliation

Providers may request to be removed from a group provider's membership by sending a letter on letterhead stationery, signed by the provider, to the Medicaid fiscal agent at:

Florida Medicaid
Provider Enrollment
P. O. Box 7070
Tallahassee, Florida 32314-7070

The letter must include the names and provider IDs for both the individual and the group and the date the individual left the group.

Group Payments

All payments for claims billed using a group provider ID will be paid to the group provider.

Group Provider Affiliation Limits

A Medicaid provider can be affiliated with a maximum of 99 Medicaid provider groups. A provider cannot add another group affiliation if he has reached the maximum. However, the provider can delete a group and add a new affiliation.

Medicare Crossover

Medicare Crossover Eligibility

To receive crossover payments, a provider must be enrolled in Medicaid and have his Medicare identification number on file with Medicaid. Medicaid creates a Medicare-Medicaid cross-reference file for the provider. This policy did not change with the implementation of the National Provider Identifier (NPI). Medicaid still needs to have the Medicare identification number on file for the provider with beginning and ending dates.

A single Medicare identification number cannot be cross referenced to more than one Medicaid identification number. If the provider has multiple service addresses, he must designate one of those for his cross reference; and all crossover billing must be submitted under that one Medicaid provider identification number regardless of which address services were provided.

A provider who is already enrolled in Medicaid can request his Medicare ID be cross-referenced by submitting a written request to Medicaid's fiscal agent at:

Florida Medicaid
Provider Enrollment
P. O. Box 7070
Tallahassee, Florida 32314-7070

A Medicare cross-reference can be made retroactive to the beginning date of the provider's Medicaid eligibility.

Medicare Crossover, continued

Crossover-Only Provider Enrollment Requirements

Entities may enroll as a Medicare Crossover-Only provider for payment and claim processing purposes only. See 409.907(5)(d), F.S.

The following documentation must be submitted with the Medicaid provider enrollment application:

- Medicare Approval Letter;
- An Explanation of Medicare Benefits (EOMB) showing a paid claim with a date of service within 30 days prior to the application submission;
- A letter on company letterhead, signed by an officer authorized to bind the company, attesting that the provider meets all Florida Medicaid provider enrollment criteria including requirements specific to its provider type, if Florida Medicaid enrolls such providers. The provider must also acknowledge that Florida Medicaid may conduct on-site reviews prior to approving the crossover provider identification number; and
- Completed fingerprint cards.

Providers will be required to reenroll every three years.

Note: See How to Obtain Enrollment Forms in Chapter 2 of this handbook for information on how to obtain fingerprint cards and the Criminal History Check section of this handbook.

Crossover-Only Durable Medical Equipment Provider

Durable medical equipment (DME) entities, including medical supply providers, may enroll as a Medicare Crossover-Only provider for payment and claim processing purposes only. These entities are subject to all the Crossover-Only Provider Enrollment Requirements above.

In addition, DME entities must submit proof of current accreditation from a Florida Medicaid approved accrediting organization.

Medicare Crossover-Only DME providers are exempt from the requirement to maintain an in-state business location.

Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook to review approved accrediting organizations.

Medicare Crossover, continued

Crossover-Only Provider Enrollment Exclusions

The following entities are excluded from enrollment as a Medicare Crossover-Only provider:

- Entities that (1) are currently sanctioned by Florida Medicaid, (2) have been involuntarily terminated by Florida Medicaid within the last three years, except for reason of inactivity, or (3) have voluntarily terminated from Florida Medicaid without a repayment agreement, where applicable; and
- Entities that (1) are currently sanctioned by Medicare, (2) have been involuntarily terminated by Medicare within the last three years, or (3) have voluntarily terminated from Medicare without a repayment agreement, where applicable.

More than One Medicare Number

A provider may have two different Medicare IDs with concurrent eligibility dates cross-referenced to one Medicaid provider ID, but a single Medicare ID cannot be cross-referenced to more than one Medicaid provider ID.

Criminal History Check

Criminal History Check Requirements

Criminal history checks are required for both enrolling and re-enrolling Medicaid providers. The following individuals in each provider organization are required to have criminal history checks:

- All partners or shareholders with an ownership interest of five percent or more;
- All officers (this includes the president, vice president, etc.);
- All directors (this is the board of directors);
- Financial records custodian;
- All billing agents;
- All managing employees or affiliated persons, including pharmacy managers; and
- All individuals authorized to sign on the account used for electronic funds transfer.

If individuals belong to more than one of the above categories, they only require one criminal history check.

Fingerprint Cards Requirements

The criminal history check is conducted based on the applicants' fingerprints.

Applicants are required to submit a copy of their fingerprints on the fingerprint card included in the Florida Medicaid Provider Enrollment Application package. Providers may not use other types of fingerprint cards.

Additional cards can be obtained from the fiscal agent or any area Medicaid office.

Payment for Criminal History Check

Provider applicants are required to submit a check made payable to the Agency for Health Care Administration for each fingerpint card submitted with the Enrollment Application.

Criminal History Check Process

The fiscal agent submits the fingerprint cards to the Florida Department of Law Enforcement (FDLE). FDLE conducts a state criminal-background investigation that is called a Level 1 check.

FDLE forwards the fingerprints to the Federal Bureau of Investigation (FBI) for a national criminal-history record check. This is called a Level 2 check.

Criminal History Check, continued

Rejected Fingerprint Cards

Applicant fingerprint cards that are rejected by the FBI will be returned directly to Medicaid Contract Management. Rejected fingerprint cards will be accompanied by a United States Department of Justice Form 1-17 A, Rev 5-2-96, or Form 1-12, Rev 4-28-97, that lists the various reasons a fingerprint card may be rejected. If a fingerprint card is rejected, it will be necessary for the applicant to submit a new fingerprint card.

In order to preclude duplicate payments and to receive a complete FBI record, the applicant must submit the rejected fingerprint card along with a new fingerprint card to Medicaid. If the second card is rejected and returned by the FBI, additional payment will be required before a third submission. Failure to successfully submit a new fingerprint card may result in denial of a pending enrollment or termination of an active provider.

Exemption For Board Members

Per section 409.907(8)(a) F.S., board members of a not-for-profit corporation or organization are exempt from the criminal history check if they meet all of the following criteria:

- Serve solely in a voluntary capacity;
- Do not regularly take part in the day-to-day operational decisions of the corporation or organization;
- Receive no remuneration from the corporation or organization for their service on the board of directors;
- Have no financial interest in the corporation or organization; and
- Have no family members with financial interest in the corporation or organization.

Criminal History Check, continued

Exemption for Providers

The following providers are exempt from the criminal history check:

- Hospitals licensed under Chapter 395, Florida Statutes. (This exemption does not apply to the physicians' groups, laboratories, pharmacies, or other non-institutional providers that are not licensed under Chapter 395, but are owned by or affiliated with the hospital);
- Nursing facilities, hospices, and assisted living facilities licensed under Chapter 400, Florida Statutes. (This exemption does not apply to the physicians' groups, laboratories, pharmacies, durable medical equipment companies or other non-institutional providers not licensed under Chapter 400, but are owned by or affiliated with the nursing facilities, hospices and assisted living facilities);
- School districts as an entity. (This exemption does not apply to instructional and non-instructional personnel who are hired or contracted to fill positions that require direct contact with students in any district school system or university lab school. Upon employment or engagement to provide services, schools must undergo background screening as required under section 1012.465, F.S., or section 1012.56, F.S., whichever is applicable.);
- Units of local government. (This exemption does not apply to non-governmental providers and entities that contract with the local government to provide Medicaid services. The contracted entities are responsible for the cost of the criminal history checks for all applicable staff and management); and
- Any business that derives more than 50 percent of its revenue from the sale of goods to the final consumer **AND either** the business or its controlling parent is required to file a form 10-K or similar statement with the Securities and Exchange Commission **OR** the business has a net worth of $50 million or more. (This exception is designed primarily to exclude large pharmaceutical companies. The business must submit its annual report including audited financial statements or 10-K Form with the exemption request.)

Exemption Forms for Providers

To obtain the exemption, the provider must submit an FDLE Criminal History Check and Fingerprinting Exemption Request. The FDLE Criminal History Check and Fingerprinting Exemption Request is an attachment to the Florida Medicaid Provider Enrollment Application, AHCA Form 2200-0003, which is incorporated by reference in 59G-5.010, F.A.C.

Note: An Exemption Request form may be obtained from the Medicaid fiscal agent by calling Provider Enrollment at 800-289-7799 and selecting Option 4 or by downloading the form from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment.

Criminal History Check, continued

Exemption for Government Entities with Previous Criminal History Checks

If a government agency or government-owned facility already obtains criminal history checks on its employees, Medicaid does not require another check if the following criteria are met:

- The government agency or government-owned facility submits documentation in the form of a letter or official form from the screening agency, which specifies the applicant's name and dates of the FDLE and FBI criminal history checks;
- The previously completed criminal history check is no more than 12 months old as of the date of receipt of the application; and
- Medicaid reserves the right, on a case-by-case basis, to reject any criminal history check deemed questionable, or to require that a new criminal history check be completed and the appropriate fee submitted to cover payment required by FDLE.

Criminal history check exemption policies for government agencies apply to hospital taxing districts, such as the North Broward Hospital District; state agencies, such as county health departments; and state university system facilities, such as the University of Florida, Shands Teaching Hospital.

Criminal History Check by Other Agencies

Medicaid accepts proof of level 2 criminal history checks conducted by other Florida agencies or departments that have been completed in compliance with Chapter 435, F.S., and section 408.809 F.S., within 12 months of receipt of the application.

The provider must submit a letter or official form from the agency that conducted the criminal history check with the Enrollment Application. The letter or form must specify the applicant's name, Social Security Number, date the criminal history check was completed, the level of the screening and the results.

Medicaid Provider Enrollment will review the information and approve or deny the application.

Electronic Funds Transfer (EFT)

EFT Requirements

All Florida Medicaid providers, except for those listed below must receive reimbursement by electronic funds transfer (EFT).

EFT Enrollment Process

To enroll for electronic funds transfer, the provider must:

- Complete Option 1 on an Electronic Funds Transfer Authorization form.
- Attach a voided check, deposit slip, or a letter from the bank on bank letterhead confirming ABA and account number information to the form and submit it with the enrollment package.

The Electronic Funds Transfer Authorization form is an attachment to the Florida Medicaid Provider Enrollment Application, AHCA Form 2200-0003, which is incorporated by reference in 59G-5.010, F.A.C.

Note: An Electronic Funds Transfer Authorization form may be obtained from the Medicaid fiscal agent by calling Provider Enrollment at 800-289-7799 and selecting Option 4 or by downloading the form from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment.

Electronic Funds Transfer, continued

Provider Types Exempt from EFT

The following provider types have the option of declining electronic funds transfer or do not bill Medicaid directly:

- Adult Family Care Homes (AFCH) (Assistive Care Services Program provider)
- Aging and Adult Services Agency
- Assisted Living Facilities (ALF)
- Bureau of Blind Services
- Children's Medical Services
- County Health Departments
- Developmental Services Agency
- Early Intervention Individual Providers (Group providers must use EFT)
- Licensed Practical Nurses that belong to a County Health Department, Children's Medical Services, or the Bureau of Blind Services
- Medical Foster Care
- Registered Nurses that belong to a County Health Department, Children's Medical Services, or the Bureau of Blind Services
- Residential Treatment Facilities (RTF) (Assistive Care Services Program provider)
- School Districts
- Social Worker/Case Manager
- Specialized Mental Health Individual Practitioner (Group providers must use EFT)
- State Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
- State Mental Health Hospitals
- State Vocational Rehabilitation Agency
- Transportation – Private
- Individual treating providers enrolled in a group who do not bill Medicaid separately.

Electronic Funds Transfer, continued

Individual Members of Group Provider

Since all of a group provider's payments are processed through a single account, only the group provider needs to enroll in electronic funds transfer. The Electronic Funds Transfer Authorization must be signed by the individuals authorized to sign on the account, not by all the member providers.

For individual providers who are part of a group, the following electronic funds transfer requirements apply:

- If the provider does not submit claims as an individual provider, he must complete Option 2 on an Electronic Funds Transfer Authorization and submit the form to the fiscal agent; and
- If the provider submits any claims as an individual provider, he must complete Option 1 on an Electronic Funds Transfer Authorization, using his unique Medicaid ID to establish EFT for his individual provider ID, and submit the form to the Medicaid fiscal agent.

Verifying EFT Information

The fiscal agent verifies the bank's ABA routing and transit numbers and the provider's account number with the provider's bank. There is a 14-day (two-payment cycle) test period with the provider's bank to ensure a smooth operation. During the test period, providers will receive payment by mail.

EFT Payment Cycle

EFT payments are distributed on Thursday afternoon during a normal processing week. During weeks when there is a bank holiday, there may be a one-day delay in receipt of payment.

Surety Bonds

Surety Bonds

A surety bond must be submitted as part of the enrollment application by the provider types listed in this section unless they are owned and operated by government entities.

One $50,000 bond is required for each Federal Employer Identification Number. The value of the surety bond must be increased by $50,000 for each additional service address up to a maximum bond of $250,000 per Federal Employer Identification Number.

Of the provider types required to submit bonds, only durable medical equipment providers must maintain continuous bonds for the life of their Medicaid enrollment.

Durable Medical Equipment Providers

In accordance with s. 409.912(45)(b), F.S., effective January 1, 2009, one $50,000 bond is required for each durable medical equipment (DME) and medical supply provider location, up to a maximum of five (5) bonds statewide or an aggregate bond of $250,000 statewide as identified per Federal Employer Identification Number (F.E.I.N.). Providers who qualify for a statewide or an aggregate bond must identify all their locations in any Medicaid DME and medical supply provider enrollment application or bond renewal.

A surety bond must be submitted as part of the Medicaid DME and medical supply provider enrollment application. Each provider location's surety bond must be renewed annually and the provider must submit proof of renewal, even if the original bond is a continuous bond.

Durable Medical Equipment Provider Surety Bond Exemptions

In accordance with s. 409.912(45)(b), F.S., effective January 1, 2009, a DME and medical supply business is exempt from surety bond requirements if the DME and medical supply business' physical location is:

- Owned and operated by a government entity; or
- Operated by and within a pharmacy that is currently enrolled as a Medicaid pharmacy provider; or
- Medicaid-enrolled orthopedic physician's groups that are more than 50 percent owned by physicians, providing only orthotic and prosthetic devices, and has been an active Medicaid provider in good standing; or
- A licensed orthotist or prosthetist that provides only orthotic or prosthetic devices as a Medicaid durable medical equipment provider.

Surety Bonds, continued

Home Health Agencies

A surety bond is required for home health agencies that have been or are currently sanctioned or terminated (voluntary or involuntary) by Florida's Medicaid Program within the past five years. The requirement is applicable to future sanctions or terminations of a home health agency.

Sanctions include, but are not limited to, any one of the following actions against a home health agency:

- Disciplinary action as defined in Chapter 400.474, F.S.; or
- Administrative fines as defined in Chapter 400.474 and 400.484, F.S.

Terminations include, but are not limited to, any one of the following reasons:

- The denial, suspension, or revocation of a license as defined in Chapter 400.474, F.S. and Chapter 400.484, F.S.;
- Provider termination at the request of Medicaid Program Integrity;
- "Without cause" terminations initiated by AHCA, the Department of Elder Affairs, Department of Children and Families, or the home health agency;
- Noncompliance with the Conditions of Participation as defined in Title 42 Code of Federal Regulations (CFR) 484.1 through 484.55;
- Noncompliance license standards as defined in Chapter 59A-8, Florida Administrative Code;
- Noncompliance with Medicaid provider requirements as defined in the Medicaid Provider Agreement; and
- Noncompliance with Medicaid home health policy as defined in Chapter 59G-4.130, Florida Administrative Code.

Surety bonds required by this policy shall be in the amount not to exceed $50,000 or the total amount billed by the provider to Medicaid during the current or most recent calendar year, whichever is greater, as specified in Chapter 409.907(7), F.S.

The home health agency must comply with the surety bond requirement for three consecutive years. If at the end of three years, there has been no adverse action taken against the home health agency, it then becomes exempt from the surety bond requirement. However, the surety bond will be extended for another three years from the date of any subsequent final order imposing sanctions. Each enrollment application must contain the original bond. The surety bond company must be licensed to transact business in Florida.

Surety Bonds, continued

Home Health Agencies, continued

Home health agencies must renew their bonds annually unless a continuous bond is on file. Renewal must be made at least 30 days in advance of the termination date to ensure there is no break in services (termination because of an expired bond). If there is a gap in the bond coverage dates, there will also be a gap in payments for services that would otherwise be covered by the Medicaid program. The provider is responsible for maintaining current bond coverage.

Home health agencies operating under the same corporate tax identification number, that are enrolling more than one non-exempt home health agency, may cover two or more home health agencies under one bond. A letter must accompany the bond listing the name, address, and Medicaid provider ID of all enrolling home health agencies that are covered by the bond.

A surety bond is required if an enrolled home health agency, which is currently exempt from maintaining a surety bond, subsequently receives notice of a final order imposing sanctions. AHCA will send a certified, return receipt letter to the home health agency advising that a surety bond must be submitted within 30 days of receipt of the certified letter.

Home Health Agency Surety Bond Exemption

A surety bond is not required if the home health agency is owned and operated by a government entity.

On or after January 1, 2002, a surety bond is not required for a home health agency enrolling for the first time in the Medicaid program provided there have been no licensing terminations or sanctions within the past five years.

On or after January 1, 2002, home health agencies currently enrolled in the Medicaid Program and without terminations or sanctions, described above under surety bond requirements, are exempt from maintaining surety bonds. If an enrolled home health agency is exempt, any subsequent programmatic or geographical expansions (including new home health agencies opened in different geographical areas) that are operating under the same corporate tax identification number are also exempt.

Surety Bonds, continued

Home and Community-Based Services Waiver Providers	Home health agencies that have had sanctions or terminations within the last five years that are not enrolled in Medicaid and DME providers that are not enrolled in Medicaid that are enrolling as home and community-based services waiver providers must submit a surety bond at the time of application. (See specific bond requirements for home health agencies and DME providers in this section.) An exception is home health agencies and DME providers that are already enrolled as Medicaid home health or DME provider types are not required to submit additional surety bonds to enroll as waiver services providers.
Physician Groups	If more than 50 percent of a physician group practice is owned by non-physicians, the physician group must submit a surety bond at the time of application. An exception is physician groups that are owned by non-profit hospitals.
Transportation Providers	The following types of transportation providers must submit a surety bond with their enrollment applications: • Non-emergency transport; • Taxicab companies; and • Multi-load private transport. An exception is providers who are enrolled with zero rates, because they do not receive direct payment as payment is made to them through the transportation coordinator. The other transportation provider types: ambulance, air ambulance, government and municipal transport, private transportation, and non-profit transportation are exempt from submitting surety bonds.
Independent Laboratories	Independent laboratories must submit surety bonds with their provider applications for the first year of enrollment.

On-Site Reviews

Who Must Have a Site Visit

Per 42 CFR 455.432, the state Medicaid agency must conduct pre-enrollment and post-enrollment site visits of providers who are designated as "moderate" or "high" categorical risks to the Medicaid program. The purpose of the site visit will be to verify that the information submitted to the state Medicaid agency is accurate and to determine compliance with federal and state enrollment requriements.

In accordance with this regulation, on-site reviews are required for enrollment of the following provider types:

- Community Mental Health;
- Durable Medical Equipment (DME);
- Physician groups if more than 50 percent of the practice is owned by non-physicians;
- Non-emergency transport;
- Taxicab companies; and
- Multi-load private transport.

At AHCA's discretion, site visits may be required for other provider types.

Exemptions from the Site-Visit Requirement

The following entities are exempt from the DME and physician group site visit requirement:

- Site visits are not required for physician groups based in hospitals; however, a letter with an original signature from the hospital director is required confirming that the group is located in the hospital with all hospital privileges. Examples are emergency room physicians, anesthesiologists, and neonatologists; and
- Site visits are not required for DME providers associated with rural health clinics or pharmacies if the DME and pharmacy are located at the same physical address.

Application Disposition after the Site Visit

If the on-site review results in denial, AHCA Medicaid Provider Enrollment will notify the provider by certified mail that its application is denied.

Non-Emergency Out-of-State Services

Introduction

Florida Medicaid reimburses for non-emergency services when the recipient receives the services at an out of state location, if those services cannot be obtained in Florida and if Medicaid prior authorizes the service. Services received by a recipient in an out of state location cannot be post authorized.

Note: See Out-Of-State Enrollments in Chapter 2 of this handbook for information on other types of out-of-state claims that do not require prior authorization.

Who Must Request Services

A Florida Medicaid enrolled primary care or specialist physician may refer a Medicaid recipient for out-of-state care to obtain medically-necessary services that cannot be provided in Florida. The physician must request and obtain prior authorization before the recipient receives out-of-state services.

This is not the same authorization as the MediPass primary care provider's authorization number. Florida Medicaid physicians may not authorize out-of-state services; they may only request authorization for the services.

If the recipient is enrolled with Children's Medical Services, the request for out-of-state services must be initiated through Children's Medical Services.

If the recipient is insured by a third party, Health Maintenance Organization, or Provider Service Network, the request for out-of-state services must be directed to those insurers.

Transportation

Recipients may be eligible for Medicaid to cover transportation if the recipient meets the requirements for transportation coordination.

Note: See the Transportation Coverage, Limitations and Reimbursement Handbook for more information on transportation limitations.

Recipients with Medicare Part A

If the recipient has Medicare Part A coverage, the out-of-state hospital should treat the out-of-state service as a Medicare crossover.

Note: See Chapter 4 in this handbook for Medicare crossover policy.

Home Health Services

If a Florida Medicaid recipient receives a prior-authorized out-of-state service, the recipient may be eligible to receive medically-necessary home health services out-of-state.

Non-Emergency Out-of-State Services, continued

Documentation for Out-of-State Prior Authorization

The out-of-state prior authorization request must include:

- A completed Out-of-State Prior Authorization Request Form, 2000-0016, filled out by the recipient's Florida Medicaid enrolled primary care or specialist physician;
- Documentation that justifies the medical necessity for the service, such as medical history, lab reports, etc.;
- A separate letter from the requesting physician indicating the need for out-of-state home health services if applicable;
- Contact information for the requesting physician;
- A referral from a specialty hospital or subspecialist in the area specific to the recipient's diagnosis certifying the requested service is not available in Florida;
- The Current Procedural Terminology (CPT) codes for the procedure(s) being requested;
- The name and address of the out-of-state provider;
- The name and telephone number of the out-of-state provider's contact person.

The request will not be processed without the above information.

Note: The Out-of-State Prior Authorization Request Form 2000-0016, may be copied from Appendix D of this handbook and is available on our fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, then Forms. Under General Information, select the Out-of-State Prior Authorization Request Form 2000-0016.

Non-Emergency Out-of-State Services, continued

Additional Documentation for Behavioral Health Out-of-State Prior Authorization

In addition to the general prior authorization requirements listed above, prior authorization requests for out-of-state behavioral health services must include the following:

- An assessment or comprehensive evaluation that explains the recipient's clinical status including:
  - The presenting problem;
  - The history of the present illness;
  - Previous psychiatric history, physical history, and medication history;
  - Relevant personal and family medical history;
  - Personal strengths; and
  - A brief mental status examination which concludes with a summary of findings, diagnostic formulation, and treatment recommendations.
- The recipient's clinical information as defined in the Community Behavioral Health Services Coverage and Limitations Handbook.

In addition to the prior authorization requirements listed above, requests on behalf of recipients under the age of 18 must include an evaluation from a multidisciplinary team.

- The appropriate circuit multidisciplinary team must assess whether the child may be adequately served with behavioral health services in the state of Florida.
- The multidisciplinary team must, at a minimum, be comprised of at least one representative from the Department of Children and Families' district Substance Abuse and Mental Health program office (or designee) and the area Medicaid office. Additional members should be people who know or work with the child and family. When appropriate, members should include the child, the child's biological or adoptive parents or relatives, the foster parents or emergency shelter staff, assigned counselors or case managers, a representative from the child's current mental health service provider, a school representative, advocate, and the child's health care provider.

Note: See the Community Behavioral Health Coverage and Limitations Handbook for information on what comprises clinical information. The handbook is incorporated by reference in 59G-4.050, F.A.C. and is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Non-Emergency Out-of-State Services, continued

Behavioral Health Out-of-State Provider Requirements

Out-of-state facilities providing behavioral health services to recipients must:

- Be licensed as a behavioral health treatment provider in accordance with the laws and rules of that provider's state.
- Be accredited by the Joint Commission, the Rehabilitation Accreditation Commission, Council on Accreditation, or National Committee for Quality Assurance.
- Agree to comply with federal regulations concerning the use of seclusion and restraints referenced in 42 Code of Federal Regulations 482 and 483 (as appropriate to the provider's licensure), including reporting and attestation requirements as published in the Federal Register Vol. 66, no. 14 on 1/22/01, and amended in the Federal Register Vol. 66, No. 99 on 5/22/01.
- Agree to cooperate with AHCA's Utilization Management (UM) contractor. The behavioral health provider must allow the UM contractor's assigned care coordinator to have complete access to information about recipient care, including treatment planning and rounds, discharge planning meetings, educational records, and incident reporting.
- Prepare a written report of findings at a minimum of every 30 days and submit the report, and pending discharge plans, to AHCA and the UM contractor's care coordinator.
- Meet Psychiatric Residential Treatment Facility Qualifications if facility is not a hospital.

Where to Submit the Out-of-State Prior Authorization Request

The physician must send the prior authorization request and required documentation to:

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

Medicaid Responsibility

The Medicaid consultant will review the out-of-state request and approve or deny it. The decision will be rendered within ten business days following the receipt of sufficient documentation. Medicaid or its designee will render a decision and notify both the referring and out-of-state providers. If the request is approved the out-of-state provider will need to enroll in Florida Medicaid. Medicaid will send a single case agreement to the out-of-state provider, a prior authorization number will be assigned, and instructions for filing the claim(s) will be included in the single case agreement.

Non-Emergency Out-of-State Services, continued

Provider Reimbursement

Florida Medicaid will reimburse for out-of-state services at a rate mutually agreed upon rate by the provider and Florida Medicaid.

Note: Florida Medicaid Fee Schedules are available for download on our fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support. Choose Fee Schedules.

Prior Authorization Extensions

Approved out-of-state services not rendered in their entirety during the authorization period must be extended through the out-of-state prior authorization process. Ten business days prior to the expiration of the original authorization, a new prior authorization request must be submitted by the Florida Medicaid primary care or specialist physician for consideration of continued out-of-state services.

Extension requests for recipients receiving out-of-state behavioral health services must be submitted by the behavioral health specialist currently providing care to the recipient.

The out-of-state prior authorization extension request for behavioral health services must include:

- Treatment plan;
- Goals and objectives;
- Current progress, diagnosis, and mental status exam;
- List of current medications;
- A brief mental status examination which concludes with a summary of findings, diagnostic formulation, and treatment recommendations;
- Relevant clinical data;
- Documentation on any use of seclusion and restraints; and
- Documentation on any clinical incidents.

Non-Emergency Out-of-State Services, continued

Home Health Services

Medicaid reimburses out-of-state home health services that are prior-authorized.

Whenever a Florida Medicaid recipient receives an out-of-state prior-authorized Medicaid service, that recipient may be eligible to receive medically-necessary home health services out-of-state.

The following requirements must be met in order for a recipient to qualify for out-of-state home health services:

- The recipient must meet all in-state home health program requirements;
- Out-of-state home health services must be prior-authorized by Florida Medicaid or its designee;
- The home health agency must be a Medicaid or Medicare enrolled provider in the relevant state; and
- The home health agency must enroll as a Florida Medicaid provider.

A physician's order from the attending physician is required to initiate out-of-state home health services. This order should be included in the out-of-state prior authorization request.

At a minimum, the order must describe the:

- Recipient's acute medical condition, chronic medical condition, or diagnosis that causes a recipient to need home health care;
- Documentation regarding the medical necessity for the service(s) to be provided at home;
- Home health services needed;
- Frequency and duration of the needed services; and
- Minimum skill level (nurse, home health aide) of staff who can provide the services.

Out-of-state home health services must be coordinated through the authorized facility, which must provide an anticipated plan of outpatient care that is signed and dated by the recipient's attending physician.

Out-of-State Enrollments

Providers Who Can Enroll as In-State Providers

The following providers who are located outside Florida, may enroll as in-state providers:

- Providers (including hospitals) that are located in Georgia or Alabama who regularly provide services to Florida Medicaid recipients. Durable medical equipment and medical supply and pharmacy providers must be located within 50 miles of the Florida state line.
- Durable medical equipment and medical supply providers that supply durable medical equipment or supplies not otherwise available from other enrolled providers located within the state.
- Cochlear implant device manufacturers.
- Independent laboratories that are licensed in Florida.

Providers enrolling as in-state providers must submit the same enrollment forms and meet all the in-state provider qualifications.

The specific criteria for these providers are described below.

Georgia and Alabama Providers

Providers located in Georgia or Alabama that regularly provide services to Florida Medicaid recipients may enroll as in-state providers. All the enrollment requirements that apply to in-state providers apply to Georgia and Alabama providers, except that they must have the licenses and permits applicable to the state in which they are located.

Durable medical equipment and medical supply providers and pharmacies must be located within 50 miles of the Florida state line to enroll as in-state providers.

Durable Medical Equipment and Medical Supply Providers

Durable medical equipment and medical supply providers physically located more than fifty miles from the Florida state line that supply durable medical equipment or supplies not otherwise available from other enrolled providers located within the state may enroll as in-state providers. The Bureau of Medicaid Services must approve the initial and continued enrollment of businesses that are located more than fifty miles from the Florida state line.

Cochlear implant device manufacturers must enroll as Hearing Services providers and comply with that program's policy.

Note: All Medicaid Provider Handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, then Provider Handbooks.

Out-of-State Enrollments

Out-of-State Freestanding Independent Clinical Laboratories

Out-of-state freestanding independent clinical laboratories certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and licensed by the state of Florida may enroll as in-state Florida Medicaid providers.

All enrollment requirements that apply to in-state providers also apply to out-of-state independent clinical laboratories.

Other Out-of-State Providers

All other out-of-state providers may enroll in Medicaid only if they have furnished eligible services under the circumstances listed in the following sections to an eligible Medicaid recipient. These providers follow special out-of-state enrollment procedures and are enrolled with "out-of-state" status.

Reimbursable Out-of-State Services

Florida Medicaid will reimburse out-of-state providers who provide services under the following circumstances:

- An emergency arising from an accident or illness that occurs while the recipient is out of state;
- The recipient's health will be endangered if the care and services are postponed until returning to Florida;
- The child is a non-Title-IV-E Florida foster or adoption subsidy child living out of state and is covered under the Florida Medicaid program; or
- Florida Medicaid determines, on the basis of medical advice, that the needed medical services or necessary supplementary resources are more readily available in another state and prior authorizes the out-of-state services.

Out-of-State Enrollment Procedures

To enroll, the out-of-state provider must submit the following documents to the fiscal agent:

- The appropriate Florida Medicaid Provider Agreement, either Institutional or Non-Institutional;
- Copy of facility or professional license;
- Completed claim form including billing provider's name, address, phone number, and tax identification number for payment purposes; and
- Documentation that the claim meets one of the circumstances listed above.

An out-of-state provider is enrolled retroactively for the dates on which it provided eligible services for Medicaid payment.

Out-of-State Enrollments, continued

Out-of-State Enrollment Procedures, continued	Note: See Non-Institutional Provider Enrollment and Institutional Provider Enrollment in this chapter to determine which Florida Medicaid Provider Agreement is appropriate for the out-of-state provider's type.
Claims for Emergency Treatment	An out-of-state provider completes a claim for emergency services according to the instructions in the reimbursement handbook. The provider must submit the claim to the Florida Medicaid fiscal agent for payment. The provider must attach documentation to the claim justifying the emergency.
Claims for Children in Foster Care or Adoption Subsidy	An out-of-state provider completes a claim for a service provided to a child in non-Title IV-E foster care or adoption subsidy according to the instructions in the reimbursement handbook. The provider must submit the claim to the Florida Medicaid fiscal agent for payment.
Claims for Prior Authorized Services	An out-of-state provider completes a claim for a service that was prior authorized according to the instructions in the reimbursement handbook. The provider must submit the claim to the Florida Medicaid fiscal agent for payment.
Recipients or Providers that are Out of the Country	Medicaid does not reimburse for services provided to recipients when they are out of the United States. Medicaid does not reimburse for services rendered by providers who are not in the United States.

Denying Provider Enrollment

Denying Provider Enrollment

Per section 409.907(9)(b), F.S., AHCA may:

Deny the application if the agency finds that it is in the best interest of the Medicaid program to do so. The agency may consider the factors listed in subsection (10), as well as any other factor that could affect the effective and efficient administration of the program, including, but not limited to, the applicant's demonstrated ability to provide services, conduct business, and operate a financially viable concern; the current availability of medical care, services, or supplies to recipients, taking into account geographic location and reasonable travel time; the number of providers of the same type already enrolled in the same geographic area; and the credentials, experience, success, and patient outcomes of the provider for the services that it is making application to provide in the Medicaid program. The agency shall deny the application if the agency finds that a provider; any officer, director, agent, managing employee, or affiliated person; or any partner or shareholder having an ownership interest equal to 5 percent or greater in the provider if the provider is a corporation, partnership, or other business entity, has failed to pay all outstanding fines or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services, not subject to further appeal, unless the provider agrees to a repayment plan that includes withholding Medicaid reimbursement until the amount due is paid in full.

Reasons for Denial

Per section 409.907(10), F.S., AHCA may deny enrollment if the provider or any officer, director, agent, managing employee, affiliated person, or any partner or shareholder having an ownership interest equal to five percent or greater in the provider if the provider is a corporation, partnership, or other business entity, has:

- Made a false representation or omission of any material fact in making the application, including the submission of an application that conceals the controlling ownership of any officer, director, agent, managing employee, affiliated person, partner or shareholder who may not be eligible to participate;

Denying Provider Enrollment, continued

Reasons for Denial, continued

- Been or is currently excluded, suspended, terminated from, or has involuntarily withdrawn from participation in Florida's or any other state's Medicaid program or from participation in any other governmental or private health care or health insurance program;
- Been convicted of a criminal offense relating to the delivery of any goods or services under Medicaid or Medicare or any other public or private health care or health insurance program including the performance of management or administrative services relating to the delivery of goods or services under any such program;
- Been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services;
- Been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;
- Been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
- Been convicted under federal or state law of a crime punishable by imprisonment of a year or more which involves moral turpitude;
- Been convicted in connection with the interference or obstruction of any investigation into any criminal offense listed in subsection (10);
- Been found to have violated federal or state laws, rules, or regulations governing Florida's Medicaid program or any other state's Medicaid program, the Medicare program, or any other publicly funded federal or state health care or health insurance program, and been sanctioned accordingly;
- Been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided; or
- Failed to pay any fine or overpayment properly assessed under the Medicaid program in which no appeal is pending or after resolution of the proceeding by stipulation or agreement, unless AHCA has issued a specific letter of forgiveness or has approved a repayment schedule to which the provider agrees to adhere.

Provider Re-enrollment

Description and Purpose

Provider re-enrollment is a methodology used by AHCA to verify the information currently residing on the Florida Medicaid Management Information System (FMMIS) for each active provider. The re-enrollment process gives the provider a chance to:

- Verify and update the information on the provider file;
- Sign a new Medicaid Provider Agreement; and
- Comply with all other requirements.

Failure to Re-enroll

If the provider does not fulfill the requirements for re-enrollment, his provider ID will be terminated. Claims processed for dates of service on or after the termination will be denied.

Once the provider ID is terminated, the provider must complete a new Provider Enrollment Application package to be re-enrolled in Medicaid.

Provider Terminations

Termination

A provider can be terminated for any reason, at any time, by the provider's request or by the state with 30-days written notice. All the conditions of the provider agreement remain in effect during the 30-day notice period.

Exceptions to the 30-Day Notice

Terminations can be effective in less than 30 days:

- If the provider is required to be licensed or have insurance or a surety bond, the effective date of termination will be the date that the license, insurance, or surety bond expires;
- If the provider is suspended or terminated from Medicare or any other state's Medicaid program, the effective date of termination will be the date that Medicare or Medicaid was suspended or terminated;
- If the provider's business is closed, abandoned, or non-operational, the effective date of termination will be the date that the business was closed, abandoned, or became non-operational or that the state became aware of the change;
- If any disqualifying information is found during a criminal history background check;
- If the provider is deceased, the effective date of termination will be the date of death; and

Provider Terminations, continued

Exceptions to the 30-Day Notice, continued

- The agency shall also immediately suspend or terminate, as appropriate, a provider's participation in this state's Medicaid program if the provider participated or acquiesced in any action for which any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to five percent or greater, was suspended or terminated from participating in the Medicaid program or the Medicare program by the Federal Government or any state.

Terminated Provider ID Number

When a provider is terminated from the Medicaid program, his provider Medicaid identification number becomes inactive on the Medicaid computer system, and he will not be reimbursed for services rendered on or after the date of termination.

Filing Claims After Termination

Whenever a provider is terminated from the Medicaid program, whether voluntarily or involuntarily, and has unresolved pending Medicaid claims, the Medicaid fiscal agent will assist the provider with resolving the claims. The claims must be for services that were provided with dates of service prior to the provider's termination.

Outstanding Balances or Liens in a Provider File

Whenever a provider's file shows there is an outstanding balance or a lien on file, all payments will be placed on hold to prevent the system from paying until the balance has been paid or the lien has been satisfied.

If the provider is terminated with an outstanding balance on file and reapplies to enroll as a provider, the outstanding balance must be repaid to the Medicaid program. If the provider's enrollment is approved, Medicaid Provider Enrollment will instruct the fiscal agent to activate the Medicaid provider ID and offset outstanding liens before any claims are paid to the provider.

Provider Reapplications after Termination

Reapplication Process	If a provider's number has been terminated for any reason, the provider must do the following to reapply: • Complete and submit a new Provider Enrollment Application package, and • Meet all the provider qualifications.
Reapplication with a Different Name or Tax ID Number	If the provider is reapplying under a different name or different tax ID number, the provider must furnish the prior name or tax ID number with the application.
Reapplication after Medicare Termination by HHS	If the provider's Medicare identification number was terminated by the United States Department of Health and Human Services (HHS), Medicaid must have approval from HHS before re-enrolling the provider. The provider must apply in writing to HHS to obtain approval documentation. The provider must submit the approval documentation with the Provider Enrollment Application. The provider must follow all the enrollment procedures and meet all provider qualifications.
Reapplication after Medicaid Termination by Another State	If the provider's Medicaid identification number was terminated by another state, Florida Medicaid must have documentation from the other state that the provider could be re-enrolled in that state. The provider must submit the documentation with his Provider Enrollment Application. The provider must follow all the enrollment procedures and meet all provider qualifications. Approval for re-enrollment in another state does not guarantee that the provider is eligible to be re-enrolled in Florida Medicaid.

Reporting to the IRS

Information Reported to the IRS	Federal law requires Medicaid to report to the Internal Revenue Service (IRS) all payments made during the calendar year to any provider who received payment under a tax ID number. Note: See Changes to Provider Records in this chapter for information on reporting a change in a tax ID number.
Group Providers	If an individual practitioner enrolls using a corporate identification number and then later develops a group practice, that practitioner will have to change the tax identification number on his individual Medicaid provider ID to his social security number and apply for a group Medicaid provider ID.
IRS Form 1099	Medicaid reports payments to the IRS on Form 1099. A copy is also sent to each provider.

Change of Address Procedures

Requirement to Report a Change of Address	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.

Change of Address Procedures, continued

Failure to Report a Change of Address

If first class mail to a provider's service address is returned, Medicaid will suspend claim payments to the provider or the provider's group for services rendered by that provider. After 90 days, the suspended claims will be denied if the provider has not taken corrective action.

Change of Ownership

Definition of Change of Ownership

Section 409.901(5), F.S., defines a change of ownership as follows:

"(a) An event in which the provider ownership changes to a different individual entity as evidenced by a change in federal employer identification number or taxpayer identification number;
(b) An event in which 51 percent or more of the ownership, shares, membership, or controlling interest of a provider is in any manner transferred or otherwise assigned. This paragraph does not apply to a licensee that is publicly traded on a recognized stock exchange; or
(c) When the provider is licensed or registered by the agency, an event considered a change of ownership for licensure as defined in section 408.803."

A change solely in the management company or board of directors is not a change of ownership.

Medicaid Provider Agreement

Per section 409.907(6)(a), F.S., Medicaid may revoke a provider agreement, at AHCA's option, when there is a change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement.

Change of Ownership, continued

Liability for Outstanding Payments

Per section 409.907(6)(a), F.S., in the event of a change of ownership, the transferor remains liable for all outstanding overpayments, administrative fines, and any other moneys owed to AHCA before the effective date of the change of ownership. In addition to the continuing liability of the transferor, the transferee is liable to AHCA for all outstanding overpayments identified by AHCA on or before the effective date of the change of ownership. For purposes of this subsection, the term "outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by AHCA on or before the effective date of the change of ownership.

In the event of a change of ownership for a skilled nursing facility or intermediate care facility, the Medicaid provider agreement shall be assigned to the transferee if the transferee meets all other Medicaid provider qualifications.

In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to AHCA before the effective date of the change of ownership shall be determined in accordance with s. 400.179.

If a facility undergoes a change of ownership, and an overpayment is identified during the prior ownership, the prior owner is liable even if the change of ownership occurred more than six months before the overpayment was identified.

Notification Requirement

Per section 409.907(6), at least 60 days before the anticipated date of a change of ownership, the transferor shall notify the AHCA of the intended change of ownership and the transferee shall submit a Medicaid Provider Enrollment Application, AHCA Form 2200-0003, to AHCA.

If a change of ownership occurs without compliance with the notice requirements, the transferor and transferee shall be jointly and severally liable for all overpayments, administrative fines, and other moneys due to AHCA, regardless of whether AHCA identified the overpayments, administrative fines, or other moneys before or after the effective date of the change of ownership. AHCA may not approve a transferee's Medicaid provider enrollment application if the transferee or transferor has not paid or agreed in writing to a payment plan for all outstanding overpayments, administrative fines, and other moneys due to AHCA. This subsection does not preclude AHCA from seeking any other legal or equitable remedies available to AHCA for the recovery of moneys owed to the Medicaid program.

Change of Ownership, continued

Notification Requirement, continued

In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to AHCA before the effective date of the change of ownership shall be determined in accordance with the s. 400.179, if the Medicaid Provider Enrollment Application for the change of ownership is submitted before the change of ownership.

Federal Tax Identification Numbers

If a provider's tax identification number changes, the Medicaid provider ID must be terminated and a new Medicaid provider ID must be established for the new ownership. The fiscal agent may change a tax identification number only under the following circumstances:

- The provider submits a copy of the IRS form letter indicating the provider's new tax identification number; and
- The provider acquires an existing company and requests that its tax identification number be changed to the existing provider's own tax identification number.

There are instances in which the ownership will change and the tax identification number will remain the same. In these cases, if the ownership changes, the Medicaid provider ID must be terminated and a new Medicaid provider ID must be established.

Change of Ownership Process

The change of ownership procedures are as follows:

- At least sixty (60) days before a change of ownership is scheduled to occur, the provider (owner who is transferring the business) must send a letter indicating that the change will occur and the proposed date of the change to the fiscal agent or AHCA;
- At least sixty (60) days before the anticipated date of the change of ownership, the new owner shall submit a Medicaid Provider Enrollment Application, AHCA Form 2200-0003, copy of the above letter, a copy of the Bill of Sale or Stock Purchase Agreement, and a letter from the prior owner requesting termination of prior owner's provider ID, with the new owner's application package. The new owners must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers;
- If the application is received by the fiscal agent or AHCA prior to the date of the change of ownership, the effective date for the new provider ID will be either the date the change of ownership was complete or the date the applicant became eligible to provide services under Medicaid, whichever date is later;

Change of Ownership, continued

Change of Ownership Process, continued

- If the application is received by the fiscal agent or AHCA after the date of the change of ownership, the effective date for the new provider ID will be either the date the application was received or the date the applicant became eligible to provide services under Medicaid, whichever date is later;
- In cases where the application is received by the fiscal agent or AHCA after the date of the change of ownership, there will be a lapse between the termination date of the old provider ID and the inception date of the new provider ID. There will be no retroactive eligibility for payments to the new provider. Medicaid Provider Enrollment may make exceptions on a case-by-case basis in order to ensure that recipients have continuity of care, pursuant to ss.409.907(9)(a) and 409.907(11), F.S;
- Criminal history checks are required on all new partners or shareholders with ownership interest of five percent or more and all new individual officers, directors, managers, billing agents, financial custodian of records and Electronic Funds Transfer (EFT) authorized individuals of the new company. Checks are also required on all provider practitioner members of the new organization if they will serve as treating providers. If any of the new owners, directors, or officers of the company are determined to have background checks with "hits"- i.e., criminal convictions, pleas of no contest and adjudication withheld, etc., the new provider may not be enrolled in the Medicaid program;
- If the application is properly completed and the new provider is accepted based upon criminal history checks and the other submissions, the provider will be enrolled.

Other Changes to Provider Records

Requesting Other Changes

Except for a change of address, information about a provider can only be changed by the provider submitting a written, signed and dated request on letterhead stationery. The request must be signed by an authorized person on the provider file. The Medicaid provider ID must be included.

Where Non-Institutional Providers Send Requests for Changes

Non-institutional providers must send the original change request letter to:

Florida Medicaid
Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070

Other Changes to Provider Records, continued

Where Institutional Providers Send Requests for Changes	Institutional providers must send the original change request letter to: Medicaid Provider Enrollment 2562 Executive Center Circle East, Suite 100 Tallahassee, Florida 32399
Name	The provider must report a change in name. A request for a name change must include the provider's new name, prior name, Medicaid provider ID and the effective date of the change. If the name change is due to a change in ownership, then the procedures for a change in ownership must be followed.
No Longer Accepts Medicaid	The provider must notify the Medicaid fiscal agent if it is closing its business or no longer accepts Medicaid for any reason. The notification must include the Medicaid ID, the effective date of the business closure or the effective date that the provider no longer accepts Medicaid.
Death	The executor, a family member, or the provider group must report the date of a provider's death to the Medicaid fiscal agent. A copy of an obituary from a local newspaper or a copy of a death certificate may be submitted to report a provider's death. Another individual cannot use a deceased provider's Medicaid ID to bill for Medicaid services or for any other purpose.
Telephone Number	The provider must report to the Medicaid fiscal agent changes in telephone numbers. Notice of a change in telephone number(s) must include the new telephone number(s) and the provider's previous telephone number(s).
Federal Tax ID Number	If a provider's federal tax identification number changes, the new number must be reported. A request must include the new tax ID number, the previous tax ID number, and a copy of the IRS form granting the new tax ID number. If the change is due to a change in ownership, then the procedures for a change in ownership must be followed.

Other Changes to Provider Records, continued

Social Security Number	If a provider's social security number changes, the new number must be reported to the Medicaid fiscal agent. A request for change must include the new social security number and the previous social security number.
Medicare Status	A provider that participates in Medicare must notify the Medicaid fiscal agent of any change in his Medicare number or status. Claims cannot be crossed over automatically from Medicare if the current Medicare provider ID is not on the Medicaid system.
Multiple Service Addresses	Individual or group providers who render services at more than one service address under a **single license or certification** are required to submit a Declaration of Service Address form to identify each separate physical address where services are provided. This is required for each type of service for which the provider is enrolled. Individual or group providers who provide only one type of service but are **uniquely licensed or certified for each location** are required to submit a separate Florida Medicaid Provider Enrollment Application to obtain a unique Medicaid identification suffix for each location. Any closure of a practice address must also be reported to the fiscal agent along with the effective date of the closure. Note: See Provider Identification Numbers, Suffix Codes, and Specialty Codes in this chapter for complete instructions.
Group Membership	Either the group provider or the individual member must report when an individual member joins or leaves the group. To add an individual to a group, send a letter to the fiscal agent. The letter must include the group's provider identification number, the individual's provider identification number, and the date the individual joined the group. This letter must be signed by the individual provider. To remove an individual from a group, send a letter to the fiscal agent. The letter must include the group's provider identification number, the individual's provider identification number, and the date the individual left the group. This letter may be signed by either the group or the individual provider.

Other Changes to Provider Records, continued

Medicaid Services	Providers may be eligible for reimbursement for more than one type of Medicaid service. Providers may call the fiscal agent and inquire about the range of services they may be eligible to provide. A provider may add other services by submitting a written request to the Medicaid fiscal agent that includes documents verifying the provider's eligibility to provide those services.
Specialty Changes	A change in specialty for a provider must include the effective date of the new or deleted specialty and documentation verifying eligibility for the new specialty.
Reporting the Assignment of More Than One Provider ID Number	If a provider discovers that it has been assigned more than one provider identification number for the same type of service and the same location, the provider must promptly report that assignment to the Medicaid fiscal agent. As soon as the fiscal agent receives the report, the provider will be notified that one of the identification numbers will be terminated 30 days from the date it receives the letter and is advised not to use that identification number or to cease using that identification number. If the fiscal agent discovers that a provider has more than one provider identification number, a letter informing the provider that one of the numbers will be terminated is sent to the provider and the provider is given 30 days from the date it receives the letter to respond. The notification is also referred to Medicaid Program Integrity for further investigation of possible fraud or abuse.
Electronic Funds Transfer and Automatic Deposits and Payments (EFT)	Information on the automatic deposits and payments (EFT) record can be changed only by authorized individuals. A new EFT form must be completed and submitted to the fiscal agent by individuals who are listed on the current provider file as having authorization to sign on the provider's bank account. The new EFT form must contain an original signature(s), the provider ID, and must be accompanied by a letter from the depository branch verifying the name on the account, the account number and the routing or transmittal number.

Provider Rights and Responsibilities

Right to Refuse Services

A provider is not required to provide services to every recipient who requests services. A provider can limit the number of Medicaid recipients that the provider's facility or practice serves, and accept or reject recipients according to the policies of the facility or practice, except for the reasons described below:

- A hospital cannot refuse to provide emergency services;
- A provider cannot deny services to a recipient solely due to race, creed, color, national origin, disabling condition, or disability in accordance with the federal anti-discrimination laws; and
- A provider cannot deny services to a recipient due solely to the presence of third party insurance coverage or the recipient's inability to pay a Medicaid copayment.

Note: See Chapter 1 in this handbook for information on when a provider may bill a recipient.

Federal Anti-Discrimination Laws

Providers must adhere to the following federal laws in order to maintain Medicaid eligibility:

- Civil Rights Act of 1964, which prohibits discrimination on the basis of race, creed, color or national origin;
- Section 504 of the Rehabilitation Act of 1975, which prohibits discrimination on the basis of a disabling condition; and
- Americans with Disabilities Act of 1990, which ensures equal access to services for persons with disabilities.

Solicitation (Patient Brokering)

Providers are not permitted to knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program.

Privacy of Recipient Information

General Requirements

Medicaid providers, including their staff, contracted staff, volunteers and billing agents are required to safeguard the use and disclosure of information pertaining to Medicaid applicants and current and former Medicaid recipients as required by state and federal law and regulations.

Federal Medicaid Regulations

The federal Medicaid regulations pertaining to safeguarding applicant and recipient information have been in effect since 1979.

The Medicaid regulations require that the Medicaid state plan must provide safeguards that restrict the use and disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the state plan.

These purposes include:

- Establishing eligibility;
- Determining the amount of medical assistance;
- Providing services to recipients; and
- Conducting or assisting an investigation, prosecution, or civil or criminal proceeding relating to the administration of Medicaid.

The Medicaid regulations permit exchanging information with the following entities:

- Agencies that determine Medicaid eligibility, for example, the Department of Children and Families and the Social Security Administration, and agencies whose information is used to verify income and assets, such as the Internal Revenue Service;
- The Florida Department of Health, Vocational Rehabilitation, and Title V (Maternal and Child Health) grantees that are providing services or benefits to applicants and recipients. The information must be necessary for applicants and recipients to receive services or benefits; and
- Health oversight agencies that survey certain institutions, such as nursing facilities, that provide services to applicants and recipients.

Note: For the complete text of the federal Medicaid regulations, see Title 42 CFR, Part 431, Subpart F and Subpart G, on the National Archives and Administration Web site at www.gpoaccess.gov/cfr/index.html.

Privacy of Recipient Information, continued

Types of Information the Medicaid Regulations Require to be Safeguarded

The federal Medicaid regulations require the following Medicaid applicant/recipient information to be safeguarded:

- Names and addresses;
- Medical services provided;
- Social and economic conditions or circumstances;
- Medicaid evaluation of personal information;
- Medical data, including diagnosis and past history of disease or disability;
- Any information received for verifying income eligibility and amount of medical assistance payment; and
- Any information received in connection with the identification of legally liable third party resources.

Health Insurance Portability and Accountability Act (HIPAA)

Medicaid has fully implemented the privacy provisions of the Health Insurance Portability and Accountability Act. In addition to the federal Medicaid regulations, Medicaid providers are also required to follow the HIPAA privacy regulations as well as applicable state and federal laws that pertain to patient privacy.

Note: For the complete text of the HIPAA privacy rule, see the HHS Office of Civil Rights Web site at www.hhs.gov/ocr/hipaa.

Note: For information on AHCA's HIPAA privacy regulations, see AHCA's Web site at www.ahca.myflorida.com/hipaa

HIPAA Patient Rights

Medicaid recipients are entitled to all the patient rights pertaining to their protected health information that are authorized by HIPAA.

Confidentiality for HIV/AIDS and STI

State laws place restrictions on the release of any information about HIV/AIDS testing and treatment and sexually transmitted infections (STI).

A signed patient release must state what specific information the patient is giving permission to release. General medical releases are not allowed under state law. A parent or guardian cannot be informed of the dependent's medical care related to HIV/AIDS or STI without the dependent's written permission, if the dependent is of sufficient age and capability to provide consent.

Note: See Chapter 381.004, F.S., for the laws regarding HIV/AIDS testing and consent. The Florida Statutes are available on the Florida Legislature's Web site at www.leg.state.fl.us.

Record Keeping Requirements

Record Keeping Requirement

Medicaid requires that the provider retain all business records as defined in 59G-1.010(30) F.A.C., medical-related records as defined in 59G-1.010 (154) F.A.C., and medical records as defined in 59G-1.010 160) F.A.C. on all services provided to a Medicaid recipient.

Records can be kept on paper, magnetic material, film, or other media including electronic storage, except as otherwise required by law or Medicaid requirements. In order to qualify as a basis for reimbursement, the records must be signed and dated at the time of service, or otherwise attested to as appropriate to the media. Rubber stamped signatures must be initialed.

The records must be accessible, legible and comprehensible.

Electronic Records

Medicaid providers who create or maintain electronic records pertaining to goods and services paid for by the Medicaid program must develop and implement an electronic records policy to comply with the applicable state and federal laws, rules, and regulations to ensure the validity and security of electronic records. Medicaid providers' electronic records policies should address the technical safeguards required by the Code of Federal Regulations (CFR) Title 45, Part 164.312 where applicable.

Electronic signatures are permissible as defined by Chapter 668, Part 1, F.S., and CFR Title 45, Part 164.312.

AHCA reserves the right to require modifications to a provider's electronic records policy if AHCA determines, in its sole discretion, that the provider's electronic records policy does not adequately ensure the validity or security of the provider's electronic records. Medicaid providers who maintain electronic records are required to implement a mechanism by which electronic records can be produced in a paper format within a reasonable time, upon request by AHCA.

Note: The CFR is available on the Internet at www.gpoaccess.gov/cfr/index.html.

Record Keeping Requirements, continued

Record Retention

Records must be retained for a period of at least five years from the date of service.

Types of Records That Must be Retained

Medicaid requires that the following types of records, as appropriate for the type of service provided, must be retained (the list is not all inclusive):

- Medicaid claim forms and any documents that are attached;
- Professional records, such as appointment books, patient treatment plans, and physician referrals;
- Medical, dental, optometric, hearing, hospital, and other patient records;
- Copies of sterilization and hysterectomy consents;
- Prior and post authorization, and service authorization information;
- Prescription records;
- Orders for laboratory tests and test results;
- X-ray, MRI, and CAT scan records;
- Business records, such as accounting ledgers, financial statements, invoices, inventory records, check registers, cancelled checks, sales records, etc.;
- Tax records, including purchase documentation;
- Drug utilization reports by drug NDC;
- Partnership records;
- Patient counseling documentation;
- Provider enrollment documentation;
- Purchase documentation; and
- Utilization review and continued stay approvals for psychiatric or substance abuse inpatient stays.

Right to Review Records

Authorized state and federal agencies and their authorized representatives may audit or examine a provider's or facility's records. This examination includes all records that the agency finds necessary to determine whether Medicaid payment amounts were or are due. This requirement applies to the provider's records and records for which the provider is the custodian. The provider must give authorized state and federal agencies, and their authorized representatives, access to all Medicaid patient records and to other information that cannot be separated from Medicaid-related records.

The provider must send, at his expense, legible copies of all Medicaid-related information to the authorized state and federal agencies and their authorized representatives upon request of AHCA.

At the time of the request, all records must be provided regardless of the media format on which the original records are retained by the provider. All medical records must be reproduced onto paper copies unless otherwise authorized by the requestor.

Record Keeping Requirements, continued

Requirements for Medical Records

Medical records must state the necessity for and the extent of services provided. The following requirements may vary according to the service rendered:

- Description of what was done during the visit;
- History;
- Physical assessment;
- Chief complaint on each visit;
- Diagnostic tests and results;
- Diagnosis;
- Treatment plan, including prescriptions;
- Medications, supplies, scheduling frequency for follow-up or other services;
- Progress reports, treatment rendered;
- The author of each (medical record) entry must be identified and must authenticate his entry by signature, written initials or computer entry;
- Dates of service; and
- Referrals to other services.

Note: See the service-specific Coverage and Limitations Handbook for record keeping requirements that are specific to a particular service.

Incomplete Records

Providers who are not in compliance with the Medicaid documentation and record retention policies described in this chapter may be subject to administrative sanctions and recoupment of Medicaid payments.

Medicaid payments for services that lack required documentation or appropriate signatures will be recouped.

Note: See Chapter 5 in this handbook for information on administrative sanctions and Medicaid payment recoupment.

Counterfeit-Proof Prescription Blanks and Printed Prescriptions

Requirements

Chapter 409.912(37)(a)5., Florida Statutes, requires Medicaid-participating prescribers or prescribers who write prescriptions for Medicaid recipients to use a standardized counterfeit-proof prescription blank when writing prescriptions for Medicaid recipients.

Medical practitioners (prescribers) must obtain and use a counterfeit-proof prescription blank or prescription order form produced by a vendor approved by AHCA when writing hard copy prescription(s) for Medicaid recipients for any covered service under the Florida Medicaid Prescribed Drug Services Program. Prescriptions presented via other modes of transmission, e.g., facsimile, electronic-prescribing, telephone, are exempt from this requirement.

A uniform layout, format, or style is not required when a vendor or vendor's software produces the blank or printed prescription. Prescribers may customize the layout in accordance with applicable federal and state laws and regulations. AHCA requires that all vendors ensure the blanks or printed prescriptions produced meet the minimum security feature specifications required and include a tracking identifier printed on the front of the blank or printed prescription. The minimum security features include the following: the background color of the blank or printed prescription must be blue or green and resist reproduction, the blank or printed prescription must resist erasures and alterations, and the word "void" or "illegal" must appear on a photocopy of the blank or prescription. The security features must be listed on the blank or printed prescription.

Counterfeit-Proof Prescription Blanks and Printed Prescriptions, continued

Approved Vendors

AHCA approves the vendors that may manufacture and distribute the counterfeit-proof prescription blanks. AHCA also approves vendors that market a software program that produces in conjunction with a production system, a hard copy printed prescription. The prescription blanks or printed prescription documents must meet AHCA counterfeit-proof specifications as detailed above in the Requirements information block.

The vendors must comply with vendor requirements established by AHCA as follows:

- They are accountable for the prescription blanks or documents produced, stored, and the prescription blanks' or documents' delivery.
- They are responsible for appropriate safeguards to protect against unauthorized access to the blanks or software program and production systems used for prescribing.
- They must maintain secure storage locations and deliver blanks or software programs only to authorized licensed medical practitioners.
- The software program and production system must have appropriate safeguards to allow access and use only by authorized licensed medical practitioners.
- Upon request, the vendors must provide AHCA with any records relevant to the production, security, and delivery of the prescription blanks or software program and production system outputs.

Approved vendors are assigned a unique alpha prefix identifier that is the first part of a tracking identifier that is required to be printed on the front of the blank or printed prescription.

A list of approved vendors can be found on the fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Pharmacy, and then Counterfeit-proof Prescriptions. Complaints about a vendor's products may be filed with Medicaid Program Integrity.

Practitioner Responsibility

All medical practitioners who prescribe drugs to Medicaid recipients are responsible for using, from a vendor approved by AHCA, counterfeit-proof prescription blanks or a software program and system that produces counterfeit-proof printed prescription documents. The prescriber or a professional sponsor may make payment for the counterfeit-proof prescription blanks or pads. Inquiries about type of blanks offered, cost, and professional sponsorship should be made with approved vendors.

Medical practitioners should periodically consult the fiscal agent's Web site for program and approved vendor updates.

Billing Agents and Clearinghouses

Introduction

A provider may retain a third party as a billing agent or clearinghouse to submit or transmit claims on the provider's behalf, if the third party's compensation for the service is:

- Related to the cost of processing the billing;
- Not related on a percentage or other basis to the amount that is billed or collected; and
- Not dependent upon the collection of the payment.

The billing agent or clearinghouse must enroll as a Medicaid provider. Medicaid and the Medicaid fiscal agent cannot give any information to a billing agent or clearinghouse that is not enrolled in the Medicaid program.

The requirement to enroll as a billing agent applies to contracted third parties. Employees of the provider who act as billing agents or clearinghouses are not required to enroll as Medicaid providers.

Electronic Data Interchange Agreement

If a provider contracts with a third party as a billing agent, the billing agent must enroll as a Medicaid provider. In addition, the provider must complete, sign and send to the Medicaid fiscal agent an Electronic Data Interchange Agreement, with Section 2: Florida Medicaid Billing Agent Agreement signed and dated. The Electronic Data Interchange Agreement is included in the Florida Medicaid Provider Enrollment Application, AHCA Form 2200-0003.

Electronic Data Interchange Agreement must be completed regardless of whether the provider bills on paper or electronically. It is a contract that defines the liability for information transferred between the provider and the billing agent as reported to the state of Florida and the Medicaid fiscal agent.

Obtaining an Electronic Data Interchange Agreement

The provider can obtain Electronic Data Interchange Agreement from the Medicaid fiscal agent by calling 800-289-7799 and selecting Option 4 or from the fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Enrollment. AHCA Form 2200-0003 is incorporated by reference in 59G-5.010, F.A.C.

Submitting an Electronic Data Interchange Agreement

The original of the completed and signed Electronic Data Interchange Agreement must be mailed to the state Medicaid fiscal agent at:

Florida Medicaid
Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070

Billing Agents and Clearinghouses, continued

Billing Agent Changes

If a provider's billing agent changes, the provider must send a letter to the Medicaid fiscal agent that includes the following information:

- The names and Medicaid provider IDs of the old and new billing agents;
- The effective date of the change in the billing agent; and
- A completed and signed copy of the signed Electronic Data Interchange Agreement for the new billing agent.

Accuracy of Information

All statements or documents submitted to AHCA or the Medicaid fiscal agent by the billing agent must be true and accurate. Filing of false information is sufficient cause for termination from participation of the agent or denial of a billing agent's application for enrollment.

Prohibition Against Reassignment of Provider Claims

Medicaid payments cannot be reassigned to a factor. A factor is an individual or organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. A factor does not include a billing agent as described above.

Privacy of Recipient Information

Billing agents, including their staff and contracted staff are required to safeguard the use and disclosure of information pertaining to Medicaid applicants and current and former Medicaid recipients as required by state and federal law and regulations. These regulations include the Medicaid regulations on safeguarding information and the HIPAA privacy regulations.

Note: See the section on Privacy of Recipient Information in this chapter for additional information.

Receipt of Medicaid Reimbursement

Billing agencies cannot be Medicaid pay-to providers. Medicaid will not issue reimbursement checks to billing agencies. Any billing agent attempting to receive Medicaid reimbursement in its own name or to enroll as a pay-to provider will be terminated from the Medicaid program.

If designated in writing by the provider, payment may be made in the name of the provider to the provider's billing agent. The letter must contain an original signature. Faxed letters will not be accepted.

Billing Agents and Clearinghouses, continued

Enrollment for Electronic Billing Through A Billing Agent

If a provider uses a billing agent to submit claims electronically, both the provider and the billing agent must complete and submit signed Electronic Data Interchange Agreements.

Requesting Help

By the Web Site

The Medicaid fiscal agent Web site, known as the portal, provides communication, data exchange, and self-service tools to the provider community. The Portal consists of both public and secure areas (Web pages requiring a username and password). The public area contains general information, such as program awareness, notices, and forms, and allows users to respond to surveys.

In the Portal's secure area, providers can access their personal information using their provider numbers and PINs (personal identification numbers). Providers can:

- Update information on the provider number;
- Update address information;
- Request eligibility verifications;
- Request and track prior authorization and referrals;
- Submit and track claims;
- Receive alerts and notices; and
- Receive Medicaid policy updates.

The Web portal is located at www.mymedicaid-florida.com.

By Telephone

The Medicaid fiscal agent's associates will handle basic claim or enrollment inquiries for all providers.

For provider claims inquiries, call the Provider Contact Center at 800-289-7799 and select Option 7. The telephone lines are open Monday through Friday from 7 a.m. to 6 p.m. eastern time.

For provider enrollment inquiries, call 800-289-7799 and select Option 4. Enrollment telephone lines are open Monday through Friday from 8 a.m. to 5 p.m. eastern time.

Requesting Help, continued

In Writing

The provider may prefer to write for help to obtain more detailed information about a claim. A written response can be kept as a permanent record for future reference.

A provider may use the Medicaid fiscal agent's Provider Inquiry Form, MLF 07/08, for written inquiries. A response to the inquiry will be mailed to the provider within seven working days of receipt by the fiscal agent. A copy of the Provider Inquiry Form and step-by-step instructions are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com and selecting Public Information for Providers, then Provider Support, and then Enrollment, or by calling the Provider Contact Center at 800-289-7799 and selecting Option 7.

Routine Inquiries

Routine claim and eligibility inquiries should be sent to the Medicaid fiscal agent in Tallahassee at:

Provider Contact Center
Written Correspondence
P.O. Box 7054
Tallahassee, Florida 32314-7070
800-289-7799 and select Option 7

Getting Help On-Site

The fiscal agent's provider field representatives are located in 17 different areas throughout the state to help providers with billing questions and concerns. Field representatives are responsible for:

- Training newly-enrolled providers;
- Training new staff members at established offices;
- Installing and training on electronic claims submission software; and
- Assisting the provider with troublesome claims.

Providers who encounter problems that cannot be handled by telephone or in writing can call to make an on-site appointment with a field representative.

Fiscal Agent Regional Divisions

Each field area consists of one or more counties. At least one field representative is assigned to each area. A field representative area map with phone numbers is in Appendix A of this handbook. The Miami area representatives are bilingual and will assist English and Spanish speaking providers.

To schedule an appointment with your field representative, call the field representative that represents your area or call Provider Enrollment at 800-289-7799 and selecting Option 4.

CHAPTER 3
MEDICAID RECIPIENT ELIGIBILITY

Overview

Introduction

Medicaid reimburses Medicaid providers for services rendered to Medicaid eligible recipients. Not all recipients are eligible for all services. This chapter provides information on the following:

- Who can qualify for Medicaid benefits in Florida,
- The process for verifying Medicaid eligibility including managed care enrollment,
- Valid proofs of Medicaid eligibility,
- Limited coverage categories, and
- Special instructions for other coverage categories.

In This Chapter

This chapter contains:

Eligibility Determination

Eligibility Requirements

To qualify for Medicaid, an individual must meet specific eligibility requirements, such as income, assets, age, citizenship or resident alien status, and Florida residency. The individual must have a social security number or proof of having applied for one.

Individuals Who Are Inmates of a Public Institution

Individuals who are inmates of public institutions, which include correctional and holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles, per the Code of Federal Regulations, 42 C.F.R. 435.1009, are not eligible for Medicaid services.

Who Determines Eligibility

Eligibility for Medicaid is determined by the Florida Department of Children and Families (DCF), ACCESS Florida, and by the federal Social Security Administration (SSA).

Eligibility Determined by the Department of Children and Families

The Department of Children and Families (DCF) determines eligibility for the following groups who have income and resources within established limits:

- low-income families with children and their caretakers;
- pregnant women;
- children in foster care;
- special-needs adoptees;
- low-income individuals who are age 65 and older;
- low-income individuals who are blind or permanently and totally disabled; and
- low-income individuals in need of hospice or institutional care.

Information about public assistance and other Medicaid eligibility requirements is available from any DCF service center and from DCF's Web site at: www.dcf.state.fl.us/programs/access/.

Presumptive eligibility for pregnant women (PEPW) is determined by qualified provider agencies designated by the Department of Children and Families, including County Health Departments, Regional Perinatal Intensive Care Centers, and other agencies that have been approved upon request.

Family Planning Waiver

County Health Departments determine eligibility for the family planning waiver services.

Eligibility Determination, continued

Eligibility Determined by SSA

The Social Security Administration determines eligibility for Supplemental Security Income (SSI), a federal cash assistance program that provides financial assistance to needy aged, blind, or disabled individuals. SSI recipients are automatically eligible for Florida Medicaid.

Eligibility Periods

Periods of Medicaid coverage are not the same among Medicaid eligibility programs. Depending on the Medicaid program, the recipient's eligibility may begin either on the first day of the month of application or on a specific day within the month and may end before the last day of the month. Medicaid eligibility may be approved retroactively for up to three months prior to the month of application.

Medicaid coverage will continue as long as a recipient meets all of the requirements for eligibility. A provider must verify a recipient's eligibility for the date of service prior to rendering the service. Medicaid will not reimburse a provider for any service rendered on a day on which the recipient of that service was ineligible.

Medicaid Identification Card

Introduction

The primary identification card for Medicaid is a gold plastic card with a magnetically encoded stripe. Recipients who are eligible for MediKids have a blue and white plastic card with a magnetically encoded stripe.

Card Not Proof of Eligibility

Possession of a Medicaid ID card does **not** mean a recipient is eligible for Medicaid services. A provider should verify a recipient's eligibility each time the recipient receives services.

Recipient Does Not Have an ID Card

Recipients who have not received or have lost their cards must request new or replacement Medicaid ID cards by calling the Department of Children and Families, Access FLORIDA information line at 866-762-2237. If the recipient is not in possession of an ID card, the provider can still verify eligibility; and if the recipient is eligible, provide services.

The recipient can also obtain a replacement Medicaid ID card by calling the Medicaid Fiscal Agent recipient call center at 888-367-6554 and following the prompts.

Note: See Verifying Eligibility and Managed Care Enrollment in this chapter.

Note: MediKids replacement cards are obtained by calling the MediKids Help line at 877-506-0578.

Medicaid Identification Card, continued

Use of the Medicaid ID Card

The Medicaid ID card provides direct access to the Florida Medicaid Management Information System (FMMIS) Medicaid eligibility and benefit files by using:

- Medicaid Eligibility Verification System (MEVS) software on a personal computer;
- MEVS terminal;
- Secure area on the fiscal agent's Web site at www.mymedicaid-florida.com; or
- Personal Digital Assistant (PDA).

A provider may also access the information by telephone.

Note: See Verifying Eligibility in this chapter for more information.

Card Control Number

The **eight-digit** number on the front of the Medicaid identification card is the card control number used to access the recipient's file and verify eligibility. It is **not** the recipient's ten-digit Medicaid identification number that is entered on claims for billing.

Note: See the Reimbursement Handbook for information on completing the claim form.

Magnetic Stripe

The magnetic stripe on the back of the card is coded for use with a Medicaid Eligibility Verification System (MEVS) device or terminal.

Medicaid Identification Number

The provider must submit a claim to Medicaid using the recipient's **ten-digit** Medicaid ID number.

The provider must look up the recipient's eligibility record on MEVS, the Medicaid fiscal agent's Web site, or the Automated Voice Response System (AVRS). Providers may use the card control number, the Medicaid identification number, or social security number and date of birth on the Web site; AVRS; and MEVS, depending on the MEVS vendor. AVRS gives the providers the option to receive a faxed copy of the eligibility request. The provider should record the recipient's Medicaid ID number and other relevant information obtained from the eligibility verification for billing purposes.

The Medicaid ID number is included on the valid proofs of eligibility.

Note: See the section Proofs of Eligibility in this chapter for more information regarding valid proofs of eligibility.

Medicaid Identification Card, continued

Determining Eligibility With the Medicaid ID Card

The card control number is one of the recipient identifiers that the provider may use to access the recipient's eligibility information on the Medicaid computer files.

Note: See Verifying Eligibility in this chapter for more information.

Who Receives the Medicaid ID Card

Each Medicaid eligible recipient receives an individual identification card. The recipient is instructed to retain the card even during periods of ineligibility. If the recipient becomes ineligible for Medicaid and later becomes eligible, the same ID card is used.

Verifying Eligibility

Introduction

The Florida Medicaid Management Information System (FMMIS) is the system that contains information about the recipient's Medicaid eligibility, processes claims, makes payments to Medicaid providers, and issues recipient Medicaid identification cards.

Medicaid will not reimburse a provider for a service unless FMMIS shows that a recipient is eligible on the date of service. It is the provider's responsibility to verify a patient's Medicaid eligibility prior to providing any Medicaid reimbursable services.

The Medicaid fiscal agent maintains the FMMIS. The provider verifies eligibility and obtains benefit information by accessing recipient eligibility information in the system. This section discusses how a provider can access this information, which is referred to as the Medicaid Eligibility Verification System (MEVS).

Note: If eligibility information is not available on the FMMIS, refer to Proof of Eligibility in this chapter. Please note that the "DCF Provider View" link on the provider Web portal is not a way to verify eligibility; the DCF provider view link does not contain eligibility information for Supplemental Security Income recipients. In addition, if the eligibility information is on the DCF system and not in FMMIS, FMMIS will not be able to process a claim until the eligibility information is in FMMIS.

Verifying Eligibility, continued

Ways to Access Recipient Information

Eligibility and benefit information (MEVS) is available to providers via the following:

- Point of Sale (POS) devices;
- Computer software that can be added to a personal computer;
- Automated voice response that generates a report with all the eligibility information for a particular recipient, which is automatically faxed to the provider's fax machine;
- Automated voice response that provides eligibility information using a touch-tone telephone;
- Secure area on the Medicaid fiscal agent's Web site;
- PDA at www.evs.flmmis.com (only a registered provider with a PDA will have access to this site); and
- X12N 270/271 Health Care Eligibility Benefit Inquiry and Response.

Information Available

The following recipient eligibility information for services rendered within the past 12 months is available from all the above sources:

- Medicaid program code;
- Hospital and other service limitations;
- Managed care membership;
- Third party insurance coverage and policy number;
- Medicare number;
- Medicare Part A & B coverage; and
- Nursing home status.

Eligibility Program Codes

The Medicaid program for which a recipient is eligible is identified on the FMMIS by a unique alpha identifier called a program code. The provider needs to know a recipient's program code before providing services, because some program codes indicate benefit limitations.

Note: See Limited Covered Categories in this chapter for additional information on eligibility programs with limited coverage.

Note: See Appendix C for a complete listing of the Medicaid Eligibility Program Codes.

Verifying Eligibility, continued

Medicaid Eligibility Verification Systems (MEVS)	MEVS transactions may be submitted using personal computer (PC) software or POS devices provided by MEVS switch vendors. When using a POS device the Medicaid card can be swiped through the terminal's card reader slot, or the recipient access information can be entered by hand. This option is not available when using PC software or automated voice response. Various switch vendors offer differing methods for gaining access to the eligibility system. They communicate with the FMMIS to obtain detailed recipient eligibility and coverage information. MEVS information is available 24 hours a day, seven days per week. There is a charge for each transaction and rates depend on the MEVS switch vendor selected.
MEVS Trace Number	A trace number is provided to uniquely identify each eligibility transaction submitted. The provider must retain the trace number in the recipient's medical record in case a discrepancy in the recipient's eligibility arises. The trace number is the key to obtaining the eligibility information that was returned on the original inquiry.
Available MEVS Switch Vendors	A list of current Florida MEVS switch vendors is available from the fiscal agent by calling EDI Technical Support at 866-586-0961 or 800-289-7799 and selecting Option 3 or from the fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then EDI.
Computer Software	Software is available that performs the same functions as the POS devices. This software can be purchased from private vendors and installed on a personal computer to verify eligibility.

Verifying Eligibility, continued

Automated Voice Response-FaxBACK

This verification method requires a fax machine and a touch-tone telephone.

To obtain eligibility information, the provider enters the nine-digit provider number, date of service, and one of the following:

- Ten-digit recipient Medicaid ID number;
- Eight-digit plastic card control number; or
- The recipient's social security number and date of birth.

A voice response message will be received giving eligibility status, followed immediately by a hard copy report to the provider's fax location. The hard copy fax page serves as the provider's verification of eligibility.

To update the fax number on the provider's file, call the Provider Contact Center at 800-289-7799 and select Option 7. The fax number can also be updated using the Web site at www.mymedicaid-florida.com. Select Secure Information for Providers, then Provider Demographic Maintenance, and then Location Name and Address.

This method is available 24 hours a day, seven days a week. This service is free and all providers are automatically enrolled.

Automated Voice Response System Verification

The Automated Voice Response System (AVRS) is a free service that is available to check eligibility information 24 hours a day, seven days a week. The telephone number is 800-239-7560.

AVRS is synthesized voice response for eligibility, spans of eligibility, and check inquiry only. Providers must have a touch-tone phone to use AVRS. The provider can make five inquires per AVRS call. No enrollment is necessary. All enrolled Medicaid providers may use AVRS.

AVRS Trace Number

A trace number is provided to uniquely identify each eligibility transaction submitted. The provider must retain the trace number in the recipient's medical record in case a discrepancy in a recipient's eligibility arises. The trace number is the key to obtaining the eligibility information that was returned on the original inquiry.

Verifying Eligibility, continued

Human Operator Verification

A provider can verify eligibility and determine coverage limitations by calling the Provider Contact Center at 800-289-7799, Monday through Friday, 7:00 a.m. to 6:00 p.m., Eastern Time, and selecting Option 7. English and Spanish speaking operators are available. The phone number is on the back of the Medicaid ID card.

The provider gives the associate the control number on the front of the recipient's Medicaid ID card or the recipient's ten-digit Medicaid ID number and requests information as needed. Providers are limited to two inquires per phone call.

The associate will tell the provider if the recipient is Medicaid eligible on the date of service, the recipient's ten-digit Medicaid ID number and eligibility program code, and if the recipient has exceeded the Medicaid coverage limitations.

The associate will not give the provider an audit number; therefore, the provider will not have proof of the recipient's eligibility if a discrepancy arises.

Web site

A provider can verify eligibility and determine coverage limitations by accessing the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Secure Information for Providers, and then Recipient Eligibility. The provider must be enrolled with Medicaid and have a PIN number that allows access to the Web site. Once the provider is logged in to the secure site, recipient eligibility can be accessed by the card control number, the Medicaid identification number, or the social security and date of birth.

X12N 270/271

Florida Medicaid providers who are enrolled with the Medicaid fiscal agent's Electronic Data Interchange (EDI) and are submitting electronic transactions to EDI Gateway may also submit HIPAA compliant X12N 270 (Eligibility Benefit Inquiry) transactions to receive the HIPAA-compliant X12 271 responses. There is no charge for this service.

Note: Information on EDI is available on the Medicaid's fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then EDI. Information is also available by calling 866-586-0961 or 800-289-7799 and selecting Option 3.

Managed Care Enrollment Verification

Managed Care Coverage

Medicaid reimbursement is restricted when a Medicaid recipient is enrolled in a managed care program. A provider must verify if the recipient is enrolled in a managed care program prior to delivering services.

For certain managed care plans such as HMOs and PSNs, the provider must receive authorization for the services that are included in the plan and bill the plan directly.

For MediPass, the provider must obtain authorization from the MediPass primary care provider. The provider must enter the MediPass authorization number on the claim when billing for the service.

Note: See Chapter 1 in this handbook for detailed information on the services covered by each of the Medicaid managed care plans.

Managed Care Verification

A provider can use any of the eligibility verification sources listed in this chapter to verify a recipient's enrollment in a managed care plan. The name and telephone number of the managed care plan are given along with other eligibility information. If the recipient is enrolled in MediPass, the MediPass primary care provider's name and telephone number are given.

Managed Care Assigned Plans

When verifying eligibility using MEVS or AVRS, the managed care assignment plans are:

- Child Welfare PPD Mental Health;
- Children Medical Services;
- CMS - Reform PSN;
- Disease Management;
- Disease Management – Hemophilia;
- Frail-Elder;
- Hospice;
- Medicaid HMO;
- Optional Transportation Service-PSN;
- Medicaid Reform HMO;
- MediPass;
- Minority Physician Network;
- Pediatric Reform PSN;
- Pediatric Emergency Room Diversion;
- Prepaid Dental;
- Prescribed Pediatric Extended Care;
- Provider Service Network-Reform;
- Provider Service Network-Non Reform;
- Healthy Start Waiver;
- Nursing Home Diversion Waiver;
- Program of all Inclusive Care for Elderly; and
- Pre-paid Mental Health Plan.

Proof of Eligibility

Introduction

FMMIS receives eligibility updates from the Department of Children and Families (DCF) within one business day. If a recipient requires services within this time period (prior to the FMMIS update), DCF will provide the recipient with acceptable proof of eligibility. These acceptable proofs of eligibility may be used in lieu of a MEVS response even if eligibility has been transmitted to FMMIS.

Acceptable Proof of Eligibility from a Recipient

Acceptable proofs of eligibility from a recipient are:

- FLORIDA generated temporary Emergency Medicaid Identification Card (AMIC), July 2008
- CF-ES Form 2681, Notice and Proof of Presumptive Eligibility for Pregnant Women, February 2003
- CF-ES Form 2014, Authorization for Medicaid/MediKids Eligibility, February 2003

Refusal of Services

Medicaid providers are prohibited from refusing to furnish a covered Medicaid service to a Medicaid recipient solely because the recipient's eligibility has not yet transmitted to FMMIS when the recipient possesses one of the above listed acceptable proofs of eligibility. Although providers can choose which Medicaid recipients they will serve, they cannot refuse services to recipients solely due to delay in eligibility updates.

Note: See Chapter 2, Provider Rights and Responsibilities, for information on the right to refuse service and federal anti-discrimination laws.

No Proof of Eligibility

A recipient may state that he is covered by Medicaid, but does not have a permanent Medicaid ID card or one of the above documents issued by the Department of Children and Families to prove eligibility.

The provider must verify eligibility by using one of the methods explained in the section Verifying Eligibility in this chapter.

Time Required

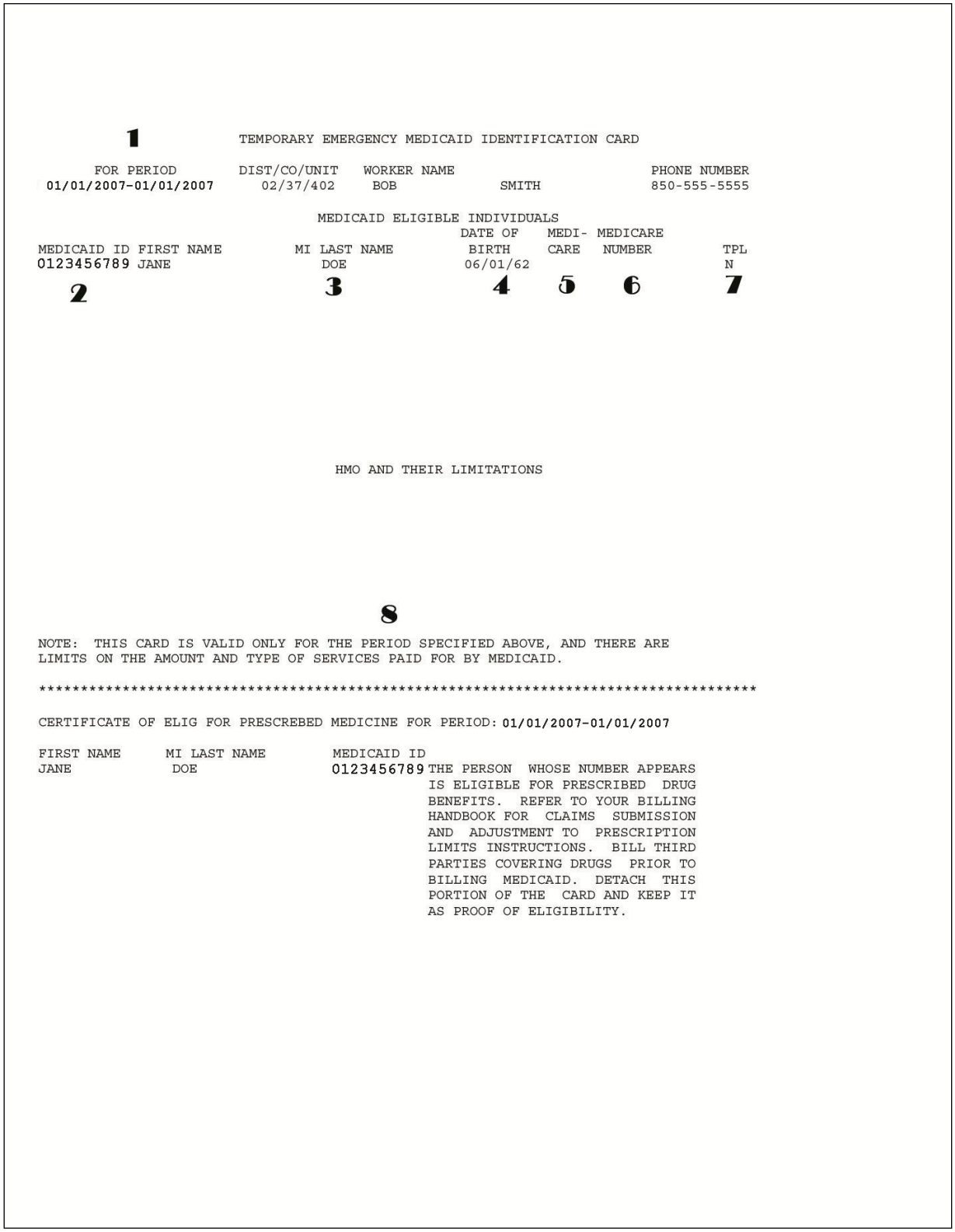
There may be a delay between the time an individual recipient is notified that he is eligible for Medicaid and the appearance of the information on the FMMIS system.

Temporary Emergency Medicaid Identification Card (AMIC)

This card is provided to recipients as a temporary proof of eligibility. It is only valid for the time period specified on the card. Medicaid will honor the temporary ID card and pay for covered Medicaid services rendered to the recipient.

A copy of the temporary Medicaid ID card is on the following page. It contains information critical for billing purposes.

Illustration 3-4: Temporary Emergency Medicaid Identification Card



1

TEMPORARY EMERGENCY MEDICAID IDENTIFICATION CARD

FOR PERIOD	DIST/CO/UNIT	WORKER NAME		PHONE NUMBER
01/01/2007-01/01/2007	02/37/402	BOB	SMITH	850-555-5555

MEDICAID ELIGIBLE INDIVIDUALS

MEDICAID ID	FIRST NAME	MI	LAST NAME	DATE OF BIRTH	MEDI-CARE	MEDICARE NUMBER	TPL
0123456789	JANE		DOE	06/01/62			N
2		3		4	5	6	7

HMO AND THEIR LIMITATIONS

8

NOTE: THIS CARD IS VALID ONLY FOR THE PERIOD SPECIFIED ABOVE, AND THERE ARE LIMITS ON THE AMOUNT AND TYPE OF SERVICES PAID FOR BY MEDICAID.

****

CERTIFICATE OF ELIG FOR PRESCREBED MEDICINE FOR PERIOD: 01/01/2007-01/01/2007

FIRST NAME	MI	LAST NAME	MEDICAID ID
JANE		DOE	0123456789

THE PERSON WHOSE NUMBER APPEARS IS ELIGIBLE FOR PRESCRIBED DRUG BENEFITS. REFER TO YOUR BILLING HANDBOOK FOR CLAIMS SUBMISSION AND ADJUSTMENT TO PRESCRIPTION LIMITS INSTRUCTIONS. BILL THIRD PARTIES COVERING DRUGS PRIOR TO BILLING MEDICAID. DETACH THIS PORTION OF THE CARD AND KEEP IT AS PROOF OF ELIGIBILITY.

Proof of Eligibility, continued

Explanation of the Card

The temporary Emergency Medicaid Identification card is a two-part form. The top part contains recipient identification and general eligibility information. The bottom part contains eligibility information for prescribed medicine, and is detached and retained by the pharmacist.

The numbers on Illustration 3-4 correspond to the following explanations.

ITEM	TITLE	WHAT ITEM MEANS
1	**For Period**	Dates of service covered by the card are located under the "For Period" on the first line. They are also located at the end of the detachable certificate of eligibility for prescribed medicine section. The card is valid to and from the dates shown in the "For Period." There are limits on the amount and type of services paid for by Medicaid. Before providing a service, providers must verify that Medicaid will reimburse for the service and the recipient has not exceeded the service limitations. Note: See the Coverage and Limitations Handbook for general information on Medicaid reimbursable services and coverage limitations. Note: Call the Provider Contact Center at 800-289-7799 and select Option 7 to determine if a recipient has exceeded the coverage limitations.
2	**Medicaid ID Number**	The recipient's Medicaid identification number has 10 digits. This is the number that the provider must use to bill Medicaid for services rendered to the recipient. The Medicaid ID number appears in the first column at the top of the card, and in the last column in the detachable certificate of eligibility for prescribed medicine section located at the bottom of the card.
3	**Recipient's Name**	The recipient's name appears twice: at the top of the card following the Medicaid ID number, and before the Medicaid ID number in the detachable certificate of eligibility for prescribed medicine section located at the bottom of the card.
4	**Date of Birth (DOB)**	The eligible recipient's date of birth is listed by month, day and year, e.g., 06/01/62.
5	**Medicare Indicator**	An alpha code here indicates the type of Medicare coverage that the recipient has: Part A, Part B, or both. When present, claims must be submitted to Medicare first.

Proof of Eligibility, continued

ITEM	TITLE	WHAT ITEM MEANS
6	**Medicare Number**	If applicable, the recipient's ten or eleven-digit alphanumeric Medicare number is listed here.
7	**TPL (Third Party Liability)**	An alpha designation of "Y" (Yes) or "N" (No) indicates if the recipient has third party coverage showing on the Medicaid computer system. If the indicator is an "N," verify with the recipient whether he has a third party resource. If the indicator is a "Y," claims must be submitted to the insurance carrier before billing Medicaid. Medicaid claims will deny if there is an indication of third party coverage that would normally cover the service being provided. The provider must obtain the coverage information from the recipient or local Department of Children and Families office. Medicaid is the payer of last resort.
8	**HMOs and Their Limitations**	Managed care information is not provided on the Emergency Medicaid Identification Card. Providers must verify managed care enrollment through: • Automated Voice Response system (800-289-7799, Option 1); • Medicaid fiscal agent's Web site at www.mymedicaid-florida.com (Select Secure Information for Providers, and then Recipient Eligibility; or • Medicaid Eligibility Verification System (MEVS) vendor. If Medicaid coverage is not yet on the system, the recipient is not enrolled in managed care. An exception is newborns whose Medicaid coverage is not yet on the system; please see Presumptively Eligible Newborns, Mother Is in an HMO. Before rendering a service, the provider must verify HMO coverage. Except for an emergency or family planning services, the provider must get prior authorization from the HMO and request the HMO's billing procedures. • Payment for an emergency service is contingent upon the level of screening, evaluation and examination required to determine whether or not a recipient's condition is an emergency medical condition. The determination as to whether an emergency medical condition exists shall be made by a physician of the hospital. Emergency services and care subsequent to this determination should be coordinated with the HMO; and

Proof of Eligibility, continued

ITEM	TITLE	WHAT ITEM MEANS
8	**HMOs and Their Limitations**, continued	• If the condition is not an emergency and the HMO does not give authorization to provide the services, the recipient must be advised to return to the HMO for services or the recipient will be responsible to pay for the services. Limitations for Presumptively Eligible Pregnant Women and Qualified Medicare Beneficiary recipients are also listed in this item. Note: See Appendix B, Glossary, for the definition of an emergency.

CF-ES Form 2681

The CF-ES Form 2681, Feb 2003, is issued by agencies with the authority to determine presumptive eligibility for pregnant women who meet the income and asset criteria.

A copy of a CF-ES Form 2681 can be found on the following page. It contains information critical for billing purposes.

Illustration 3-5: CF-ES Form 2681

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

NOTICE AND PROOF OF PRESUMPTIVE ELIGIBILITY FOR MEDICAID FOR PREGNANT WOMEN

1 _____

FROM: 2 MM/DD/YYYY TO: MMDD/YYYY

_____

_____

3 _____ Medicaid Number

You are eligible for Medicaid covered services for the dates shown above.

ABOUT YOUR TEMPORARY ELIGIBILITY (PRESUMPTIVE):

- You are eligible for all outpatient Medicaid covered services, which do not include post partum care.
- This Medicaid coverage is for the dates above.
- This coverage will **NOT** pay for the delivery of your baby even if you have the baby during this temporary period of eligibility.

WHAT YOU MUST DO TO GET ONGOING MEDICAID:

- You must complete an application/interview with the Medicaid eligibility specialist.
- You must also provide all the information that was requested by the Medicaid eligibility specialist.
- The Medicaid eligibility specialist will determine your ongoing eligibility for Medicaid, which will also cover hospital services, including delivery and post-partum care, for you and your baby.

NOTE: You do not have to apply for or receive financial assistance to be eligible for Medicaid.

NOTE TO PROVIDERS:

- Please call the following numbers to verify Medicaid eligibility for after the dates shown above: 1-800-925-1955 or 1-800-289-7799

4 _____

Signature

CF-ES 2681, Feb 2003
(Stock Number: 5747-000-2681-8)

Office Address:

5

Telephone:

Incorporated by reference in 59G-5.020, F.A.C

Proof of Eligibility, continued

Explanation of the Form

The following information is on the Notice and Proof of Presumptive Eligibility for Medicaid for Pregnant Women, CF-ES 2681.

ITEM	TITLE	WHAT ITEM MEANS
1 (Top Left)	**Name and Address**	The name and address of the pregnant woman who is presumed Medicaid eligible.
2 (Top Right)	**From and To Dates**	The date when Medicaid coverage begins and ends.
3 (Top Right)	**Medicaid Number**	The ten-digit number used for Medicaid recipient identification.
4 (Bottom Left)	**Signature**	The signature of the person who determined the recipient's presumptive eligibility for Medicaid.
5 (Bottom Right)	**Office Address and Telephone**	The address and telephone number of the agency authorized to determine presumptive Medicaid eligibility.

CF-ES Form 2014

The CF-ES Form 2014, Feb 2003, is issued by the Department of Children and Families public assistance specialist and is used for temporary proof of Medicaid eligibility.

A copy of a CF-ES Form 2014 can be found on the following page. It contains information critical for billing purposes.

Illustration 3-6: CF-ES Form 2014

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

Authorization for Medicaid/Medikids Eligibility

Section I: ☐ **Proof of Eligibility:** ***Notice to Providers:*** ***This form cannot serve as proof of eligibility for any month after the month in which it was authorized.***

☐ If checked, attach Form 2902 (Medically Needy Billing Authorization) to your billing.

☐ If checked, client is enrolled in an HMO.

Section II: ☐ **Change** ☐ **Add File** ☐ **Language Indicator for Payee:** _____

Recipient ID/PIN: _|_|_|_|_|_|_|_|_| _| SSN: _|_|_| - _|_| - _|_|_|_|

FLORIDA Case/Seq: _|_|_|_|_|_|_|_|_|_| _|_| Medicare ID #: _|_|_|_|_|_|_|_|_|_|_|_|

Recipient Name: _|_|_|_|_|_|_|_|_|_|_|_| (LAST (If "JR," enter after last name unless matching SDX.)) _|_|_|_|_|_|_|_|_|_|_|_| (FIRST) _| (MI)

Payee Name: _|_|_|_|_|_|_|_|_|_|_|_| (LAST) _|_|_|_|_|_|_|_|_|_|_|_| (FIRST) _| (MI)

Address: _|_|_|_|_|_| (Number) _|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| (Street) _|_|_|_| (Apt. No.)

_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| (Mailing Address (if different)) _|_|_|_|_|_|_|_|_|_| (Phone Number)

_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| (City/Town) _|_| (State) _|_|_|_|_| - _|_|_|_| (Zip)

DOB: _|_|_|_| _|_|_|_| (Month Day Century Year) DOD: _|_|_|_|_|_|_|_| (M M D D C C Y Y) Race*: _| Sex*: _| (* Use FLORIDA Code)

District: _|_| County: _|_| Billing County: _|_| Unit: _|_|_|_|_|

Section III: (SBI)

Begin (mmddccyy)	End (mmddccyy)	Category	MN Split Billing Day?
_|_|_|_|_|_|_|_|	_|_|_|_|_|_|_|_|	_|_|_|_|	☐ Y ☐ N
_|_|_|_|_|_|_|_|	_|_| _|_|_|_|_|_|	_|_|_|_|	☐ Y ☐ N
_|_|_|_|_|_|_|_|	_|_|_|_|_|_|_|_|	_|_|_|_|	☐ Y ☐ N

Section IV: Authorization.

Before requesting this be added as a new file, I checked FMMIS by: ☐ **PIN** ☐ **SSN** ☐ **Name(s)**

_____ (Print name of person completing the form) _|_|_|_|_|_| (FLORIDA User ID) _|_| (District) _|_| (County) _|_|_|_|_| (Uniit)

_____ (ESSS Signature) _|_|_|_|_|_|_|_| (M M D D C C Y Y) _|_|_| (Area Code) _|_|_| - _|_|_|_| (Local Phone No.)

_____ **DCF District Program Office Authority or designee** _|_|_|_|_|_|_|_| (M M D D C C Y Y) _|_|_| - _|_|_|_| (SUNCOM)

Section VI: Fiscal Agent Use Only. *Before adding as a new file, I checked FMMIS by:* ☐ **PIN** ☐ **SSN** ☐ **Name(s)**

_____ (Name of person entering data on FMMIS) _____ (Phone Number) Date Entered: _|_|_|_|_|_|_|_| (M M D D C C Y Y)

CF-ES 2014, Feb 2003
(Stock Number: 5747-000-2014-3)

Incorporated by reference in 59G-5.020, F.A.C

Proof of Eligibility, continued

Explanation of the Form	Following is an explanation of the Authorization for Medicaid/MediKids Eligibility, CF-ES Form 2014.

ITEM TITLE	WHAT ITEM MEANS
❑ **Proof of Eligibility**	❑ This box must be checked in order for this form to serve as proof of eligibility. The form cannot serve as proof of eligibility for any month after the month in which it was authorized (signed by the DCF public assistance specialist in the authorization box). ❑ If checked, the recipient is enrolled in an HMO.
❑ **Change** ❑ **Add File**	To be completed by staff.
Recipient ID/PIN	The recipient's Medicaid Identification number.
SSN	The recipient's social security number. Most 2014s will have a SSN number, but it is not required.
FLORIDA Case/Sq.	The FLORIDA case number has 10 digits and the sequence number has 2.
Medicare ID#	The Medicare ID number contains 9 numbers and 1 or 2 letters. If the Medicare number is the same as the SSN, then the letter must be an A, M, or T.
Recipient Name (Last, First, MI)	The recipient's last name, first name, and middle initial.
Payee Name (First, MI, Last)	The payee name can be the name of the recipient, the recipient's parent or a person who is responsible for the recipient.
Address	Recipient's street or P.O. Box, city, state and zip code.
DOB	The recipient's date of birth in month, day, century, and year (mmddccyy) format.
DOD	Date of the recipient's death.
Race	The recipient's race.
Sex	The recipient's sex.
District	The Department of Children and Families district (region) number.
County	The county in which the public assistance specialist works.

Proof of Eligibility, continued

ITEM TITLE	WHAT ITEM MEANS
Billing County	This county is the county in which the recipient currently resides, except when an institutionalized recipient lived in another county before going into the institution. For institutionalized recipients, the billing county is the county where the recipient resided in the community prior to entering the institution.
Unit	The unit in which the public assistance specialist works.
Begin	The first day of recipient's Medicaid eligibility.
End	The last day of the recipient's Medicaid eligibility.
Category	The recipient's assistance category code.
Authorization	The Authorization Box must be signed and dated by the DCF public assistance specialist or the form is not valid.
Fiscal Agent Use Only	The fiscal agent enters the date the recipient was added to the FMMIS.

Limited Coverage Categories

Programs with Limited Medicaid

The following programs cover limited Medicaid benefits:

Program	Program Codes
Pharmaceutical Expense Program	5007
Enhanced Benefit Account	EBA
Emergency Medicaid for Aliens	MLA, MLS, NLA, NLS
Family Planning Waiver Services	FP
MediKids	MKA, MKB, MKC
Non-Institutional Care Only	MIT, MRIT
Presumptively Eligible Pregnant Woman	MU
Qualified Medicare Beneficiaries	QMB, QMBR
Special Low Income Medicare Beneficiary	SLMB
Qualified Individuals I	QI1

The Medicaid benefits covered under each of the above programs are described in the following sections.

Note: See Appendix C in this handbook for a complete list of all program codes.

5007

Description

This is a limited program funded with state general revenue to provide assistance with the Medicare Part B coinsurance for specific Medicare Part B drugs.

Enhanced Benefit Account

Description

This program does not provide any services. It is an account that permits recipients who have earned credits for Healthy Behaviors to purchase over-the-counter health related items from a pharmacy. Refer to the AHCA Web Site at: http://ahca.myflorida.com/medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml.

Emergency Medicaid For Aliens

Description

This program reimburses for emergency services provided to aliens who meet all Medicaid eligibility requirements except for citizenship or alien status.

Medicaid for Aliens

Eligibility can be authorized only for the duration of the emergency. Medicaid will not pay for continuous or episodic services after the emergency has been alleviated.

All claims must be accompanied by documentation of the emergency nature of the service. Exceptions are labor, delivery, and dialysis services. These are considered emergencies and are payable without documentation when the emergency indicator is entered on the claim form.

Note: See the Glossary, Appendix B, in this handbook for the definition of emergency.

Note: See the Medicaid Provider Reimbursement Handbook for the applicable claim form for instructions on entering an emergency indicator.

Alien Program Codes

Individuals eligible for Emergency Medicaid for Aliens are assigned the following program codes:

- MLS Emergency Medicaid Alien;
- MLA Emergency Medicaid Alien ;
- NLS Medically Needy, Emergency Alien; and
- NLA Medically Needy, Emergency Alien.

These codes indicate the Medicaid coverage is only for the duration of the emergency.

Family Planning Waiver Services

Description

The Florida family planning waiver expands the provision of family planning and family planning-related services to women, ages 14 through 55, losing Medicaid coverage, who have family income at or below 185 percent of the Federal poverty level (FPL), and who are not otherwise eligible for Medicaid, Children's Health Insurance Program (CHIP), or health insurance coverage that provides family planning services. Eligibility is limited to two years after losing Medicaid coverage, subject to an annual redetermination.

Eligibility Requirements

Recipients who lost their Medicaid eligibility within the last two years enroll for family planning waiver services at their local county health departments.

In order to receive the second year of extended family planning benefits, recipients must reapply at their local county health departments.

Recipients are no longer eligible if they leave Florida, become Medicaid eligible in another category, request that their Medicaid be terminated, or become pregnant.

Recipients who become pregnant or think they may be eligible for Medicaid coverage under a different category must reapply for Medicaid though the Department of Children and Families.

Note: A list of county health departments' addresses and phone numbers is available on the Department of Health's Web site at www.doh.state.fl.us.

Family Planning Waiver Services, continued

Covered Services

Eligible recipients may receive Medicaid-covered family planning services listed under the "Family Planning Services" topic in the Medicaid Coverage and Limitations Handbooks; family-planning related pharmacy services; antibiotics and vaginal antifungals and anti-infectives to treat sexually-transmitted infections (STIs); sterilization; and colposcopy.

Certain evaluation and management procedures are reimbursable when the recipient either returns for STI counseling and treatment or is referred for this service.

Colposcopies and treatment for STIs are limited to a six-week period after a family planning examination, a family planning counseling visit, or a family planning supply visit.

No other Medicaid services are covered, including inpatient services.

Note: See the service-specific Medicaid Coverage and Limitations Handbook for a list of the family planning services that Medicaid reimburses. The handbooks are available on the fiscal agent Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. The Medicaid Coverage and Limitations Handbooks are incorporated by reference in the Medicaid Services Rules in 59G-4, F.A.C.

Program Code

Recipients who are eligible for family planning waiver services are assigned the program code FP – Family Planning Services Only.

MediKids

Description	MediKids is a health insurance program for children from one through four years of age that is administered by the Agency for Health Care Administration. MediKids is a component of the Florida KidCare Program enacted by the 1998 Florida Legislature. MediKids provides health insurance to children age one to five who are U.S. citizens or qualified aliens and who are ineligible for Medicaid. MediKids is not an entitlement program. Families must pay low monthly premiums.
MediKids Eligibility	MediKids eligibility is determined by the Florida Healthy Kids Corporation. A family may obtain an application by calling the KidCare Information Line at 888-540-5437. Applications are also available at county health departments and Department of Children and Families service centers. Families may apply online at www.floridakidcare.org. In counties where there are two or more Medicaid HMOs, the child's family must select an HMO. In counties where there is one Medicaid HMO, the family must select the HMO or a MediPass provider. In counties with no HMO coverage, the family may select a MediPass provider. The child's family must select a plan in order for coverage to begin.
Covered Services	MediKids enrollees are eligible for all Medicaid benefits except home and community-based waiver services. They receive services from Medicaid providers or providers contracted with Medicaid HMOs.
MediKids Program Codes	Children eligible for the MediKids program are assigned program codes of MKA, MKB, or MKC.

Presumptively Eligible Pregnant Women (PEPW)

Description of PEPW	This program allows staff at County Health Departments, Regional Perinatal Intensive Care Centers, and other designated qualified providers to make a presumptive determination of Medicaid eligibility for low-income pregnant women. This presumptive determination allows a woman to access prenatal care while Department of Children and Families' eligibility staff makes a regular determination of eligibility.
PEPW Coverage	Only outpatient, office services, and transportation are reimbursed by the PEPW Program. The PEPW Program does not reimburse for inpatient and delivery services.
PEPW Periods of Coverage	The presumption of eligibility may begin on any day within a month and lasts until the Department of Children and Families makes a regular determination of eligibility.
PEPW Limitations	Costs associated with labor, delivery, postpartum and any inpatient services are not covered by Medicaid during the presumptive period.
PEPW Program Codes	PEPW recipients are assigned the program code: MU Presumptively Eligible Pregnant Woman.

Qualified Medicare Beneficiaries (QMBs)

Description of QMB

Qualified Medicare Beneficiary (QMB) entitles low-income individuals to have Medicaid pay for their Medicare premiums, deductibles and coinsurance. An individual can have QMB only coverage, or QMB coverage and a full Medicaid coverage program. Recipients who are eligible for QMB coverage only are not eligible for any other Medicaid benefits.

QMB Eligibility

Qualified Medicare Beneficiary eligibility is determined by the Department of Children and Families. A recipient must have Medicare coverage in order to qualify for QMB coverage.

QMB Program Codes

The following program codes indicate that the recipient is a QMB and is not eligible for Medicaid services except for reimbursement of Medicare premiums, deductibles and coinsurance:

- QMB
- QMBR

QMB and Other Medicaid Eligibility

A recipient may be eligible for QMB and another aid category such as MI I, MW A, and MH H. They will have both QMB and the other aid category present in FMMIS. Someone who is eligible for Supplemental Security Income (MS aid category) and also eligible for Medicare is automatically considered QMB eligible with full Medicaid, even when the QMB category is not present in FMMIS.

Qualified Medicare Beneficiaries (QMBs), continued

Prohibition on Provider's Billing

Providers may not bill recipients who are eligible as a QMB only or Medicaid and QMB for the Medicare coinsurance or deductible.

The Balanced Budget Act (BBA) of 1997 requires Medicare providers to consider whatever amount they are paid by Medicaid for Medicare cost sharing to be payment in full for any QMBs that they serve. Under the BBA, QMBs are relieved of the liability to pay any Medicare cost sharing to any Medicare providers or Medicare managed care entities, whether those providers participate in Medicaid or not. Providers or managed care entities are subject to sanctions if they charge recipients for any cost sharing at all.

Special Low Income Medicare Beneficiaries (SLMB) and Qualifying Individuals I (QI1)

Description of SLMB and QI1

Special Low Income Beneficiaries (SLMB) and Qualifying Individuals I (QI1) entitle individuals above a certain percentage of the federal poverty level to have Medicaid pay the Medicare Part B premiums. Recipients who are eligible for only SLMB or QI1 are not eligible for any other Medicaid benefit. Recipients may be eligible for SLMB and a full Medicaid coverage program for the same date of service. When the individual is enrolled in SLMB and another benefit program for the date(s) of service, the individual is eligible for the benefits available under the other benefit plan as well as payment of the Part B premium under SLMB.

Entitlement for the QI1 program is limited by the availability of the capped federal funding allocated to the state.

SLMB and QI1 Eligibility

Eligibility for these programs is determined by the Department of Children and Families. A recipient must be entitled to Medicare Part A to qualify for either of these programs.

SLMB and QI1 Program Codes

Individuals eligible for SLMB or QI1 will have the program codes SLMB or QI1. If the recipient has no other coverage than SLMB or QI1, they are eligible for payment of their Part B premium only, no other Medicaid benefits.

If the recipient has other Medicaid coverage in addition to SLMB and QI1, they are eligible for the benefits available under the other Medicaid coverage as well as payment of the Medicare Part B premium under QI1 or SLMB.

Special Coverage Categories

Programs with Special Medicaid Coverage

The following programs have special Medicaid benefits:

Program	Program Codes
Institutional Care Program	MI A, MI I, MI M, MI P, or MI S
Mary Brogan Breast and Cervical Cancer Program	MBC
Medically Needy Program	Program codes that begin with "N" (exception: see Emergency Medicaid for Aliens for NL A and NL S program codes)
Presumptively Eligible Newborns	MN, NN, MRN, or NRN

The Medicaid benefits covered under each of the above programs are described in the following sections.

Note: See Appendix C in this handbook for a complete list of all program codes.

Institutional Care Program

Description

Medicaid reimburses institutional care services for Medicaid-eligible residents who meet Medicaid Institutional Care Program (ICP) eligibility requirements described in the Eligibility Requirements section below.

Medicaid covers the services listed in the Nursing Facility, Intermediate Care Facility for the Developmentally Disabled (ICF/DD), and State Mental Hospital Coverage and Limitations Handbooks for recipients who meet the eligibility requirements defined below.

Note: The Coverage and Limitations Handbooks are incorporated by reference in the Medicaid Services' Rule Division 59G, F.A.C. They are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Institutional Care Program, continued

Eligibility Requirements	In order to qualify for ICP services, the individual must be enrolled in one of the following program codes: MI I, MI A, MI M, MI P, MI S. Exception: This requirement to have institutional care coverage does not apply to "Level of Care X" recipients in the Medicare Part A coinsurance period who have Medicare and are either enrolled in the MS benefit plan for the date(s) of service or have QMB coverage (with or without other Medicaid coverage) for the date(s) of service. The Department of Children and Families (DCF) determines eligibility for ICP. ICP eligibility must be approved for all individuals whose care will be paid for by Medicaid prior to the facility billing Medicaid, except for the exception noted above. This includes SSI recipients and individuals who were eligible for Medicaid in the community before entering a facility. Eligibility for ICP is determined using program-specific technical, financial and medical eligibility criteria. A disposition notice is provided by DCF to the facility and the recipient when ICP eligibility is approved. This form must be retained by the facility in the recipient's file.
Covered Services	ICP recipients are eligible for full Medicaid coverage in addition to the Medicaid services listed in the Nursing Facility, Intermediate Care Facility for the Developmentally Disabled (ICF/DD), and State Mental Hospital Coverage and Limitations Handbooks.
Program Codes	ICP recipients are identified by the codes MI A, MI I, MI M, MI P, or MI S.

Mary Brogan Breast and Cervical Cancer Program

Description	Women who are screened and diagnosed with breast or cervical cancer through the Department of Health's Florida Breast and Cervical Cancer Early Detection Program may be eligible for Medicaid services. The screening program is administered by the Department of Health through various county health departments and contracts. Enrollment into Medicaid's Mary Brogan Breast and Cervical Cancer Treatment Program is extended to eligible women age 50 to 64, whose income is at or below 200 percent of the Federal Poverty Level.
Covered Services	If determined eligible for this program, a woman is entitled to all Medicaid services while receiving cancer treatment, or until she has attained age 65.
Program Code	Recipients who are eligible for the breast and cervical cancer treatment program are assigned the program code MBC.

Medically Needy Program

Description	A Medically Needy recipient is an individual who would qualify for Medicaid, except that the individual's income or resources exceed Medicaid's income or resource limits. On a month-by-month basis, the individual's medical expenses are subtracted from the individual's income, and if the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid from the day he became eligible until the end of the month.
Month of Eligibility	A Medically Needy recipient may be eligible for a full month or part of a month. The provider must check the recipient's eligibility before providing services.
Period of Medically Needy Eligibility	A Medically Needy recipient becomes eligible on the day that the recipient incurs allowable medical expenses that equal the amount by which his income exceeds the Medicaid income standard (share of cost). The recipient must submit his medical bills to DCF, and DCF makes the eligibility determination. The recipient will be eligible through the end of the month. If the program code is NL A or NL S, refer to the additional limitations specified in this chapter for Emergency Medicaid for Aliens. Note: For information on an individual recipient's share of cost, please contact the Department of Children and Families service center.

Medically Needy Program, continued

Medically Needy Program Codes

Medicaid recipients are identified with program codes that begin with "N." Medically Needy recipients' eligibility may change from month to month. NL A and NL S are program codes for Emergency Medicaid for Aliens who are Medically Needy.

Medically Needy Coverage Limitations

Medically Needy recipients are not eligible for:

- Assistive Care Services
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)
- Home and Community Based Services Waiver Programs
- Nursing Facility Services
- Regional Perinatal Intensive Care Center Services
- State Mental Hospital Services
- Statewide Inpatient Psychiatric Program (SIPP) services

Medicaid does not pay Medicare premiums for Medically Needy recipients unless they are also eligible as a Qualified Medicare Beneficiary (QMB), Special Low Income Medicare Beneficiary (SLMB), or Qualifying Individual 1 (QI1).

Presumptively Eligible Newborns (PEN)

Description

A newborn is deemed eligible for Medicaid when the mother is eligible for Medicaid at the time the baby is born, unless the mother is eligible under the Presumptively Eligible Pregnant Women (PEPW) category. These deemed eligible newborns are eligible for all Medicaid services.

Unborn's Medicaid ID Number

A pregnant woman may obtain a Medicaid identification number and Medicaid identification card (gold card) for her unborn child. Providers can use the gold card to inquire about the unborn baby's eligibility with the card control number. The baby's Medicaid ID number will not be active until after the baby is born.

Note: See the topic, Medicaid Identification Number, in this chapter for information on the ID number and verifying eligibility.

Activating the Medicaid ID Number

The provider uses the following instructions to activate the newborn's Medicaid coverage:

- Look up the newborn's eligibility record on MEVS, FaxBACK, or AVRS using the card control number. If MEVS, FaxBACK, or AVRS indicate that the newborn's number is active, no further action is required. The provider should record the newborn's Medicaid ID number obtained from the eligibility verification for billing purposes.
- If the newborn's Medicaid ID number is inactive, the provider will need to fax a completed Unborn Activation Form, AHCA Form 5240-006, January 2007, to the Medicaid fiscal agent to have the coverage activated. The fax number is 877-231-2170. The form must be filled out completely. **Incomplete forms will be returned to the provider**.
- Within two working days the fiscal agent will add the newborn's name and birth date and activate the coverage.

Note: See Verifying Eligibility in this Chapter for information on MEVS, FaxBACK, and AVRS.

When Coverage Will Be Denied

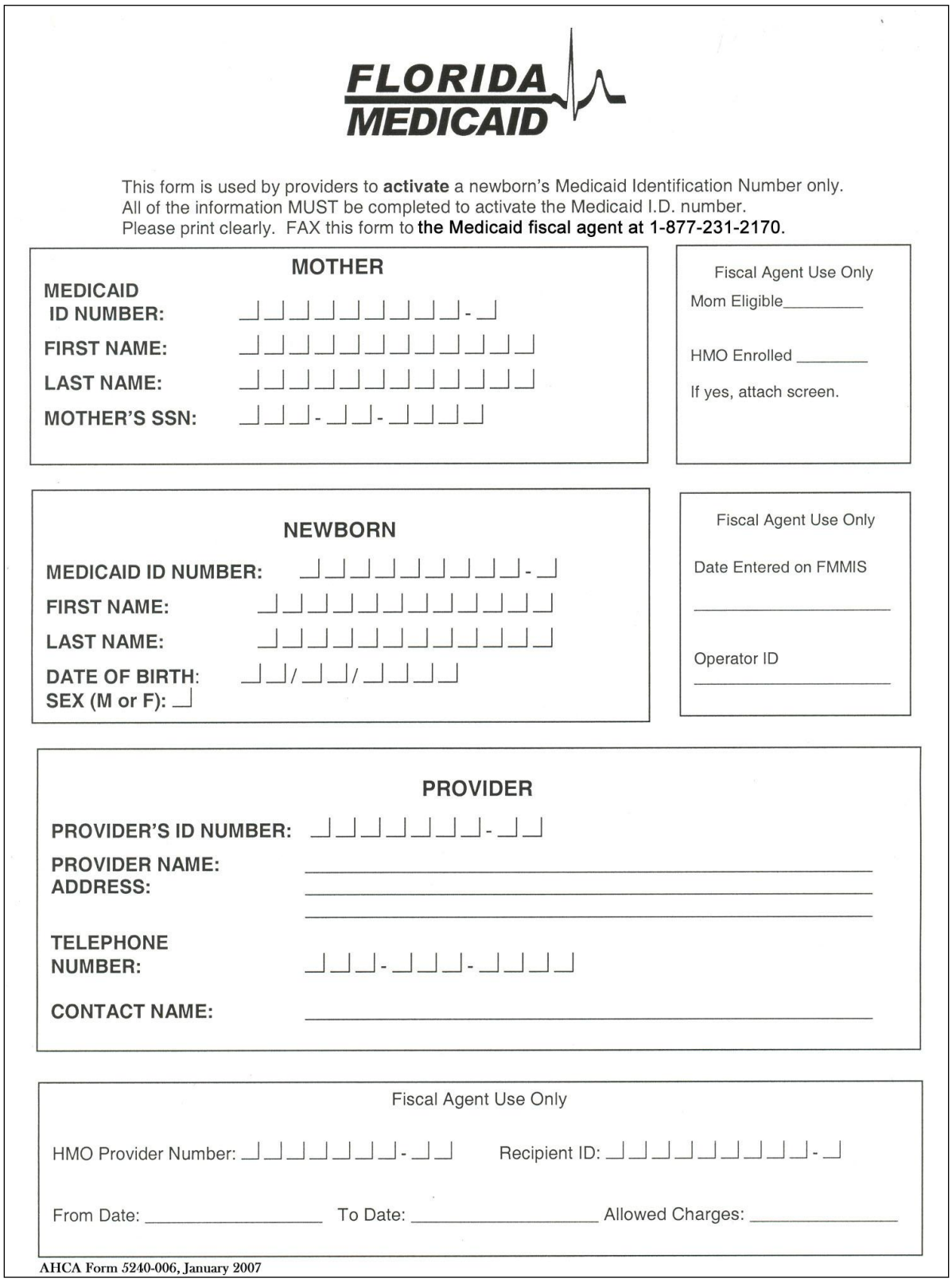
The fiscal agent will not activate the newborn's Medicaid coverage if:

- The mother is not eligible for Medicaid at the time of the baby's birth,
- The mother is eligible under the Presumptively Eligible Pregnant Women (eligibility code MU) or Family Planning Waiver (eligibility code FP) coverage groups, or
- The Unborn Activation Form is incomplete.

Unborn Activation Form

A copy of the Unborn Activation Form, AHCA Form 5240-006, January 2007, is on the next page. Providers may photocopy this form or obtain a copy from AHCA's Web site at www.ahca.mymedicaid.com. Select Medicaid and then Newborn Eligibility. It is incorporated by reference in 59G-5.020, F.A.C.

Illustration 3-1: Unborn Activation Form



FLORIDA MEDICAID

This form is used by providers to **activate** a newborn's Medicaid Identification Number only.
All of the information MUST be completed to activate the Medicaid I.D. number.
Please print clearly. FAX this form to **the Medicaid fiscal agent at 1-877-231-2170.**

MOTHER

MEDICAID ID NUMBER: _ _ _ _ _ _ _ _ _ - _
FIRST NAME: _ _ _ _ _ _ _ _ _ _ _ _
LAST NAME: _ _ _ _ _ _ _ _ _ _ _ _
MOTHER'S SSN: _ _ _ - _ _ - _ _ _ _

Fiscal Agent Use Only
Mom Eligible_____
HMO Enrolled _____
If yes, attach screen.

NEWBORN

MEDICAID ID NUMBER: _ _ _ _ _ _ _ _ _ - _
FIRST NAME: _ _ _ _ _ _ _ _ _ _ _ _
LAST NAME: _ _ _ _ _ _ _ _ _ _ _ _
DATE OF BIRTH: _ _/ _ _/ _ _ _ _
SEX (M or F): _

Fiscal Agent Use Only
Date Entered on FMMIS
_____
Operator ID
_____

PROVIDER

PROVIDER'S ID NUMBER: _ _ _ _ _ _ _ - _ _
PROVIDER NAME: _____
ADDRESS: _____
_____
TELEPHONE NUMBER: _ _ _ - _ _ _ - _ _ _ _
CONTACT NAME: _____

Fiscal Agent Use Only

HMO Provider Number: _ _ _ _ _ _ _ - _ _ Recipient ID: _ _ _ _ _ _ _ _ _ - _

From Date: _____ To Date: _____ Allowed Charges: _____

AHCA Form 5240-006, January 2007

Incorporated by reference in 59G-5.020, F.A.C.

Presumptively Eligible Newborns (PEN), continued

Mother is in an HMO

A newborn whose mother is enrolled in a Medicaid HMO is **not** automatically enrolled in the HMO. The HMO must create an unborn record and the HMO, Department of Children and Families, hospital, or any other provider must activate the unborn record by completing an activation form and faxing it to the Medicaid fiscal agent. The HMO must ensure that these steps are completed in order for the newborn to be enrolled in the HMO and to receive payment for the newborn.

If the Newborn Does Not Have an ID Number

If the provider knows the recipient is pregnant and Medicaid eligible and that her unborn child does not have a Medicaid ID number, the provider may have the newborn assigned a number by sending a CF-ES 2039, Medical Assistance Referral Form, which is described below, to the Department of Children and Families regional office.

Medical Assistance Referral Form

Introduction

Providers should send the Medical Assistance Referral form, CF-ES 2039, September 2002, to the regional Department of Children and Families office to request that a Medicaid-eligible newborn be added to the eligibility file on an expedited basis. The forms are available from the local Department of Children and Families office or may be downloaded at the following Web address: www.dcf.state.fl.us/DCFForms/Search/OpenDCFForm.aspx?FormId=82.

The Medical Assistance Referral Form may be used by providers for referrals other than establishing an unborn record or requesting newborn coverage. A copy of the Medical Assistance Referral Form and instructions for completion follow this page.

Note: To find an office select a county on the DCF Web site at http://www.dcf.state.fl.us/programs/access/servicecenters.shtml.

Illustration 3-2: CF-ES 2039, Medical Assistance Referral Form

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

Medical Assistance Referral

Date received by C & F:

Please mail form to: | ***This referral is from:***

C&F District/ Local Office Address:

Name and Address of Referral Agency:

Name of Person Completing Form _____ Date _____ Phone Number _____

1. The following individual is being referred for an eligibility determination for: Newborn eligibility Medicaid
Emergency Medicaid for Aliens Nursing Home Care Unborn Other:_____
Is individual a pregnant woman? If yes, give due date_____ and the Medicaid number of the woman_____

Priority (Check only one): Inpatient hospital Pregnant woman Dialysis/Cancer outpatient All others

The following are attached: Application Medical Information Proof of Emergency Medical Bills
Registration Form Proof of pregnancy Other: _____

Give the following information about the individual being referred:

a) _____ (Last Name First Maiden Name)
b) _____ (Address)
c) _____ (City State Zip Code)
d) _____ (Social Security Number) **e)** _____ (Telephone Number)
f) Number of children under age 21 in the home:_____
g) If individual is mother of newborn, give:
_____ (Name of newborn) _____ (Date of Birth)
_____ (Medicaid ID Number of mother)
h) Current Status of Individual: Outpatient
Inpatient: _____ (Unit) _____ (Wing) _____ (Room No.)
If patient cannot be interviewed, give name and phone number of relative or friend, if known:
_____ (First Name) _____ (Last Name) _____ (Phone Number)

Date discharged: _____ If discharged to other than home, give address and phone number where can be reached.
_____ (Address)
_____ (Phone Number)
i) Marital Status: single married separated divorced widowed
j) Gross **Income:** Individual receives approximately:
$ _____ Social Security (monthly)
$ _____ Other income (monthly)
k) The individual is:(Check all appropriate boxes)
age 65 or older blind pregnant
totally & permanently disabled
new mother who receives cash assistance or SSI
not currently receiving Medicaid benefits through cash assistance, SSI or Medically Needy.
l) Approximate amount of bill: $ _____

For RPICC County Health Department Use Only: Date that Presumptive Eligibility Pregnant Woman coverage determined: _____ (MM DD YY). **Note:** Application worksheet and Notice **must** be attached.

2. This Section Completed By DCF

The following action has been taken on this referral: Unable to locate Declined to apply Application denied Enrolled in the Medically Needy Program with a share of cost Eligible for Medicaid for the following periods: (Use MM/DD/YY format)
beginning _____ through _____ beginning _____ through _____

Medicaid Number: _____

_____ (Authorized Signature) _____ (Unit) _____ (Telephone) _____ (Date)

CF-ES 2039, Sep 2002 (Replaces December 2000 edition which may not be used.) Stock Number: 5747-000.2039

Incorporated by reference in 59G-5.020, F.A.C.

Illustration 3-3: CF-ES 2039, Reverse Side of the Medical Assistance Referral Form

Medically Needy Pre-Screening
(Optional for Referring Agency)

INSTRUCTIONS: In order to determine if this is an appropriate referral for the Medically Needy program, ask the individual or her representative the following questions:

Do you now have Medicaid coverage?	☐ Yes	☐ No
Do you receive TCA, SSI or Medically Needy benefits?	☐ Yes	☐ No
Are you currently enrolled in an HMO?	☐ Yes	☐ No
Are you pregnant or a new mother (recent delivery)?	☐ Yes	☐ No
Do you have children under age 21 in your home?	☐ Yes	☐ No
Are you 65 years old or older?	☐ Yes	☐ No
Are you blind, or totally and permanently disabled?	☐ Yes	☐ No
Are you a non-citizen who needs emergency service?	☐ Yes	☐ No

If the individual answered NO to the first three questions, and YES to at least one other question, you should refer the individual to the Department of Children and Families by completing the "Medical Assistance Referral form, CF-ES 2039. EXCEPTION: If the individual is age 65 or over, blind or totally and permanently disabled, and not currently receiving Supplemental Security Income (SSI), and has zero income or has combined income less than the maximum Federal Benefit Rate for SSI, then refer the individual to SSI. In Florida, individuals eligible for SSI are also eligible for Medicaid benefits.

INSTRUCTIONS FOR COMPLETING THE MEDICAL ASSISTANCE REFERRAL FORM (CF-ES 2039)

SECTION 1: This section should be completed by the Referring Agency. Complete all items, giving as much information as possible.

SECTION 2: This section is completed by the Department of Children and Families, and a copy returned to the Referring Agency.

NOTE: Send original and 2 copies to the Department of Children and Families; retain copy for your files.

CHAPTER 4
MEDICARE CROSSOVER POLICY

Overview

Introduction

This chapter describes the relationship between the Medicare program and Florida Medicaid. It explains:

- What crossover claims are;
- Who can bill crossover payments;
- Medicaid payment policy for crossover claims;
- Claim filing tips; and
- How to resolve denied claims.

In This Chapter

This chapter contains:

Medicare Coverage

Medicare

Medicare was enacted by Congress as part of the Social Security Amendments of 1965. It is a federal program managed by the Centers for Medicare and Medicaid Services (CMS). The state of Florida has no authority over the rules and laws that govern the Medicare program.

Dually-Eligible Recipient

A dually-eligible recipient is a recipient who is eligible for both Medicaid and Medicare benefits.

Medicare Coverage, continued

Medicare Part A

Medicare Part A insurance provides coverage for medically-necessary inpatient hospital care, specified skilled nursing care, specified services of a home health agency, and other services.

Medicare imposes cost sharing expenses by requiring deductible and coinsurance amounts that may be paid by the Medicare beneficiary, a supplemental insurance policy, or Medicaid.

Note: For details on Medicaid's cost-sharing of Medicare Part A coinsurance and deductibles refer to the Medicare Crossover Reimbursement for UB-04 Billers section in this chapter.

Medicare Part B

Medicare Part B Insurance provides basic health care coverage for the services provided by doctors, suppliers, therapists, and other health care providers.

Medicare imposes cost sharing expenses by requiring deductible and coinsurance amounts that may be paid by the Medicare beneficiary, a supplemental insurance policy, or Medicaid.

Per 42 Code of Federal Regulations, Section 431.625 (d)(3), Medicaid cannot reimburse expenditures that could have been paid for under Medicare Part B, but were not, because the person was not enrolled in Part B. This limit applies to all recipients who are eligible for enrollment under Part B, whether individually or through an agreement under section 1843(a) of the Social Security Act.

Note: For details on Medicaid's cost-sharing of Medicare Part B coinsurance and deductibles refer to the Medicare Crossover Claims Filing for CMS-1500 Billers section in this chapter.

Medicare Part C (Medicare Advantage Plans)

The Balanced Budget Act of 1997 permits Medicare beneficiaries to select either the traditional fee-for-service Medicare program or the Medicare Part C program, known as Medicare Advantage Plans or Medicare Replacement HMOs. The Medicare Part C program allows the beneficiary to choose among various private health care including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Provider Sponsored Organizations (PSOs), or Medical Savings Account (MSA). Persons who are eligible for Medicare Part A and who are enrolled in Medicare Part B are eligible for enrollment in the Medicare Part C program.

Note: For details on Medicaid's cost-sharing of Medicare Part C coinsurance and deductibles refer to the Medicare Crossover Claims Filing for CMS-1500 Billers section in this chapter.

Medicare Coverage, continued

Medicare Part D

Medicare Part D provides prescription drug coverage through private prescription drug plans (PDPs) that offer drug-only coverage and through Medicare Advantage Plans that offer both prescription drug and health care coverage. A Medicare beneficiary must be enrolled in a plan in order to receive the prescription drug coverage. Dually-eligible recipients who fail to enroll in a plan will be automatically enrolled in a prescription drug plan by Medicare.

Drugs that are excluded from Part D coverage by Federal Statute are covered by Medicaid if the recipient is in Medicaid program code which covers prescribed drugs and the drug is a covered service under Medicaid. However, all restrictions and limitations of the Medicaid Prescribed Drug Program apply.

Medicaid does not reimburse for Part D premiums, copays, and coinsurance. Medicaid does not reimburse for prescriptions for recipients who are eligible for Medicare Part D, but refuse to participate in Part D.

Medicare Crossover Claims

Definition

Medicare crossover claims are claims that have been approved for payment by Medicare and sent to Medicaid for consideration of payment towards the Medicare deductible and coinsurance within Medicaid program limits.

Medicaid Program Limits

Medicaid will **not** pay a crossover claim if:

- Medicare has paid the claim in an amount that equals or exceeds Medicaid's fee for the specified service;
- The combined amount received from Medicare and any other third party exceeds Medicaid's fee for the service;
- The Medicaid program limitations for the service have already been met for a recipient who has no QMB coverage and who is not eligible for Supplemental Security Income;
- Both Medicare and Medicaid cover the service, and Medicare has determined that the service is not medically necessary. If Medicare determines that a service that Medicaid also covers is not medically necessary, it is also considered to be not medically necessary by Medicaid. This does not apply to services that Medicare does not cover, but Medicaid covers such as dental care;
- The recipient is eligible as SLMB only or QI1 only.

Medicare Crossover Claims, continued

Medicaid Program Limits, continued

A provider who bills Medicaid for reimbursement of a Medicaid-covered service may not bill the recipient, the recipient's relatives, or any person or persons acting as the recipient's designated representative.

Note: See Payment for Services in Chapter 1 for additional information on Billing the Recipient.

Exceptions to the Medicaid Program Limits

The following are exceptions to the Medicaid program limits described above:

- Emergency Transportation Providers: Medicare covered ambulance and air ambulance trips will be reimbursed at 100 percent of the deductible and coinsurance;
- County Health Departments: Medicare approved services will be reimbursed at 100 percent of the deductible and coinsurance for county health department allowed procedure codes;
- Portable X-ray Providers: Medicare approved services will be reimbursed at 100 percent of the deductible and coinsurance for allowable portable x-ray services;
- Freestanding Dialysis Centers: Medicaid-covered freestanding end stage renal dialysis center services will be reimbursed at 100 percent of the deductible and coinsurance; and
- Medicare-Only Covered Service: For more information, see Medicaid Coverage of Part B Medicare Crossovers in this chapter.

How Medicaid Receives Crossover Claims

After providing a service to a dually-eligible recipient, the provider sends a claim to its Medicare carrier or intermediary. After Medicare processes the claim, it sends the provider an explanation of Medicare benefits (EOMB). If Medicare has approved the claim, Medicaid can pay towards the deductible and coinsurance according to Medicaid policy.

Medicare crossover claims are submitted to the Medicaid fiscal agent by one of the following methods:

- An electronic submission generated automatically by the Medicare intermediary or carrier;
- A paper submission by the provider that includes the claim and the Explanation of Medicare Benefits (EOMB) also known as the Medicare Remittance Advice (RA); or
- Electronic claims submission by the provider.

Participation in Medicare Crossovers

Unlisted Crossover Carriers and Intermediaries

If a provider's Medicare carrier or intermediary does not automatically send crossover claims to the Medicaid fiscal agent, the provider must submit Medicare crossover claims to the Medicaid fiscal agent either electronically or on paper claim forms.

Note: For instructions on claim submissions, see Medicare Crossover Claims Filing for CMS-1500 or UB-04 Billers in this chapter.

Part A Buy-in

If a Medicaid recipient is eligible to enroll in Medicare Part A, but has to pay a premium to receive coverage, Medicaid will cover the cost of the Part A premium in a process called Part A buy-in for recipients who are either QMB or in a Medicaid full coverage category. Someone who is Medically Needy only with Medicare, and is not QMB or in the SSI eligibility category, is not eligible for Medicare Part A buy-in.

Part A buy-in is an automated process between Medicaid and the Centers for Medicare and Medicaid Services (CMS).

Part B Buy-in

If a Medicaid recipient is entitled to Medicare Part B, Medicaid will cover the cost of the Part B premium in a process called Part B buy-in if the person is QMB, SLMB, or QI1 eligible or eligible for full Medicaid benefits. Someone who is Medically Needy with Medicare, but without QMB, SLMB or QI1 coverage, is not eligible for Medicare Part B buy in.

Part B buy-in is an automated process between Medicaid and CMS.

Medicaid Eligibility is Provided to Medicare

When Medicaid pays the Medicare premium, eligibility information is sent to the Medicare carriers and intermediaries that supply automated crossovers. This process provides information to the carriers and intermediaries so automatic crossover claims are sent to Medicaid for dually-eligible recipients.

Who Can Bill Crossover Claims

A provider must be enrolled as a Medicaid provider in order to submit Medicare crossover claims. When enrolling in the Medicaid program, providers must include their Medicare provider number on the Provider Enrollment Application.

Participation in Medicare Crossovers, continued

Provider Cross Reference File

Medicaid must have the provider's Medicare number cross-referenced or linked to their Medicaid provider number. This information is supplied by the provider and entered into the provider's computerized Medicaid file.

Automated crossover claims will not process unless the provider has given this information to the Medicaid fiscal agent, and the fiscal agent has cross-referenced the provider's Medicaid file to the correct Medicare provider number.

To correct or add a Medicare provider number, the provider should call the Medicaid fiscal agent's Provider Enrollment Unit at 800-289-7799. Select Option 4.

Changes in Medicare Number

If the Medicare provider number changes, the provider must report the change to the Medicaid fiscal agent immediately. Claims cannot be crossed over automatically from Medicare if the correct Medicare provider number is not on the Medicaid system.

Note: See Chapter 2 of this handbook for information on reporting changes to the provider file.

Answers to Questions

If providers have questions or concerns about Medicare claim processing or Medicare policy, they must follow Medicare's procedures for resolving those issues.

If there are problems or concerns regarding Medicaid's payment of crossover claims, the provider should contact the fiscal agent or the area Medicaid office.

Note: See Appendix A in this handbook for the addresses and phone numbers of the fiscal agent and the area Medicaid offices.

General Crossover Reimbursement Policies

Time Limits

The filing limit for Medicare claims crossing over to Medicaid is the greater of 36 months from the date of service or 12 months from Medicare's adjudication date.

Claims that are over 36 months from the date of services must be sent to the area Medicaid office for consideration of payment.

Note: The area Medicaid offices' addresses and phone numbers are listed in Appendix A.

Medicaid Copayments and Coinsurance

A dually-eligible Medicare and Medicaid recipient is required to pay Medicaid copayments and coinsurance, unless the recipient is otherwise exempt. The Medicaid copayment and coinsurance applies to services that will be billed first to Medicare and then crossover to Medicaid for payment of the Medicare deductibles and coinsurances.

When the Medicare payment or third party liability payment exceeds the Medicaid payment so that no Medicaid payment is made, the Medicaid copayment or coinsurance cannot be deducted. If the provider has collected the Medicaid copayment or coinsurance, he must reimburse it to the recipient.

Note: See Chapter 1 in this handbook for information on Medicaid copayments.

Payment in Full

Section 1905(n) of the Social Security Act prohibits a provider from billing an individual with coverage as a Qualified Medicare Beneficiary (QMB), with or without other Medicaid coverage, or someone receiving Supplemental Secuirty Income benefits (MS program code) and Medicare for the Medicare deductible or coinsurance.

General Crossover Reimbursement Policies, continued

Payment in Full, continued

Providers who submit a claim to Medicare are required to accept Medicaid's payment as payment in full. This policy applies even when Medicaid does not reimburse a claim because Medicare's payment, or Medicare's payment in combination with payment from a third party, is the same or more than Medicaid's fee for the service.

A provider who bills Medicaid for reimbursement of a Medicaid-covered service may not bill the recipient, the recipient's relatives, or any person or persons acting as the recipient's designated representative.

Exception: These rules do not apply to recipients who are eligible for only SLMB or only QI1 coverage and no other Medicaid coverage. A recipient who is SLMB only or QI1 only with no other Medicaid coverage is not eligible for any claims payment.

Third Party Liability (TPL)

Description of a Third Party

Federal regulations require Medicaid to deny a crossover claim if another source, such as a medical insurance policy, is available to pay the claim. This additional source for payment of medical expenses is called a third party.

When to Bill a Third Party

If a crossover claim is denied by Medicaid because third party coverage is available, the provider must file a claim with the payer before attempting to re-bill Medicaid.

If it is known prior to submitting the crossover claim that the recipient has coverage other than Medicare and Medicaid, the provider must file with that payer first.

Provider Exemption from Billing Medicaid

If Medicare's and the third party's payment is the same or more than the Medicaid fee for the service, the provider is not required to bill Medicaid. This is considered payment in full and the recipient cannot be billed for any balance.

Third Party Liability (TPL), continued

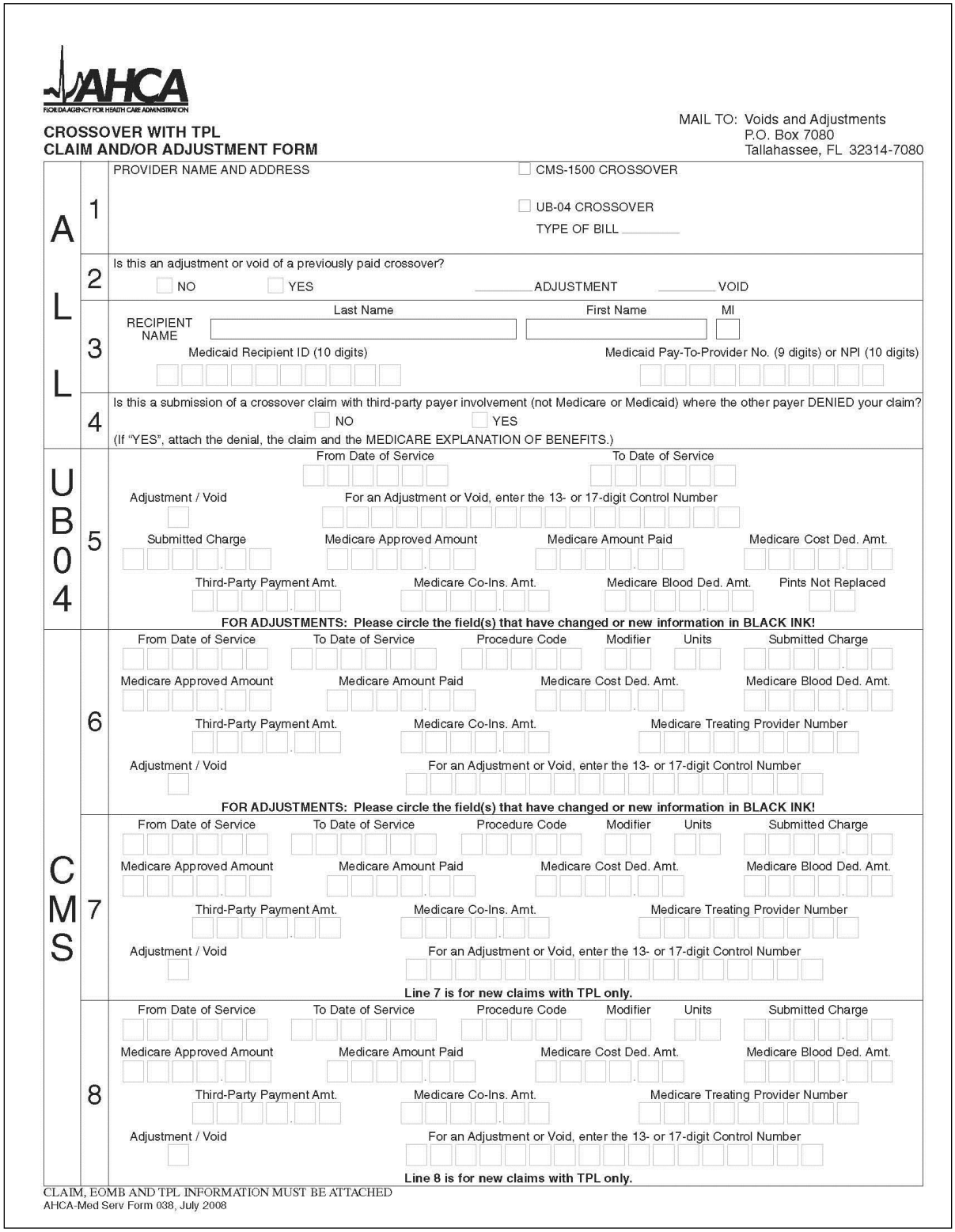
Crossover with TPL Claim and Adjustment Form

If the third party resource paid, but Medicaid is still liable for a portion of the claim, or if the third party resource denied the claim, the provider may submit a Crossover with TPL Claim and/or Adjustment form, AHCA-Med Serv Form 038, March 2008, to Medicaid for reimbursement, along with the TPL payment or denial and Medicare EOMB. Medicare Part C claims require the Medicare Part C Crossover Claim Form.

Note: The Crossover with TPL Claim and/or Adjustment form, AHCA-Med Serv Form 038, and the Medicare Part C Crossover Claim Form are available by photocopying the respective form in this chapter. It is also available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms. It is incorporated by reference in 59G-5.020, F.A.C.

Note: See Medicare Crossover Claims Filing for CMS-1500 or UB-04 Billers in this chapter for information on how to complete the form, and information on the Medicare Part C Crossover Claim Form.

Illustration 4-1: Crossover with TPL Claim and/or Adjustment Form



AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

CROSSOVER WITH TPL
CLAIM AND/OR ADJUSTMENT FORM

MAIL TO: Voids and Adjustments
P.O. Box 7080
Tallahassee, FL 32314-7080

ALL

1 PROVIDER NAME AND ADDRESS — ☐ CMS-1500 CROSSOVER ☐ UB-04 CROSSOVER TYPE OF BILL _____

2 Is this an adjustment or void of a previously paid crossover? ☐ NO ☐ YES _____ADJUSTMENT _____VOID

3 RECIPIENT NAME — Last Name | First Name | MI
Medicaid Recipient ID (10 digits) | Medicaid Pay-To-Provider No. (9 digits) or NPI (10 digits)

4 Is this a submission of a crossover claim with third-party payer involvement (not Medicare or Medicaid) where the other payer DENIED your claim? ☐ NO ☐ YES
(If "YES", attach the denial, the claim and the MEDICARE EXPLANATION OF BENEFITS.)

UB04

5 From Date of Service | To Date of Service | Adjustment / Void | For an Adjustment or Void, enter the 13- or 17-digit Control Number | Submitted Charge | Medicare Approved Amount | Medicare Amount Paid | Medicare Cost Ded. Amt. | Third-Party Payment Amt. | Medicare Co-Ins. Amt. | Medicare Blood Ded. Amt. | Pints Not Replaced

FOR ADJUSTMENTS: Please circle the field(s) that have changed or new information in BLACK INK!

CMS

6 From Date of Service | To Date of Service | Procedure Code | Modifier | Units | Submitted Charge | Medicare Approved Amount | Medicare Amount Paid | Medicare Cost Ded. Amt. | Medicare Blood Ded. Amt. | Third-Party Payment Amt. | Medicare Co-Ins. Amt. | Medicare Treating Provider Number | Adjustment / Void | For an Adjustment or Void, enter the 13- or 17-digit Control Number

FOR ADJUSTMENTS: Please circle the field(s) that have changed or new information in BLACK INK!

7 From Date of Service | To Date of Service | Procedure Code | Modifier | Units | Submitted Charge | Medicare Approved Amount | Medicare Amount Paid | Medicare Cost Ded. Amt. | Medicare Blood Ded. Amt. | Third-Party Payment Amt. | Medicare Co-Ins. Amt. | Medicare Treating Provider Number | Adjustment / Void | For an Adjustment or Void, enter the 13- or 17-digit Control Number

Line 7 is for new claims with TPL only.

8 From Date of Service | To Date of Service | Procedure Code | Modifier | Units | Submitted Charge | Medicare Approved Amount | Medicare Amount Paid | Medicare Cost Ded. Amt. | Medicare Blood Ded. Amt. | Third-Party Payment Amt. | Medicare Co-Ins. Amt. | Medicare Treating Provider Number | Adjustment / Void | For an Adjustment or Void, enter the 13- or 17-digit Control Number

Line 8 is for new claims with TPL only.

CLAIM, EOMB AND TPL INFORMATION MUST BE ATTACHED
AHCA-Med Serv Form 038, July 2008

Incorporated by reference in 59G-5.020

Medicare Crossover Reimbursement for CMS-1500 Billers

Introduction

This section applies to the following Medicaid providers who bill Medicare on the CMS-1500 (08/05) claim form:

- Ambulatory Surgical Centers;
- Audiologists;
- Chiropractors;
- Community Mental Health Providers;
- County Health Departments (see additional information below);
- Dentists;
- Durable Medical Equipment Providers;
- Emergency Transportation (see additional information below);
- Home Health Agencies (Durable Medical Equipment services);
- Independent Laboratories;
- Licensed Midwives;
- Nurse Practitioners;
- Optometrists;
- Pharmacies (see additional information below);
- Physician Assistants;
- Physicians (M.D., D.O.);
- Podiatrists; and
- Portable X-ray Companies.

Note: The CMS-1500 (08/05) claim form is incorporated by reference in 59G-4.001, F.A.C. The CMS-1500 Provider Reimbursement handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Medicare Crossover Reimbursement for CMS-1500 Billers, continued

Medicaid Coverage of Medicare Part B Crossovers

For emergency transportation providers, freestanding dialysis centers, portable x-ray providers and county health departments, Medicaid pays 100 percent of both the deductible and coinsurance.

For rural health centers and federally qualified health centers, Medicaid reimburses the deductible and coinsurance up to the difference between Medicare's payment and the facility's Medicaid rate.

For all other Part B providers Medicaid pays the coinsurance or deductible up to the Medicaid fee amount or the amount due on the coinsurance or deductible, whichever is less.

Medicare-Only Covered Service. The following applies to services covered by Medicare that are not covered by Medicaid. The policy applies to recipients with QMB coverage (with or without other Medicaid) or who are SSI recipients (MS aid category).

- For dates of service prior to October 1, 2010, Medicaid will pay the coinsurance and deductible in full; and
- For dates of service on or after October 1, 2010, Medicaid will pay up to 50% of the Medicare allowed amount, less any amounts paid by Medicare or other third party insurance.

Medicare Part C Deductible, Coinsurance, Copayment

Florida Medicaid covers the Medicare Part C deductible, coinsurance and copayment up to the Medicaid fee, less any amounts paid. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the deductible, coinsurance or the copayment amount up to the billed or allowed amount, whichever is less.

Florida Medicaid covers the Part C deductible, coinsurance and copayment for QMB, QMB Plus and other Full Benefit Dual Eligibles. Florida Medicaid does not cover Medicare Part C deductible, coinsurance and copayment for QI1 and SLMB. Coverage for other Full Benefit Dual Eligibles is limited to those services in which:

- The Medicare service is also a covered service under the State Plan.
- The Medicare provider is also a Medicaid provider; and
- The amount specified in the State Plan is greater than the Medicare payment amount.

Note: See Appendix B, Glossary, for the definition of Full Benefit Dual Eligible.

Medicare Crossover Reimbursement for CMS-1500 Billers, continued

How to Determine Medicaid's Fee

Refer to the Medicaid fee schedules to determine if the procedure code is covered by Medicaid and, if yes, to obtain the Medicaid fee.

Subtract Medicare's payment from the Medicaid fee. If the remainder is negative, Medicaid will not pay the crossover claim. If the remainder is positive, Medicaid pays the lesser of the coinsurance plus deductible or the Medicaid fee minus the Medicaid copayment.

Note: The Medicaid fee schedules are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules. If a particular Medicaid service's fee schedule is not listed on the Fee Schedule Web page, then it is included in the Medicaid service-specific Coverage and Limitations Handbook. The handbooks are also available on the Medicaid fiscal agent's Web site Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Medicare Crossover Claims Filing For CMS-1500 Billers

Introduction

The following section applies to providers who bill Medicare on the CMS-1500 claim form.

Note: The CMS-1500 claim form may be ordered from the Medicaid fiscal agent by calling the Provider Contact Center at 800-289-7799 and selecting Option 7. It is incorporated by reference in 59G-4.001, F.A.C.

When to File Crossover Claims

The provider may submit a crossover claim to Medicaid by paper claim or electronically when:

- Medicaid is still liable for a portion of the claim;
- There is no automated crossover arrangement with the carrier;
- The carrier did not forward the claim to Medicaid;
- It has been over 45 days from Medicare's payment and no remittance has been received from Medicaid;
- Medicare adjusted or voided the claim; or
- The recipient has an additional third party payer.

Medicare Crossover Claims Filing For CMS-1500 Billers, continued

How to File Part B or Part C Crossover Claims on the CMS-1500

The following are step-by-step instructions for filing a paper crossover claim:

- Prepare a CMS-1500 claim form according to Medicare guidelines.
- Part B claims-In field 1, enter Xs in the boxes labeled “Medicare” and “Medicaid.”
- Part C claims-In field 1, enter Xs in the boxes labeled “Other” and “Medicaid.”
- Ensure that the recipient’s ten-digit Medicaid number is in field 10d; field 1a must contain the recipient’s Medicare number.
- Enter qualifier code 1D and the nine-digit Medicaid provider number in field 33b or the National Provider Identifier (NPI) in field 33a. If the provider’s NPI is mapped to a taxonomy code, enter qualifier ZZ and the taxonomy code in field 33b. If field 33b or 33a contains a group provider number, enter the nine-digit Medicaid treating provider number in field 24J.
- Leave field 29 blank.
- Circle the corresponding claim information on the EOMB. **Do not highlight**. Paper clip the EOMB to the back of the claim. The EOMB should be one page and must contain headers or descriptions identifying the payment, coinsurance and deductible amounts in order for the Medicaid fiscal agent to enter it into the Medicaid computer system.
- Medicare Part C claims (electronic and paper) are required to have attachments (EOMB and Medicare Part C Crossover Claim Form). Medicare Part C claims submitted without these attachments will deny.
- Sign and date the claim form. If the provider uses a facsimile signature or a signature stamp, the entry must be initialed. The provider is responsible for ensuring that the signature complies with all the signature requirements that are stated in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for Item 31.

Note: The Medicare Part C Crossover Claim Form is available by photocopying the form in this chapter. It is also available on the Medicaid fiscal agent’s Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms. It is incorporated by reference in 59G-5.020, F.A.C.

Medicare Crossover Claims Filing for CMS-1500 Billers, continued

Where to Submit the CMS-1500 Crossover Claim

Submit the claim, attached EOMB, and Medicare Part C Crossover Claim Form if indicated to:

CMS-1500 Crossover Claims
P.O. Box 7074
Tallahassee, Florida 32314-7074

How to File Part B or C Crossover Adjustments on the CMS-1500

Claims adjusted by Medicare are not considered for Medicaid payment through the automated crossover process.

If Medicare adjusts a claim and Medicaid has not paid, this is not a Medicaid adjustment. Follow the instructions in the section How to File Part B and C Medicare Crossover Claims on the CMS-1500 in this chapter and attach the adjusted EOMB and Medicare Part C Crossover Claim Form, if applicable, to the claim.

If Medicare adjusts a claim and Medicaid has already paid the original claim or if a crossover claim has been over or underpaid:

- Follow the above instructions on "How to File Part B Crossover Claims on the CMS 1500";
- Write the incorrectly paid internal control number (ICN) in the upper left corner, above the top line of the form;
- Write the incorrectly paid ICN on the most recent EOMB;
- Write a large A in the Medicaid box in Item 1;
- Re-sign or initial and date item 31;
- Circle the line that contains the incorrectly paid amount on the claim, EOMB, Medicare Part C Crossover Claim Form if applicable and Medicaid remittance advice; and
- Circle the item(s) that requires adjusting that is within the encircled lines.

Note: The Medicare Part C Crossover Claim Form is available by photocopying the form in this chapter. It is also available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms. It is incorporated by reference in 59G-5.020, F.A.C.

Where to Submit the CMS-1500 Crossover Adjustment

Mail the claim, EOMB, Medicare Part C Crossover Claim form if applicable and Medicaid remittance to:

Adjustments and Voids
P.O. Box 7080
Tallahassee, Florida 32314-7080

Note: See special procedures on the next page for claims for procedure codes J3490, J3590, and J9999.

Medicare Crossover Claims Filing for CMS-1500 Billers, continued

Medicare Crossover Claims for J3490, J3590, and J9999

Medicare Crossover claims for J codes J3490, J3590, and J9999 are submitted from Medicare directly to the fiscal agent and are automatically paid by the system. Crossover claims for unclassified drugs do not come to AHCA for review and pricing.

When More Than One Claim Line Requires An Adjustment

Each line of the claim EOMB is considered a separate claim and is assigned its own unique ICN. If more than one line requires an adjustment, follow the instructions listed above for each claim line.

How to File Part B or C Crossover Claims When a Third Party Has Paid the Claim

If a third party resource has paid but Medicaid is still liable for a portion of the claim, the provider may bill Medicaid by attaching a completed Crossover with TPL Claim and Adjustment form to the claim and EOMB. A Medicare Part C Crossover Claim Form is also required when submitting claims for recipients with Medicare Part C.

The provider must complete Sections 1, 2, 3, 4 and 6 on the Crossover with TPL Claim and Adjustment form.

Note: The Crossover with TPL Claim and/or Adjustment form is in the Third Party Liability section in this chapter. The Medicare Part C Crossover Claim Form is included in this chapter.

Note: The Medicare Part C Crossover Claim Form is available by photocopying the form in this chapter. It is also available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms.

Medicare Crossover Claims Filing for CMS-1500 Billers, continued

How to File Part B or C Crossover Claims When a Third Party Has Denied the Claim

If a third party resource denied the claim, the provider may bill Medicaid by attaching a completed Crossover with TPL Claim and/or Adjustment form, AHCA-Med Serv Form 038, to the claim and EOMB. A Medicare Part C Crossover Claim Form is also required when submitting claims for recipients with Medicare Part C.

The provider must complete Sections 1, 2, 3, and 4 on the Crossover with TPL Claim and/or Adjustment form.

The provider must check "Yes" to the question asked in Section 4, "Is this a submission of a crossover claim with third party payer involvement (not Medicare or Medicaid) where the other payer denied the claim?"

Note: The Crossover with TPL Claim and/or Adjustment form is in the Third Party Liability section in this chapter.

Note: The Medicare Part C Crossover Claim Form is available by photocopying the form in this chapter. It is also available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms.

Attachments to the Crossover with TPL Claim and Adjustment Form

Whether the third party paid or denied the claim, the provider must attach the following documents in the order listed or the claim will deny:

- Crossover with TPL Claim and/or Adjustment form;
- Claim form;
- EOMB; and
- Third party's remittance advice, EOB or denial letter.
- Medicare Part C Crossover Claim Form, for recipients with Medicare Part C.

Where to Submit the Crossover with TPL Claim and Adjustment Form

Submit the Crossover with TPL Claim and Adjustment form, Medicare Part C Crossover Claim Form, (if submitting a claim for a recipient with Medicare Part C) and attachments to:

CMS-1500 Crossovers
P. O. Box 7074
Tallahassee, Florida 32314-7074

Continuation Claim

If the patient section on the EOMB contains more than 6 lines, the provider must submit more than 1 claim. On the first claim indicate "Continued on page 2" in fields 28 through 30, then list the remaining lines and the grand total on the second claim.

Medicare Crossover Claims Filing for CMS-1500 Billers, continued

Multiple EOMBs for One Recipient

Only one "recipient section" on the EOMB is allowed per claim form. A recipient section is defined as the claim information between the recipient's name and the claim total line.

If the recipient's name is listed more than once on the EOMB, submit another claim and another copy of the EOMB for each occurrence. Each claim must match the recipient section on the EOMB, line by line.

Claims Resolution for the CMS-1500

Altered EOMBs

The Medicare Explanation of Medicare Benefits (EOMB) must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider may line out any claim line that has been previously paid by Medicaid, that the provider chooses not to bill Medicaid, or has been paid in full by Medicare;
- If the claim lines on the EOMB have been lined out, the "claim totals" line on the EOMB must be changed to reflect the deleted line(s);
- The claim lines or "recipient section" on the EOMB that are being submitted for reimbursement must be circled, dated and initialed; and
- For psychiatric reduction claims, subtract the PR122 amount from the Medicare Allowed Amount. Indicate the new allowed amount on the EOMB. Circle this information and initial and date the EOMB. Submit psychiatric reduction claims and attachments to:

Attention: Manual Processing of Psychiatric Reduction Claims
P. O. Box 13800
Tallahassee, FL 32314-3800

Claims Resolution for the CMS-1500, continued

Medicare Denied Claims for CMS-1500s

Claims denied by Medicare are not considered for Medicaid payment through the automated crossover process. Medicaid may consider the claim for "Medicaid only" payment. To determine if the claim may be paid by Medicaid, use the following instructions.

- Complete the claim for "Medicaid only" services, following the claim completion guidelines in the Medicaid Provider Reimbursement Handbook, CMS-1500.
- Attach the EOMB from Medicare that reflects the denied service and a note requesting that the claim be considered for Medicaid payment, because Medicare will not cover the service.
- Complete the Medicare Part C Crossover Claim Form and attach to claim if submitting for a recipient with Medicare Part C.
- Send these documents to the area Medicaid office for consideration.

Medicaid will consider payment for "non-covered" services by Medicare for a Medicaid-covered service. Medicaid will also consider payment if the service exceeds Medicare's limits, but are within Medicaid's limits.

Note: See Appendix A in this handbook for a list of the area Medicaid offices.

Medicare Denial for No Medicare Benefits

If Medicare denies a claim because the recipient does not have Medicare and FMMIS is showing Medicare coverage for the date(s) of service, confirm that the correct Medicare number was entered on the claim to Medicare.

If the Medicare coverage information in FMMIS is not correct, contact the area Medicaid office for assistance.

Note: See Appendix A for the addresses and telephone numbers of the area Medicaid offices. The area Medicaid offices' telephone numbers are also available on the Agency for Health Care Administration's Web site at www.ahca.myflorida.com. Select Medicaid, and then Area Offices.

Claims Resolution for the CMS-1500, continued

Invalid Medicare Identification Numbers

If Medicaid's recipient file indicates a different Medicare number than the one used to bill Medicare, rebill Medicare using the correct number.

If Medicare was billed using the Medicare number Medicaid has on its recipient file, complete the claim for "Medicaid only" services, following the claim completion guidelines in the Medicaid Reimbursement Handbook.

Attach the EOMB that indicates that the claim was denied and attach a note requesting that the claim be considered for Medicaid payment, because the recipient was not covered by Medicare on the date of service. Send all three documents to the area Medicaid office, and include a Medicare Part C Crossover Claim Form if indicated.

Note: See Appendix A in this handbook for a list of the area Medicaid offices.

Claims Without Correct Information

If the claim was denied by Medicare because appropriate information was not submitted (i.e., documentation required), resolve these problems through the Medicare carrier or intermediary.

Medicare Crossover Reimbursement for UB-04 Billers

Introduction

This section applies to the following Medicaid providers who bill Medicare on the UB-04 claim form:

- Federally Qualified Health Centers;
- Freestanding Dialysis Centers;
- General Inpatient and Outpatient Hospitals;
- Hospital-Based Skilled Nursing Units;
- Independent Therapists;
- Nursing Facilities;
- Rural Health Clinics;
- State Mental Hospitals;
- Statewide Inpatient Psychiatric Program (SIPP) Providers; and
- Swing-Bed Facilities.

Medicare Crossover Reimbursement for UB-04 Billers, continued

General Inpatient and State Mental Health Hospitals

The Medicaid program covers Medicare Part A deductible and coinsurance in general inpatient and state mental hospitals with the following limits:

- Medicaid covers the Medicare Part A deductible and coinsurance up to the Medicaid per diem rate, less any amount paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the deductible and coinsurance up to the Medicare allowed amount or the Medicaid per diem rate, whichever is less; and
- Medicaid will pay the covered blood deductible up to a limit of 3 pints at $25.00 per pint.

Inpatient Hospital and Medicare Part A or C Benefit Exhausted

When Medicare benefits, including all the lifetime reserve days, have been exhausted in a Medicare calendar year, additional Medicaid inpatient days are available to cover part of or the remainder of the hospitalization not covered by Medicare if the inpatient stay overlaps the beginning of the Medicaid fiscal year on July 1.

Medicaid inpatient days are simultaneously depleted through usage of Medicare days. For this reason, additional Medicaid coverage is available only at the beginning of the new Medicaid fiscal year when the Medicaid benefits are replenished.

To receive reimbursement for additional Medicaid coverage, the provider must:

- Complete a straight Medicaid claim with an attached document that furnishes proof that Medicare Part A or C coverage is exhausted, including all lifetime reserve days; and
- Submit the claim and its attachments to the area Medicaid office for an override of the Medicaid edit for Medicare present.

Medicare Crossover Reimbursement for UB-04 Billers, continued

Inpatient Hospital Part A Coinsurance

Medicaid covers Medicare Part A coinsurance for inpatient hospital under the following conditions:

- The amount of payment received from Medicare and other third parties is less than the Medicaid reimbursement rate; and
- The recipient has QMB coverage with or without other Medicaid or has coverage under Supplemental Security Income (MS program code).

Inpatient Hospital and Medicare Part B Only Reimbursement

To file a Part B Only claim, the recipient must have only Medicare Part B coverage and not be covered by Medicare Part A (this does not include Medicare Part A benefits exhausted).

The billing procedure for a Medicare Part B Only claim for Medicaid reimbursement is as follows:

- Submit a claim to Medicare for payment of the ancillary charges.
- Then submit a paper claim to Medicaid for reimbursement of the full per diem. (This type of claim requires a paper submission.)
- Enter financial class code FC510 (Medicare Part B) in form locator 80 on the inpatient claim.
- Enter type of bill 0121 (Inpatient Part B Only) in form locator 4.

Outpatient Hospital and Medicare Part B or C Reimbursement

Medicaid pays the deductible or coinsurance up to the Medicaid fee amount, minus any amounts paid by Medicare and to any other third party. If this amount is negative, Medicaid pays zero. If this amount is positive, Medicaid pays up to the Medicaid fee allowed or the coinsurance or deductible amount, whichever is less.

Additionally, Medicaid pays the Part B or C deductible and blood deductible.

Medicare Crossover Reimbursement for UB-04 Billers, continued

Medicare Part C Deductible, Coinsurance, Copayment

Florida Medicaid covers the Medicare Part C deductible, coinsurance and copayment up to the Medicaid fee, less any amounts paid. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the deductible, coinsurance or the copayment amount up to the billed or allowed amount, whichever is less.

Florida Medicaid covers the Part C deductible, coinsurance and copayment for QMB, QMB Plus and other Full Benefit Dual Eligibles. Florida Medicaid does not cover Medicare Part C deductible, coinsurance and copayment for QI1 and SLMB. Coverage for other Full Benefit Dual Eligibles is limited to those services in which:

- The Medicare service is also a covered service under the State Plan.
- The Medicare provider is also a Medicaid provider; and
- The amount specified in the State Plan is greater than the Medicare payment amount.

Note: See Appendix B, Glossary, for the definition of Full Benefit Dual Eligible.

Medicare Crossover Reimbursement for UB-04 Billers, continued

Nursing Facilities, Swing-Bed Facilities, and Hospital-Based Skilled Nursing Units

Nursing facilities, swing-bed facilities, and hospital-based skilled nursing units have the following Medicaid program limits:

- Medicaid pays a portion of the Medicare Part A coinsurance for Medicaid eligible beneficiaries when Medicare has paid less than the Medicaid per diem minus the patient responsibility.
- Medicaid will not pay the coinsurance, deductibles or copayment if the resident is enrolled in a Medicare Advantage HMO (also called a Medicare Replacement HMO).
- Medicaid will pay Part Bcoinsurance and deductibles for items or services that are not included in the facility's cost report.

If a recipient is enrolled in QMB (with or without other Medicaid) or is receiving Supplemental Security Income (MS program code),there is no patient responsibility assessed during the Medicare coinsurance days (day 21 up to day 100 of the nursing facility stay covered by Medicare).

If you have questions about QMB eligibility or the recipient's patient responsibility, first check the DCF Provider view available through the provider Web portal. If you still need assistance, you may email a DCF Customer Call Center to request information:

Jacksonville - NFCC_Providers@dcf.state.fl.us;
Tampa - sr_call_center@dcf.state.fl.us;
Miami - SN_Providers_SCFCC@dcf.state.fl.us,
or by calling the DCF customer call center at (1-866-762-2237).

Note: See Medicare Crossover Filing for UB-04 billers for instructions on entering the Medicare Part A coinsurance rate on the claim.

Note: See the Medicaid service-specific Coverage and Limitations Handbooks for the service limitations.

Medicare Crossover Reimbursement for UB-04 Billers, continued

Rural Health Centers and Federally Qualified Health Centers

Rural health centers and federally qualified health centers have the following Medicaid program limits:

- 100 percent of the Medicare deductible and coinsurance up to the Medicaid allowable for the procedure. The Medicaid allowable is obtained by subtracting Medicare's payment from the Medicaid encounter rate; and
- No crossover claim will be paid if Medicare has already paid the claim in an amount that equals or exceeds Medicaid's encounter rate.

Independent Therapists

Independent therapists have the following Medicaid program limits:

- Medicare deductible and coinsurance;
- The combined amounts received from Medicare, any other third party and Medicaid cannot exceed the Medicaid fee for the service; and
- Coinsurance is calculated as 20 percent of Medicare's approved charge, not the billed amount.

Freestanding Dialysis Centers

Freestanding dialysis centers have the following Medicaid program limits:

- 100 percent of the Medicare deductible, and
- 100 percent of the coinsurance.

Medicare Crossover Claims Filing for UB-04 Billers

Introduction

The following section applies to providers who bill Medicare on the UB-04 claim form.

Note: The UB-04 claim form may be ordered from the Medicaid fiscal agent by calling the Provider Contact Center at 800-280-7799 and selecting Option 7. It is incorporated by reference in 59G-4.003, F.A.C., and is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Medicare Crossover Claims Filing for UB-04 Billers, continued

When to File Crossover Claims

The provider may submit a crossover claim to Medicaid by paper claim or electronically when:

- Medicaid is still liable for a portion of the claim;
- There is no automated crossover arrangement with the intermediary;
- The intermediary did not forward the claim to Medicaid;
- It has been over 45 days from Medicare's payment and no remittance has been received from Medicaid;
- Medicare denied the claim;
- Medicare adjusted or voided the claim; or
- The recipient has an additional third party payer.

How to File Paper Crossover Claims on the UB-04

The following are step-by-step instructions for filing a paper crossover claim:

- Prepare a UB-04 claim form according to Medicare guidelines. For Medicare Part C claims, prepare a Medicare Part C Crossover Claim Form.
- Part A claims-enter the word "CROSSOVER" in line 3 of form locator 80.
- Part C claims-enter the words "PART C" in line 3 of form locator 80.
- Enter the nine-digit Medicaid provider number in form locator 57 or NPI in form locator 56.
- Ensure that the recipient's ten-digit Medicaid number is in form locator 60B; form locator 60A must contain the recipient's Medicare number.
- Circle the corresponding claim information on the Medicare EOMB. Do not highlight or use liquid correction fluid. Paper clip the EOMB to the back of the UB-04 claim.

Note: The Medicare Part C Crossover Claim Form is available by photocopying the form in this chapter. It is also available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms.

Where to Submit the UB-04 Crossover Claim

Submit the claim and the attached Medicare EOMB and Medicare Part C Crossover Claim Form if indicated to:

UB-04 Crossover Claims
P.O. Box 7064
Tallahassee, Florida 32314-7064

Medicare Crossover Claims Filing for UB-04 Billers, continued

Nursing Facility Medicare Part A Crossover Claims

Nursing facility providers must use the following instructions when completing Medicare Part A crossover claims:

- For each dually-eligible recipient for whom the Medicare coinsurance applies (residents in level of care X), enter the Medicare rate on the claim form;
- If the Medicare rate for a recipient changed during the month, provide the weighted average Medicare rate (weighted based on the number of days each rate is paid);
- Enter the respective Medicare per diem in Form Locator 81D of the UB-04 claim form or for electronic billing using the 837i, use segment CN102 within loop 2300, for each level of care X billed to Medicaid; and
- Enter the Medicaid Patient Responsibility amount for each level of care X billed to Medicaid, identical to a straight Medicaid claim, unless the recipient is a Qualified Medicare Beneficiary (QMB) only or a recipient eligible for QMB and full Medicaid (QMB+). There is no Patient Responsibility for QMB or QMB+ nursing facility recipients during the Medicare coinsurance period.

See Medicare Part A Crossover Claim Calculation on the next page for calculation examples.

Providers are required to maintain in their records documentation supporting the calculation of the Medicare per diem for each dually-eligible recipient for each month.

Note: See the Medicaid Provider Reimbursement Handbook, UB-04, for additional instructions on completing the claim.

When Nursing Facilities Should Not File Crossover Claims

Nursing facility providers shall not bill Medicaid for a Part B crossover claim if the items or services are included in the facility's cost report when Medicaid is paying the per diem rate.

Illustration 4-2: Medicare Part A Crossover Claim Calculations

Calculation Logic:

If the patient is eligible for QMB or QMB+ coverage, during the Medicare coinsurance days, the Patient Responsibility is always $0.

If during the Medicare coinsurance days, the Medicare Part A Coinsurance amount that Medicaid owes per day is less than or equal to $0, then the Patient Responsibility is always $0.

If during the Medicare coinsurance days, Medicaid owes any amount of Medicare Part A coinsurance per day and the patient is not QMB eligible, the amount of the difference owed can be taken from the Patient Responsibility up to the amount owed. If the Patient Responsibility does not totally pay the amount owed, the difference can then be billed to Medicaid.

Example 1

- → Medicare paid $2,200 (after the coinsurance is subtracted) for 10 days. This calculates out to $220 per day.
- → The Medicaid nursing facility per diem is $200 per day. The Medicare payment exceeds the facility's per diem rate.
- → Medicaid owes $0 coinsurance payment.
- → The Patient Responsibility is $0, because no Medicaid payment is due.

Example 2

- → Medicare paid $2,200 (after the coinsurance is subtracted) for 10 days. This calculates out to $220 per day.
- → The Medicaid nursing facility per diem is $225 per day. The Medicare payment is less than the facility's per diem rate.
- → Medicaid owes $5 X 10 Days = $50 total coinsurance payment.
- → The Patient Responsibility amount is $0 if the patient is QMB eligible. If not QMB eligible, see example 3.

Example 3

- → Medicare paid $2,200 (after the coinsurance is subtracted) for 10 days. This calculates out to $220 per day.
- → The Medicaid nursing facility per diem is $225 per day. The Medicare payment is less than the facility's per diem rate.
- → Medicaid owes $5 X 10 Days = $50 total coinsurance payment.
- → The patient is not QMB. The patient has a monthly Patient Responsibility of $500.
- → The nursing facility collects $50 of the 10 days prorated Patient Responsibility and Medicaid would pay $0.

Example 4

- → Medicare paid $2,200 (after the coinsurance is subtracted) for 10 days. This calculates out to $220 per day.
- → The Medicaid nursing facility per diem is $235 per day. The Medicare payment is less than the facility's Medicaid per diem rate.
- → Medicaid owes $15 X 10 Days = $150 total coinsurance payment.
- → The patient is not QMB. The patient's prorated has a monthly Patient Responsibility for 10 days is $125.
- → The nursing facility collects $125 of the Patient Responsibility and Medicaid would then pay $25 additionally.

Medicare Crossover Claims Filing for UB-04 Billers, continued

How to File Crossover Adjustments on the UB-04

Claims adjusted by Medicare are not considered for Medicaid payment through the automated crossover process.

If Medicare adjusts one of the claims and Medicaid has not paid, this is not a Medicaid adjustment. Follow the above instructions on "How to File Paper Crossover Claims on the UB-04," submitting the adjusted Medicare EOMB and Medicare Part C Crossover Claim Form if indicated with the claim.

If Medicare adjusts a claim and Medicaid has already paid the original claim or if a crossover claim has been over or underpaid, follow the above instructions on "How to File Paper Crossover Claims on the UB-04," and

- Write the incorrectly paid internal control number (ICN) in form locator 80 of the claim;
- Write the incorrectly paid ICN on the Medicare EOMB;
- Circle the incorrectly paid line on the Medicare EOMB and the Medicaid remittance advice;
- Circle the item(s) that requires adjusting within the encircled line;
- If TPL is involved, complete a Crossover with TPL Claim and/or Adjustment form and Medicare Part C Crossover Claim Form if indicated; and
- Change the bill type (the last digit will be a 7).

Note: Please see the Florida Medicaid Provider Reimbursement Handbook, UB-04, for instructions on submitting claim adjustments. The handbook is available on the Medicaid fiscal agent's Web site at www.mymedicaid-Florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. It is incorporated by reference in 59G-4.003, F.A.C.

Note: The Medicare Part C Crossover Claim Form is available by photocopying the form in this chapter. It is also available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms.

Nursing Facilities UB-04 Adjustment Procedures

For a nursing facility provider, if the Medicaid payment on a crossover claim is incorrect, enter the incorrectly paid Internal Control Number (ICN) in form locator 80 of the claim and also on the Medicare EOMB.

Circle the incorrectly paid line on the EOMB. Also within that encircled line, circle the items on the EOMB that require adjusting.

Attach the Medicaid remittance voucher, circle the items that requires adjusting, and mail all three documents to the fiscal agent adjustment address:

Adjustments/Voids
P.O. Box 7080
Tallahassee, Florida 32314-7080

Medicare Crossover Claims Filing for UB-04 Billers, continued

Nursing Facilities Crossover Adjustments on the UB-04

Claims adjusted by Medicare are not considered for Medicaid payment through the automated crossover process.

If Medicare adjusts one of the claims, and Medicaid has already paid on the original claim, follow the instructions listed above for UB-04 adjustments.

If Medicare adjusts one of the claims, and Medicaid has not paid, this is not a Medicaid adjustment. Follow the instructions on How to File Paper Crossover Claims on the UB-04 in this chapter, and submit only the new or adjustment EOMB with the claim.

Form Locator 4 of the UB-04 must contain the Medicaid bill type for adjustments.

Where to Submit the UB-04 Crossover Adjustment

Mail the claim, Medicare EOMB, Medicare Part C Crossover Claim Form if indicated and Medicaid remittance advice to:

Adjustments and Voids
P.O. Box 7080
Tallahassee, Florida 32314-7080

How to File Crossover Claims on a UB-04 When a Third Party has Paid the Claim

If a third party resource has paid, but Medicaid is still liable for a portion of the claim, the provider may bill Medicaid by attaching a completed Crossover with TPL Claim and/or Adjustment form and Medicare Part C Crossover Claim Form if indicated to the claim and Medicare EOMB.

The provider must complete Sections 1, 2, 3, 4 and 5 on the Crossover with TPL Claim and/or Adjustment form.

Note: See the Crossover with TPL Claim and/or Adjustment form in the Third Party Liability section in this chapter.

Note: The Medicare Part C Crossover Claim Form is available by photocopying the form in this chapter. It is also available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms.

Medicare Crossover Claims Filing for UB-04 Billers, continued

How to File Crossover Claims on a UB-04 When a Third Party has Denied the Claim

If a third party resource denied the claim, the provider may bill Medicaid by attaching a completed Crossover with TPL Claim and/or Adjustment form and Medicare Part C Crossover Claim Form if indicated to the claim and Medicare EOMB.

The provider must complete Sections 1, 2, 3, and 4 on the Crossover with TPL Claim and/or Adjustment form.

The provider must check "Yes" to the question asked in Section 4, "Is this a submission of a crossover claim with third party payer involvement (not Medicare or Medicaid) where the other payer denied the claim?"

Note: See the Crossover with TPL Claim and/or Adjustment form in the Third Party Liability section in this chapter.

Note: The Medicare Part C Crossover Claim Form is available by photocopying the form in this chapter. It is also available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Forms.

Attachments to the TPL Form

Whether the third party paid or denied the claim, the provider must attach the following documents in the order listed or the claim will deny:

- Crossover with TPL Claim and/or Adjustment form;
- Medicare Part C Crossover Claim Form if indicated;
- Claim form;
- Medicare's EOMB; and
- Third party's remittance advice, EOB, or denial letter.

Where to Submit the TPL Form

Submit the Crossover with TPL Claim and Adjustment form and attachments to:

UB-04 Crossovers
P. O. Box 7074
Tallahassee, Florida 32314-7074

Claims Resolution for the UB-04

Altered EOMBs

The Medicare Explanation of Medicare Benefits (EOMB) must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider may line out any claim line that has been previously paid by Medicaid, that the provider chooses not to bill Medicaid, or has been paid in full by Medicare;
- If the claim lines on the EOMB have been lined out, the "claim totals" line on the EOMB must be changed to reflect the deleted line(s); and
- The claim lines or "recipient section" on the EOMB that are being submitted for reimbursement must be circled, dated and initialed.

Note: See Appendix A in this handbook for the area Medicaid offices' addresses and phone numbers.

Medicare Denied Claims for UB-04

Claims denied by Medicare are not considered for Medicaid payment through the automated crossover process. Medicaid will consider the claim for "Medicaid only" payment.

If the claim was denied by Medicare because the procedure is not covered by Medicare, e.g., sterilization procedures, dental caries, etc., complete the claim for "Medicaid only" services, following the claim completion guidelines in the Medicaid Reimbursement Handbook, UB-04. If the recipient has Medicare Part C, the Medicare Part C Crossover Claim Form is required.

Attach the EOMB from Medicare that reflects the denied service and a note requesting that the claim be considered for Medicaid payment because Medicare will not cover the service.

Send all these documents to the area Medicaid office.

Note: See Appendix A in this handbook for a list of the area Medicaid offices.

Claims Resolution for the UB-04, continued

Medicare Denial for No Medicare Benefits

If Medicare denies a claim because the recipient does not have Medicare and FMMIS is showing Medicare coverage for the date(s) of service, confirm that the correct Medicare number was entered on the claim to Medicare.

If the Medicare coverage information in FMMIS is not correct, contact the area Medicaid office for assistance.

Note: See Appendix A for the addresses and telephone numbers of the area Medicaid offices. The area Medicaid offices' telephone numbers are also available on the Agency for Health Care Administration's Web site at www.ahca.myflorida.com. Select Medicaid, and then Area Offices.

Invalid Medicare Identification Numbers

If Medicaid's recipient file indicates a different Medicare number than the one used to bill Medicare, rebill Medicare using the correct number.

If Medicare was billed using the Medicare number Medicaid has on its recipient file, complete the claim for "Medicaid only" services, following the claim completion guidelines in the Medicaid Provider Reimbursement Handbook, UB-04.

Attach the Medicare EOMB that indicates that the claim was denied and attach a note requesting that the claim be considered for Medicaid payment, because the recipient was not covered by Medicare on the date of service. If indicated, the Medicare Part C Crossover Claim Form is also required. Send these documents to the area Medicaid office.

Note: See Appendix A in this handbook for a list of the area Medicaid offices.

Claims Resolution for the UB-04, continued

Limitations and Policy Denials	If the claim was denied by Medicare for limitations or policy that is the same as Medicaid's limitation or policy (e.g., incidental procedure, fee covered in surgical allowance, etc.), the provider may bill the recipient for non-covered procedures, if discussed with the recipient in advance and documented in the patient's medical record.
Claims Without Correct Information	If the claim was denied by Medicare because appropriate information was not submitted (i.e., documentation required, etc.), resolve these problems through the Medicare intermediary.

Medicare Part C Crossover Claim Form for CMS 1500 Billers

STATE OF FLORIDA
MEDICARE PART C - MEDICAID
CMS-1500 CROSSOVER INVOICE

Use a separate form for each Medicare Part C crossover claim.

Medicaid Recipient ID#		Last Name (first 2)		First Name (first 3)		Medicare Date Paid	

	From DOS	CPT/HCPC	Allowed	Deductible	Co-Pay	Co-insurance	Medicare Paid
1			$	$	$	$	$
2			$	$	$	$	$
3			$	$	$	$	$
4			$	$	$	$	$
5			$	$	$	$	$
6			$	$	$	$	$
7			$	$	$	$	$
8			$	$	$	$	$
9			$	$	$	$	$
10			$	$	$	$	$
11			$	$	$	$	$
12			$	$	$	$	$
13			$	$	$	$	$
14			$	$	$	$	$
15			$	$	$	$	$
16			$	$	$	$	$
17			$	$	$	$	$
18			$	$	$	$	$
19			$	$	$	$	$
20			$	$	$	$	$
21			$	$	$	$	$
22			$	$	$	$	$
23			$	$	$	$	$
24			$	$	$	$	$

*If more than 24 detail lines are needed, please submit additional invoice forms. page___of___

Medicaid Provider #	

By signing below, I certify that the foregoing information is accurate and complete, and understand that falsifying essential information to receive payment from federal and state funds requested by this form may, upon conviction, be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the event of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payment claimed for providing such services as the state agency may request. I further agree to accept as payment in full the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

Provider Signature _____ Date _____

Mail with accompanying CMS-1500 to:
CMS-1500 Crossover Claims
P.O. Box 7074
Tallahassee, FL 32314-7074

Provider Name and Address

AHCA Form 5000-3527 6/12

Incorporated by reference in 59G-5.020, F.A.C.

Medicare Part C Crossover Claim Form for UB-04 Billers

STATE OF FLORIDA
MEDICARE PART C - MEDICAID
UB-04 CROSSOVER INVOICE

Use a separate form for each Medicare Part C crossover claim.

Blood **Deductible** Amount	$	
Allowed Amount	$	
Co-Pay Amount	$	
Co-Insurance Amount	$	
Deductible Amount	$	
Medicare **Paid** Amount	$	

Medicare Paid Date	

Statement Covers Period (from box 6 of UB-04)	
From	
To	

Medicaid Recipient #	

Last Name		First Name	

Medicaid Provider ID #	

By signing below, I certify that the foregoing information is accurate and complete, and understand that falsifying essential information to receive payment from federal and state funds requested by this form may, upon conviction, be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the event of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payment claimed for providing such services as the state agency may request. I further agree to accept as payment in full the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

Provider Signature _____ Date _____

Provider Name and Address

Mail with accompanying UB-04 to:
UB-04 Crossover Claims
P.O. Box 7064
Tallahassee, FL 32314-7064

AHCA Form 5000-3528 6/12

Incorporated by reference in 59G-5.020, F.A.C.

CHAPTER 5
MEDICAID ABUSE AND FRAUD

Overview

Introduction

This chapter describes Medicaid provider abuse and fraud, its detection and correction, and the rights of the provider relative to abuse and fraud investigations. For more information, please refer to section 409.913, Florida Statutes.

In This Chapter

This chapter contains:

Oversight Agencies

Medicaid Program Integrity

The Agency for Health Care Administration (AHCA), Office of the Inspector General, Bureau of Medicaid Program Integrity (MPI) audits and investigates all providers suspected of overbilling or defrauding the Florida Medicaid program. MPI recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation to the Medicaid Fraud Control Unit. MPI may also originate an investigation due to a complaint being filed.

AHCA shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate.

Only accepted and valid auditing, accounting, analytical, statistical or peer-review methods, or combinations thereof will be used.

Oversight Agencies, continued

Medicaid Fraud Control Unit

The Medicaid Fraud Control Unit (MFCU), under the Florida Office of the Attorney General, investigates fraud committed by health care providers. MFCU also investigates the abuse, neglect and exploitation of the elderly, ill and disabled residents of long term care facilities such as nursing homes, facilities for the mentally and physically disabled, and assisted care living facilities, as well as the investigation of corruption in the administration of Medicaid.

Reporting Suspected Fraud or to File a Complaint

Under Florida's False Claims Act, persons who report on Medicaid Fraud are entitled to share in any funds recovered by the state.

To report fraud, individuals may use the statewide hotline number or contact the MFCU nearest them.

The statewide hotline number is 866-966-7226.

The local MFCU numbers are:

Tallahassee	(850) 414-3300
Orlando	(407) 999-5588
Tampa	(813) 287-7940
Ft. Lauderdale	(954) 712-4600
Miami	(305) 377-5441
Jacksonville	(904) 858-6919
West Palm Beach	(561) 837-5000
Pensacola	(850) 595-6057

The hearing impaired may report Medicaid Provider Fraud Monday through Friday, 7:30 a.m. to 4:30 p.m., by contacting the MCFU at (850) 414-3935 (voice/TTY) or through the Florida Relay at 800-955-8771 (TTY).

Reporting Suspected Abuse or to File a Complaint

A complaint means an allegation that abuse or an overpayment has occurred.

To report suspected abuse of the Medicaid system, call:
Tallahassee: (850) 921-1802
Toll-Free: (888) 419-3456
or
Go to AHCA's Web site and fill out a complaint form online at www.ahca.myflorida.com/Medicaid/abuse/index.shtml. Select the link "Report Medicaid Abuse and Overpayment."

Provider Abuse

Abuse	Abuse means provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary, coded incorrectly on the claim, or that fail to meet professionally recognized standards for health care. Abuse includes recipient activities that result in unnecessary cost to the Medicaid program. Abuse may also include a violation of state or federal law, rule or regulation. Note: See the Florida Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook for information regarding recipient overutilization or fraud of prescription drugs.
Overpayment	Overpayment includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claims, unacceptable practices, fraud, abuse or mistake.

Provider Fraud

Fraud	Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law. AHCA shall require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.
Person	"Person" means any natural person, corporation, partnership, association, clinic, group, or other entity, whether or not such person is enrolled in the Medicaid program or is a provider of health care.

Provider Responsibility

Provider Responsibility

When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

- Have actually been furnished to the recipient by the provider prior to submitting the claim;
- When required by federal or state law, the provider rendering the service is actively licensed or certified to provide the service;
- Are Medicaid-covered goods or services that are medically necessary;
- Are of a quality comparable to those furnished to the general public by the provider's peers;
- Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such co-payments, coinsurance, or deductibles as are authorized by AHCA;
- Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state and local law; and
- Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

Right to Review Records

In accordance with s. 409.907 and 409.913, F.S., authorized state and federal agencies and their authorized representatives may audit or examine a provider or facility's Medicaid-related records. This examination includes all records that the agency finds necessary to determine whether Medicaid payment amounts were or are due and applies to the provider's records and records for which the provider is the custodian. The provider must give authorized state and federal agencies and their authorized representatives access to all Medicaid patient records and to other information that cannot be separated from Medicaid-related records. The provider must send, at his expense, legible copies of all Medicaid-related information to the authorized state and federal agencies and their authorized representatives upon request.

Administrative Sanctions

Administrative Sanctions

AHCA shall impose sanctions on providers in accordance with Section 409.913, F.S. and Rule 59G-9.070, F.A.C. A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to five percent or greater, in which the provider participated or acquiesced.

Sanctions include the following:

- Suspension from participation in the Medicaid Program;
- Termination from participation in the Medicaid Program;
- Imposition of fines;
- Imposition of liens against provider assets;
- Prepayment reviews of claims;
- Comprehensive follow-up reviews; and
- Corrective-action plans.

Violation Definition

Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered to be a separate violation.

Each instance of the following actions is considered to be a separate violation:

- Improper billing of a Medicaid recipient;
- Including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report the cost is not allowable;
- Furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment;
- Knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request or cost report;
- Inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and
- Filing a false or erroneous Medicaid claim leading to an overpayment to a provider.

Administrative Sanctions, continued

Examples of Sanctionable Violations

AHCA may seek any remedy provided by law when:

- The provider's license has not been renewed, or has been revoked, suspended, or terminated, for cause, by the licensing agency of any state;
- The provider has failed to make available or refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of AHCA, the Attorney General, a state attorney, or the federal government;
- The provider has not furnished or has failed to make available such Medicaid-related records as AHCA has found necessary to determine whether Medicaid payments are or were due and the amounts thereof;
- The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered.

Administrative Sanctions, continued

Examples of Sanctionable Violations, continued

- The provider is not in compliance with provisions of the:
  - Medicaid provider publications that have been incorporated by reference as rules in the Florida Administrative Code;
  - State or federal laws, rules, and regulations;
  - Medicaid provider agreement between AHCA and the provider; or
  - Certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;
- The provider or person who ordered or prescribed the care, services, or supplies has furnished or ordered the furnishing of goods or services to a recipient that are inappropriate unnecessary, excessive, or harmful to the recipient, or of inferior quality;
- The provider has demonstrated a pattern of failure to provide goods or services that are medically necessary;
- A provider or an authorized representative of the provider, or a person who ordered or prescribed the goods or services has submitted or caused to be submitted false or erroneous Medicaid claims or encounter data that have resulted in overpayments to a provider or that exceed those to which the provider was entitled under the Medicaid program;
- The provider, his or an authorized representative of the provider, or a person who has ordered or prescribed the goods or services has submitted or caused to be submitted a Medicaid provider enrollment application, a request for prior authorization for Medicaid services, a drug exception request, or a Medicaid cost report that contains materially false or incorrect information;
- The provider or an authorized representative of the provider has collected from or billed a recipient or a recipient's responsible party improperly for amounts that should not have been so collected or billed by reason of the provider's billing the Medicaid program for the same service;
- The provider or an authorized representative of the provider has included in a cost report costs that are not allowable under a Florida Title XIX reimbursement plan, after the provider or authorized representative had been advised in an audit exit conference or audit report that the costs were not allowable;
- The provider is charged by information or indictment with fraudulent billing practices. The sanction applied for this reason is limited to suspension of the provider's participation in the Medicaid program for the duration of the indictment unless the provider is found guilty pursuant to the information or indictment;
- The provider or a person who has ordered or prescribed the goods or services is found liable for negligent practice resulting in death or injury to the provider's patient;

Administrative Sanctions, continued

Examples of Sanctionable Violations, continued

- The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program;
- The provider has failed to comply with the notice and reporting requirements of section 409.907, F.S;
- AHCA has received information of patient abuse or neglect or of any act prohibited by section 409.920, F.S.; and
- The provider has failed to comply with an agreed-upon repayment schedule.

Note: Additional information pertaining to sanctions may be found in Rule 59G-9.070, F.A.C., Administrative Sanctions on Providers, Entities, and Persons.

Recovery of Costs

Withholding of Payment

Pursuant to Section 409.913(25)(a), F.S., AHCA shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime was committed while rendering goods or services to Medicaid recipients, pending completion of legal proceedings.

Pursuant to section 409.913(27), when AHCA has made a probable cause determination and alleged that an overpayment to a Medicaid provider has occurred, AHCA, after notice to the provider, shall:

- Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to Chapter 120, F.S., any medical assistance reimbursement payments until such time as the overpayment is recovered, unless within 30 days after receiving notice thereof the provider:
  - Makes repayment in full; or
  - Establishes a repayment plan that is satisfactory to the AHCA; and
- Withhold, and continue to withhold during the pendency of an administrative hearing pursuant to Chapter 120, F.S. medical assistance reimbursement payments if the terms of a repayment plan are not adhered to by the provider.

Recovery of Costs, continued

Recovery of Costs	AHCA is entitled to recover all investigative, legal, and expert witness costs if the provider did not contest AHCA's findings or, if contested, AHCA ultimately prevailed.
Incomplete or Missing Records	Incomplete records are records that lack documentation that all requirements or conditions for service provision have been met. Medicaid shall recover payment for services or goods when the provider has incomplete records or does not provide the records. Note: See Chapter 2 in this handbook for Medicaid record keeping and retention requirements.

Prepayment Reviews

Prepayment Reviews	AHCA may conduct or contract for, prepayment review of the provider claims or encounter claims to ensure cost-effective purchasing, billing and provision of care to Medicaid recipients. Such prepayment reviews may be conducted as determined appropriate by AHCA, without any suspicion or allegation of fraud, abuse or neglect.

Self Audits

Self Audits	A provider has an obligation to ensure that claims or encounter claims submitted to the Medicaid program are true and accurate. Section 409.913, F.S., obligates AHCA to impose a sanction on providers when AHCA has discovered certain specified violations of Medicaid laws, including the laws governing the provider's profession. However, it also authorizes AHCA to institute amnesty programs wherein Medicaid providers may repay an overpayment without the imposition of sanctions. If, as a result of a self-audit, a provider determines that a claim or encounter claim was paid by the Medicaid program in error, the provider has the opportunity to report the violation and repay the overpayment to AHCA without resulting in the imposition of sanctions. Note: For information on sanctions, see 59G-9.070, F.A.C.

Self Audits, continued

Self Audit Submissions	Unless otherwise agreed upon, send self audit submissions to: Agency for Health Care Administration Medicaid Program Integrity Attention: Special Audit Coordinator 2727 Mahan Drive, MS 6 Tallahassee, Florida 32308

Appeals on Medicaid Overpayments

Appeals	Providers may appeal final AHCA actions that pertain to provider abuse and fraud.

APPENDIX A
IMPORTANT ADDRESSES AND TELEPHONE NUMBERS

APPENDIX A
IMPORTANT ADDRESSES AND TELEPHONE NUMBERS

Medicaid Fiscal Agent

Florida Medicaid's fiscal agent is HP Enterprise Services (HP). The Medicaid fiscal agent is responsible for provider enrollment; processing claims; and answering provider's billing, claims status, and recipient eligibility questions.

The Medicaid fiscal agent cannot change recipient eligibility records from provider-supplied information or claim attachments. The Medicaid fiscal agent cannot respond to recipient inquiries.

Area Medicaid Offices

The area Medicaid offices conduct provider training, assist the provider with claim, billing and adjudication issues, and assist with provider enrollment. The area Medicaid offices also assist recipients in resolving Medicaid claim problems by acting as liaisons between the recipient and the Medicaid provider.

Recipient Eligibility

The Department of Children and Families and the Social Security Administration (SSA) are responsible for establishing, correcting, and updating recipient eligibility. Please refer recipients to the Department of Children and Families Call Center at 866-762-2237 or the Social Security Administration Call Center at 800-772-1213 for assistance with Medicaid eligibility.

In This Appendix

This appendix contains:

HP Addresses and Telephone Numbers

HP Phone Numbers

The following services are available at 800-289-7799 (7am-6pm ET) by selecting the following options:

First Health Pharmacy Contact Center	Option 2
Provider Enrollment	Option 4
Provider Contact Center (PCC)	Option 7
Provider Field Representatives	Option 7
Automated Voice Response System (AVRS)	800-239-7560
Electronic Data Interchange	866-586-0961 or 800-289-7799, Option 3

Written Correspondence and Claim Submissions

Provider Enrollment
P.O. Box 7070
Tallahassee, FL 32317-7070

Provider Re-Enrollment
P.O. Box 13800
Tallahassee, FL 32317-3800

CMS-1500
P.O. Box 7072
Tallahassee, FL 32314-7072

UB-04 Claims
P.O. Box 7062
Tallahassee, FL 32314-7062

Transportation
P.O. Box 7052
Tallahassee, FL 32314-7052

UDDR/PA
P.O. Box 7090
Tallahassee, FL 32314-7090

Adjustments and Voids
P.O. Box 7080
Tallahassee, FL 32314-7080

Attachment for Electronic Claims
P.O. Box 7050
Tallahassee, FL 32314-7050

CMS-1500 Crossover
P.O. Box 7074
Tallahassee, FL 32314-7074

UB-04 Crossover
P.O. Box 7064
Tallahassee, FL 32314-7064

Pharmacy
P.O. Box 7082
Tallahassee, FL 32314-7082

Dental / RPICC
P.O. Box 7084
Tallahassee, FL 32314-7084

General Written Correspondence
P.O. Box 7054
Tallahassee, FL 32314-7054

Ordering Claim Forms

Providers may order claim forms by completing and submitting a claims order form to the Medicaid fiscal agent. The order form is available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Forms. Providers may also obtain the form by calling the Provider Contact Center at 800-289-7799 and selecting Option 7.

HP Addresses and Telephone Numbers, continued

HP Web Site

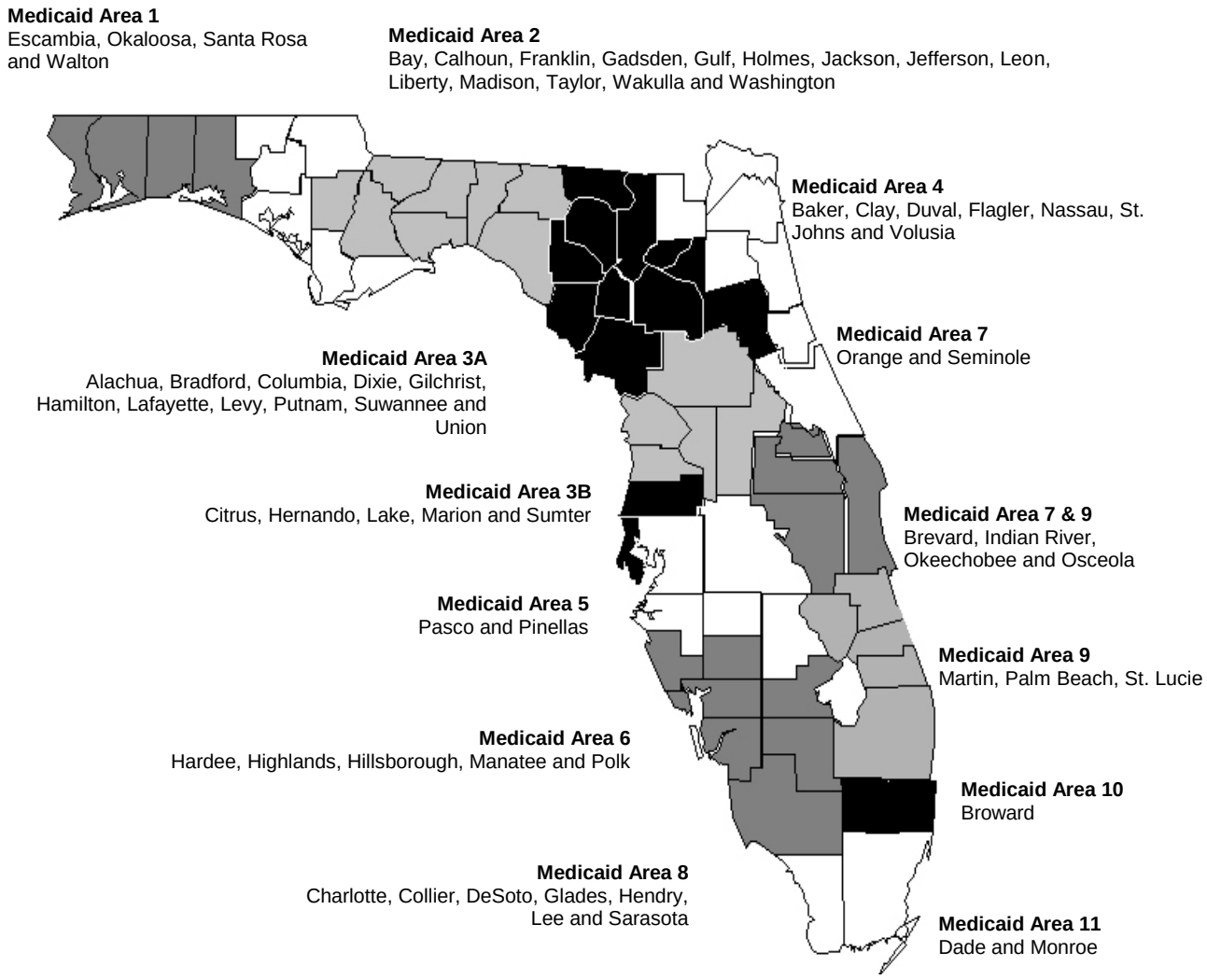
The HP Florida Medicaid Web site at www.mymedicaid-florida.com has extensive information such as:

- Provider Forms;
- Provider Handbooks and Bulletins;
- Fee Schedules;
- Provider Alerts; and
- Third Party Carrier Listing.

In the Portal's secure area, providers can update their provider enrollment information, submit and track claims, request authorization for certain services, and receive alerts and notices.

Illustration A-1: Field Representative Area Map

Please call the Provider Contact Center at 800-289-7799 and select Option 7 to contact your Field Representative.



State Medicaid Office Addresses

Medicaid Policy	Agency for Health Care Administration Medicaid Services 2727 Mahan Drive, Mail Stop 20 Tallahassee, Florida 32308
Medicaid Program Analysis	Agency for Health Care Administration Medicaid Program Analysis 2727 Mahan Drive, Mail Stop 21 Tallahassee, Florida 32308
Medicaid Contract Management	Agency for Health Administration 2562 East Executive Circle, Suite 100 Tallahassee, Florida 32301-5002
Medicaid Program Integrity	Agency for Health Administration Medicaid Program Integrity 2727 Mahan Drive, Mail Stop 6 Tallahassee, Florida 32308
Third Party Recovery	ACS Florida TPL Recovery Unit 2308 Killearn Center Blvd., Bldg A1 Tallahassee, Florida 32309 Phone: 877-357-3268 (FL-RECOV) Fax: 866- 443- 5559 Web site: www.FLMedicaidTPLRecovery.com E-Mail: FLMedicaidTPLRecovery@acs-inc.com
To Report Suspected Fraud or Abuse	Florida Medicaid Fraud Control: 800-892-0375 HHS: 800-HHS-TIPS (800-447-8477)

Helpful Government Web Sites

All State Agencies	www.myflorida.com
Agency for Health Care Administration (AHCA)	www.ahca.myflorida.com
Medicaid	www.ahca.myflorida.com. *Select Medicaid.*
Medicaid HMOs	www.ahca.myflorida.com. *Select Medicaid, then Medicaid HMOs.*
Department of Children and Families (DCF)	www.state.fl.us/cf_web
Department of Health (DOH)	www.doh.state.fl.us
Florida KidCare	www.floridakidcare.org
Florida Statutes	www.leg.state.fl.us
Code of Federal Regulations	http://www.gpoaccess.gov/cfr/index.html
Department of Health and Human Services	www.hhs.gov
Centers for Medicare and Medicaid Services	www.cms.gov
Centers for Disease Control Recommended Immunization Schedules	www.cdc.gov/vaccines/
National Provider Identifier	www.cms.hhs.gov/nationalprovidentstand/
Florida Administrative Code	www.flrules.org

Area Medicaid Offices Addresses and Telephone Numbers

The local area Medicaid offices are the primary source of information for:

- Medicaid policy and covered services questions,
- Medicaid provider relations, and
- Exceptions to the Filing Time Limits.

Areas—Counties Covered	Address	Phone
Area 1—Escambia, Okaloosa, Santa Rosa, Walton Counties	160 Governmental Center, Room 510 Pensacola, Florida 32502	(850) 595-5700 (850) 595-5718 (fax) (800) 303-2422 (toll free)
Area 2A—Bay, Gulf, Franklin, Holmes, Jackson, Washington Counties	651 West 14 Street, Suite K Panama City, Florida 32401	Bay County (850) 872-7690 (850) 747-5456 (fax) Franklin, Gulf, Holmes, Jackson, and Washington Counties (850) 747-5456 (fax) (800) 699-7068 (toll free)
Area 2B—Calhoun, Gadsden, Jefferson, Liberty, Leon, Madison, Taylor, Wakulla Counties	2727 Mahan Drive, MS #42 Tallahassee, Florida 32308	Calhoun, Gadsden, Jefferson, Leon, Madison, and Wakulla Counties (850) 487-2272 (850) 921-0394 (fax) Taylor and Calhoun Counties only (850) 921-0394 (fax) (800) 248-2243 (toll free)
Area 3A—Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union Counties	14101 N.W. Hwy. 441, Suite 600 Alachua, Florida 32615-5669	(386) 418-5350 (386) 418-5370 (fax) (800) 803-3245 (toll free)
Area 3B—Citrus, Hernando, Lake, Marion, and Sumter Counties	2441 West Silver Springs Blvd. Ocala, Florida 34475	(352) 732-1349 (352) 620-3076 (fax) (877) 724-2358 (toll free)
Area 4—Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia Counties	Duval Regional Service Center 921 North Davis St., Bldg. A, Suite 160 Jacksonville, Florida 32209-6806	(904) 353-2100 (904) 353-2198 (fax) (800) 273-5880 (toll free)
Area 5—Pasco and Pinellas Counties	525 Mirror Lake Drive North Suite 510 St. Petersburg, Florida 33701	(727) 552-1900 (727) 552-1216 (fax) (800) 299-4844 (toll free)
Area 6—Hardee, Highlands, Hillsborough, Manatee, and Polk Counties	North Park Center, Suite 220 6800 N. Dale Mabry Hwy. Tampa, Florida 33614	(813) 871-7600 (813) 673-4592 (fax) (800) 226-2316 (toll free)
Area 7—Brevard, Orange, Osceola, and Seminole Counties	400 West Robinson Street Suite 309 – South Tower Orlando, Florida 32801	(407) 317-7851 (877) 254-1055 (toll free)

Area Medicaid Offices Addresses and Telephone Numbers, continued

Areas—Counties Covered	Address	Phone
Area 8—Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota Counties	2295 Victoria Ave., Room 309 Ft. Myers, Florida 33901 *All mail should be addressed to*: P. O. Box 60127 Ft. Myers, Florida 33906-0127	(239) 338-2620 (239) 338-2642 (fax) (800) 226-6735 (toll free)
Area 9—Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties	1655 Palm Beach Lakes Blvd. Bldg. C, Suite 300 West Palm Beach, Florida 33401	(561) 616-5255 (561) 616-1545 (fax) (800) 226-5082 (toll free)
Area 10—Broward County	1400 W. Commercial Blvd. Suite 110 Ft. Lauderdale, Florida 33309	(954) 202-3200 (954) 202-3220 (fax) (866) 875-9131 (toll free)
Area 11—Miami-Dade and Monroe Counties	Doral Center, Manchester Bldg. 8355 NW 53 Street, 2nd Floor Miami, Florida 33166	(305) 499-2000 (305) 499-2022 (fax) (800) 953-0555 (toll free)

County and Area Medicaid Office Cross Reference List

County	Area Medicaid Office	County Number
Alachua	3A	1
Baker	4	2
Bay	2A	3
Bradford	3A	4
Brevard	7	5
Broward	10	6
Calhoun	2B	7
Charlotte	8	8
Citrus	3B	9
Clay	4	10
Collier	8	11
Columbia	3A	12
Desoto	8	14
Dixie	3A	15
Duval	4	16
Escambia	1	17
Flagler	4	18
Franklin	2A	19
Gadsden	2B	20
Gilchrist	3A	21
Glades	8	22
Gulf	2A	23

County and Area Medicaid Office Cross Reference List, continued

County	Area Medicaid Office	County Number
Hamilton	3A	24
Hardee	6	25
Hendry	8	26
Hernando	3B	27
Highlands	6	28
Hillsborough	6	29
Holmes	2A	30
Indian River	9	31
Jackson	2A	32
Jefferson	2B	33
Lafayette	3A	34
Lake	3B	35
Lee	8	36
Leon	2A	37
Levy	3A	38
Liberty	2B	39
Madison	2B	40
Manatee	6	41
Marion	3B	42
Martin	9	43
Miami-Dade	11	13
Monroe	11	44
Nassau	4	45
Okaloosa	1	46
Okeechobee	9	47
Orange	7	48
Osceola	7	49
Palm Beach	9	50
Pasco	5	51
Pinellas	5	52
Polk	6	53
Putnam	3A	54
St. Johns	4	55
St. Lucie	9	56
Santa Rosa	1	57
Sarasota	8	58

County and Area Medicaid Office Cross Reference List, continued

County	Area Medicaid Office	County Number
Seminole	7	59
Sumter	3B	60
Suwannee	3A	61
Taylor	2B	62
Union	3A	63
Volusia	4	64
Wakulla	2B	65
Walton	1	66
Washington	2A	67

APPENDIX B
GLOSSARY

APPENDIX B
GLOSSARY

Adult Family Care Homes (AFCH)	An adult family care home (AFCH) is a residential facility that is licensed pursuant to Chapter 429, Part II, F.S.
Adjustment	Correction to an incorrectly paid claim, which would result in a partial refund to Medicaid or additional payment to the provider.
Administrative or Grace Days	Days that a patient remains in the hospital beyond the point of medical necessity while awaiting placement in a nursing home or other place of residence.
Adult Health Screening	A service provided to assess the health status of recipients age 21 and older in order to detect and prevent disease, disability, and other health conditions.
AHCA	The Agency for Health Care Administration is the state agency responsible for the administration of the Florida Medicaid Program.
AHCA Organ Transplant Advisory Council	A statewide technical council consisting of twelve physicians who represent the interest of the public. This council formulates guidelines and recommends to AHCA indicators for Medicaid adult and pediatric organ transplants.
Assistive Care Services	Services provided to eligible recipients in assisted living facilities, adult family care homes, and residential treatment facilities.
Assisted Living Facility (ALF)	A facility that provides housing, food service, and one or more personal services to four or more adults who require such services and who are not related to the owner or administrator. Assisted living facilities are licensed pursuant to Chapter 429, Part I, F.S.
Bed Hold	Medicaid payment to a facility to reserve a bed in a nursing facility or ICF/DD while a recipient is in the hospital or on therapeutic leave.
Beneficiaries	Persons receiving medical benefits under Medicare. Persons eligible for Medicaid are also sometimes referred to as beneficiaries.

Glossary, continued

Billing Agent	A billing agent is an entity that offers claims submission services to providers. Providers may submit claims themselves or choose to have a billing agent. Billing agents must be enrolled in the Medicaid program.
Board Certified Psychiatrist	A physician who is board certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
CARES	CARES is the Comprehensive Assessment and Review for Long-Term Care Services Program. CARES is administered by the Department of Elder Affairs.
Case Manager	A case manager for Home and Community-Based Waiver services is the person who writes a recipient's plan of care and authorizes, in advance, the services that will be provided to a recipient. A case manager for the Developmental Disabilities, Family and Supported Living, and Traumatic Brain and Spinal Cord Injury Waivers is called a support coordinator. Mental Health and Children's Health targeted case management practitioners are also referred to as case managers.
Centers for Medicare and Medicaid Services (CMS)	This federal agency within the Department of Health and Human Services is responsible for the regulation of the various states' Medicaid programs.
Child Health Check-Up (CHCUp)	Child Health Check-Up (CHCUp), known in the federal regulations as Early and Periodic Screening, Diagnosis, and Treatment, is a comprehensive, preventive child-health screening to identify and correct medical conditions before the conditions become serious or disabling.
Children's Medical Services (CMS)	Children's Medical Services is a division of the Florida Department of Health that provides children with special health care needs with a family centered, managed system of care through the CMS Network. Children with special health care needs are those children under age 21 whose serious or chronic physical or developmental conditions require extensive preventive and maintenance care beyond that required by typically healthy children.
Children's Medical Services (CMS) Network	The Children's Medical Services Network is a managed system of care for children under age 21 with special health care needs. The CMS Network is managed by the Department of Health, Children's Medical Services.

Glossary, continued

Children's Multi-disciplinary Team (CMAT)	A specialized team of individuals from different medical specialties, state agencies, and the child's family that assesses and recommends treatments for a child based on medical necessity.
Chiropractic Physician	A doctor of chiropractic medicine who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 460, F.S., or the applicable laws of the state in which the service is furnished.
Chiropractic Physician Services	Medical care rendered by a doctor of chiropractic medicine, licensed to practice in the state where the service is provided, and provided within the scope of the practice of chiropractic medicine as defined by state law.
Claim	A request for Medicaid to pay for health care services. A claim may be submitted on paper or electronically through the Medicaid fiscal agent's Provider Electronic Solutions, Web Portal via X12N Transaction submission or Web Direct Data Entry, or on CDs or DVDs mailed to the fiscal agent.
Clean Claim	A clean claim is a claim that is submitted in the correct format, is signed and dated, and has all the required attachments needed for processing.
CLIA	The Clinical Laboratory Improvement Amendments of 1988 (CLIA) prescribes nationwide quality assurance standards applicable to all laboratory facilities that examine materials from the human body for the diagnosis or treatment of disease or for the assessment of health.
Concurrent Days	The days when a Medicaid recipient and her newborn(s) are inpatients of the same hospital at the same time.
Cosmetic Surgery	A surgical procedure for aesthetic purposes only.
Crossover Claim	Medicare crossover claims are claims that have been adjudicated for payment by Medicare and sent to Medicaid for consideration of the payment of the Medicare deductible and coinsurance.
Custodial Care	Care, which does not provide continued medical or paramedical attention, given to assist a person in performing daily living activities.

Glossary, continued

DEA	Drug Enforcement Agency
Deny	To refuse to pay a claim as submitted.
Department of Children and Families (DCF)	The state agency responsible for Florida Medicaid eligibility determinations except for those individuals who are eligible because they have Supplemental Security Income.
DESI	Drug Efficacy Study Implementation (DESI) drugs are drugs that lack substantial evidence of effectiveness according to the classification process of the DESI panel. These drugs do not receive federal financial participation and are not covered by Medicaid.
Disease Management Organization (DMO)	Disease management organizations are private vendors who provide disease management services to Medicaid recipients enrolled in the Primary Care Case Management Program (MediPass) who have been diagnosed with certain chronic diseases, such as diabetes, HIV/AIDS, asthma, and hemophilia.
Disproportionate Share Hospital	A hospital that serves a disproportionate number of low-income patients with special needs.
Drug Utilization Review (DUR)	Drug utilization review (DUR) is a process whereby the pharmacist reviews the prescription and the patient record for therapeutic appropriateness.
Durable Medical Equipment (DME)	Equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home.
Dx Code	Diagnosis code as found in the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM).
Early Intervention Services	Services that are designed to meet the medical needs of a child who is developmentally delayed or has an established condition that has a high probability of resulting in a developmental delay.

Glossary, continued

Elective Surgery	Surgery that can be safely deferred without threatening the life of the recipient, causing irreparable physical damage, or resulting in irretrievable loss of growth and development.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient, including a pregnant woman or a fetus; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.
Emergency Medical Treatment and Labor Act (EMTALA)	The federal Emergency Medical Treatment and Labor Act (EMTALA) requires emergency rooms to conduct a medical screening exam on any patient presenting to the emergency room for medical services. The purpose of the medical screening exam is to determine if an emergency medical condition exists. If the screening determines that an emergency medical condition exists, the provider must either stabilize the condition or appropriately transfer the patient to a facility that can stabilize the condition.
Emergency Services and Care	Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.
Encounter Claim	An individual transaction that contains a record of diagnostic or treatment procedures or other medical or allied care provided to a health plan's enrollees, excluding services paid by Medicaid on a fee-for-service basis. An "encounter" is an interaction between a patient and provider (health plan, rendering physician, pharmacy, lab, etc.) who delivers services or is professionally responsible for services delivered to a patient.
Encounter Data	A record of diagnostic or treatment procedures or other medical or allied care provided to a health plan's enrollees, excluding services paid by Medicaid on a fee-for-service basis.
EOMB	Explanation of Medicaid or Medicare Benefits
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Glossary, continued

Established Patient	A recipient who is known to the center, office, or provider or whose records are normally available. For physicians, an established patient is an individual who has received professional services from the provider or another provider with the same specialty who belongs to the same provider group, within the past three years.
Examination	The evaluation of a Medicaid recipient during the process of inspection or investigation inherent to the diagnosis and treatment of any disease, complaint, or disorder by a health care practitioner.
Experimental or Clinically Unproven Procedures	Those newly developed procedures undergoing systematic investigation to establish their role in treatment or procedures that are not yet scientifically established to provide beneficial results for the condition for which they are being used.
F.A.C.	Florida Administrative Code
Fiscal Agent	A private corporation under contract with the Agency for Health Care Administration to receive and process Medicaid claims. Electronic Data Systems (EDS) is the Florida Medicaid fiscal agent.
Fiscal Year	A budgetary, financial reporting or cost accounting time period, twelve months in length, used by health care providers, the Florida Legislature and the federal government. The state fiscal year is July 1 through June 30, and the federal fiscal year is October 1 through September 30. Health care providers generally choose one of these two but can use other twelve-month spans.
F.S.	Florida Statutes
FMMIS	The Florida Medicaid Management Information System (FMMIS). The computer system that contains provider and recipient records and processes claims.
Full Benefit Dual Eligible	A recipient who has both Medicare and full Medicaid benefits is known as "full benefit dual eligible". This includes individuals with Medicare who are eligible for Medically Needy coverage. Full benefit dual eligible enrollees may be either full benefit duals with QMB or full benefit duals without QMB. Full benefit duals who are not also QMB do not receive the same level of benefits as someone who is full benefits dual eligible with QMB. Note: Recipients who are eligible for SSI and Medicare are automatically considered to be a full benefit dual eligible with QMB.

Glossary, continued

General Hospital	In accordance with the provisions specified in section 395.002, Florida Statutes, a general hospital is an establishment that offers: • Services more intensive than those required for room, board, personal services and general nursing care; • Facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and • And regularly make available: – clinical laboratory services; – diagnostic x-ray services; – treatment facilities for surgery or obstetrical care, and – other definitive medical treatment.
HCPCS	Healthcare Common Procedure Coding System (HCPCS) is the common procedure coding system that is used by health care providers to identify the services that the provider performed. This coding system is administered by the Centers for Medicare and Medicaid Services.
High Medical Risk Pregnant Woman	A recipient whose medical history and diagnosis indicate, without consideration of Cesarean section, that a normal uncomplicated pregnancy or delivery will not occur.
HIPAA	The Health Insurance Portability and Accountability Act (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. HIPAA's Administrative Simplification provisions require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data.
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
HMO	A Health Maintenance Organization is a managed care plan that is certified by the Florida Department of Insurance under the applicable provisions of Part I of Chapter 641, F.S.
Home and Community-Based Services Waiver	A specific program and set of services authorized under section 1915(c) of the Social Security Act that are designed to assist recipients to avoid institutionalization.

Glossary, continued

Hospital	A facility licensed in accordance with the provision of Chapter 395, Florida Statutes, or the applicable laws of the state in which the service is furnished.
ICD-9-CM	A three volume set of books listing the international classification of diseases: Volume 1 - Numeric listing of diagnosis codes; Volume 2 - Alphabetic listing of diagnosis codes; and Volume 3 - Hospital surgical procedure codes.
Internal Control Number (ICN)	The Internal Control Number (ICN) is a 13-digit internal control number assigned to each claim when it is received by the fiscal agent for processing. (Previously called the Transaction Control Number, TCN.)
ICP	The Institutional Care Program (ICP) is a Medicaid eligibility category that covers individuals who meet the eligibility requirements for Medicaid services in a skilled nursing facility or swing bed, ICF/DD, or state mental hospital.
Individualized Family Support Plan	A Medicaid accepted plan of care for a child that is written by the child's family and service and health care providers. The plan identifies the child's health care, economic assistance, equipment, and educational needs.
Initial Medicaid Interim Reimbursement Rate	A rate of reimbursement calculated from budgeted fiscal data that a provider submits to the Medicaid Cost Reimbursement Section before enrollment is completed and before a provider number is assigned. The rate is subject to actual historical cost.
Inpatient	A person who has been admitted to a hospital for purposes of receiving inpatient hospital services with the expectation that he will remain at least overnight and occupy a bed even though it may later develop that he can be discharged or transferred to another hospital and does not actually use the hospital bed overnight.
Inpatient Hospital Services	Services furnished in an institution maintained primarily for the care and treatment of patients with disorders other than mental diseases or substance abuse diagnoses (except that services aimed at medical stabilization or detoxification are covered if deemed medically necessary to be performed in the inpatient setting). These services are rendered under the direction of a physician or dentist.

Glossary, continued

Intermediate Care Facility for the Developmentally Disabled (ICF/DD)	An institutional facility licensed in accordance with the provisions of Chapter 400, F.S., which provides medical, habilitative, and health-related services to individuals with developmental disabilities.
Level of Care	The level of nursing or rehabilitative care required by a Medicaid applicant or Medicaid recipient based upon his needs as defined by the criteria in Chapters 59G-4.180 and 59G-4.290, F.A.C.
Low Medical Risk Pregnant Woman	A recipient whose medical history and diagnosis indicate, without consideration of a Cesarean section, that a normal uncomplicated pregnancy or delivery will occur.
Medicaid Physician Consultant	A doctor of medicine or osteopathy licensed pursuant to Chapter 458 or Chapter 459, F.S., employed by or under contract with Medicaid.
Medical Care	The provision of medically necessary procedures rendered in the course of diagnosis and treatment of a condition, illness or injury.
Medical Supplies	Medical or surgical items that are consumable, expendable, disposable or non-durable and that are used for the treatment or diagnosis of a patient's specific illness, injury, or condition.
Medically Complex	A person is medically complex if he has chronic debilitating diseases or conditions of one or more physiological or organ systems that make the person dependent upon 24-hour per day medical, nursing or health supervision or intervention.
Medically Needy	Medically Needy is a Medicaid coverage group that includes individuals who would qualify for Medicaid, except that their income or resources exceed the Medicaid's income or resource limits. On a month-by-month basis, the individual's medical expenses are subtracted from his income; if the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid for the day he became eligible until the end of the month. This is also referred to as "share of cost" Medicaid.

Glossary, continued

Medically Fragile	An individual who is medically complex and technologically dependent on medical apparatus or procedures to sustain life. Examples are individuals who require total parenteral nutrition, are ventilator dependent, or are dependent on a heightened level of medical supervision to sustain life, and without such services are likely to expire without warning.
Medically Necessary or Medical Necessity	Per 59G-1.010 (166), F.A.C., medically necessary or medical necessity means that the medical or allied care, goods, or services furnished or ordered must: (a) Meet the following conditions: 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain; 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational; 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type; and (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
MediPass	MediPass is a primary care, case-management program designed to assure Medicaid recipients access to care, decrease inappropriate service utilization, and control costs.
Medicaid Identification Card (MIC)	A Medicaid Identification Card (MIC) is a temporary proof of Medicaid eligibility that the recipient may use until he receives his Medicaid gold card. It is also referred to as an AMIC.
National Drug Code (NDC)	The National Drug Code (NDC) is the 11-digit code from the package of the dispensed drug.

Glossary, continued

National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number).
Neonatal and Perinatal Services	Services covered under the branch of medicine that comprehends the diagnosis and treatment of specialized care for high-risk newborns.
NICU	Neonatal intensive care unit
Neonatal Perinatologist	A state licensed physician who is certified or meets the requirements for certification by the American Board of Neonatal Perinatologists.
Neurological Services	Services covered under the branch of medicine that comprehends the diagnosis and treatment of disorders of the nervous system, which services are included in the Medicaid fee schedule.
Neurologist	A state licensed physician who is certified or meets the requirements for certification as a neurologist by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
New Patient	A recipient that is new to the center, office, or provider or whose records are not normally available. For physicians, a new patient is one who has not received any professional services from a provider or another provider of the same specialty who is in the same provider group, within the past three years.
Newborn	An infant from birth through the first four weeks of life.
Non-participating Hospital	A hospital that has not signed an agreement with Florida Medicaid to participate in the Medicaid program. This type of hospital may only treat Medicaid recipients in cases of emergencies or when prior authorized services have been arranged. The recipient must be discharged or transferred to a participating hospital once he or she has been stabilized.

Glossary, continued

Organ and Tissue Transplantation	Replacing bone marrow or solid organs that are no longer functional with bone marrow or organs from another human donor.
Orthotic Device	A device or appliance to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.
Osteopathic Physician	A doctor of osteopathic medicine who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 459, F.S., or the applicable laws of the state in which the service is furnished.
Osteopathic Physician Services	Medical care rendered by an osteopathic physician, licensed to practice in the state where the service is provided, and provided within the scope of practice of osteopathy as defined by state law.
Outpatient Hospital Services	Medically-necessary preventative, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient, by or under the direction of a physician or dentist, by an institution that is licensed as a hospital.
PASRR	Preadmission Screening and Resident Review (PASRR) as required by the Code of Federal Regulations, Part 483, Subpart C.
Patient Responsibility	The portion of a Medicaid recipient's monthly income that the recipient is responsible to pay to the nursing facility, ICF/DD or hospice.
Pended Claim	A claim in the FMMIS awaiting final adjudication.
Per Diem	A daily rate established by AHCA based upon an institutional facility's submitted cost report.
Personal Needs Allowance	The portion of a Medicaid recipient's monthly income that he is allowed to keep to pay for incidental expenses.
Personal Supervision	The supervision of services furnished while the supervising practitioner is in the building, and for which the supervising practitioner signs and dates the medical records (charts) within 24 hours of the provision of the service.

Glossary, continued

Physician	A doctor of medicine who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 458, F.S., or the applicable laws of the state in which the service is furnished.
Physician Services	Medical care rendered by a physician, licensed to practice in the state where the service is provided, and provided within the scope of practice of medicine as defined by state law.
Podiatric Physician	A doctor of podiatric medicine who holds a valid and active license in full force and effect pursuant to the provisions of Chapter 461, F.S., or the applicable laws of the state in which the service is furnished.
Podiatric Physician Services	Medical care rendered by a doctor of podiatric medicine, licensed to practice in the state where the service is provided, and provided within the scope of the practice of podiatric medicine as defined by state law.
POS	Place of service or point of sale claim submission.
Post Authorization	The approval to bill Medicaid for medical or allied care, goods, or services obtained by a provider from the agency, or from a provider under contract with the agency to manage a client's care, after the care, goods, or services have been furnished.
Prepaid Mental Health Plan (PMHP)	Prepaid Mental Health Plans (PMHP) cover inpatient and outpatient hospital services, psychiatric and physician services, community mental health services, and targeted case management services.
Prescribed Pediatric Extended Care (PPEC)	A prescribed pediatric extended care (PPEC) center is a non-residential rehabilitation facility that serves children under age 21 who require short or long-term continual medical care that is licensed pursuant to Chapter 391, F.S.

Glossary, continued

Provider Service Network (PSN)	A Provider Service Network (PSN) is an integrated health care delivery system owned and operated by Florida hospitals or other providers. The PSN is a Medicaid managed-care option for Medicaid recipients in many Florida counties (Reform and non-Reform), in addition to HMOs, MediPass, and the CMS Network. PSNs may be capitated health plans, like HMOs, or may be fee-for-service (FFS) health plans. Capitated PSNs pay authorized claims directly. In FFS health plans, claims for services approved by the plan are generally submitted by providers to the plan for authorization. FFS health plan-approved claims are forwarded by the plan to the Medicaid fiscal agent for payment directly to the provider.
Prior Authorization	A request submitted to the fiscal agent, Medicaid, or a peer review organization for permission to perform one or more specific procedures.
Procedure Code	A number that Medicaid uses to identify the procedures that providers render to Medicaid recipients.
Prosthetic Device	A prosthetic device is a device or appliance to replace all or part of the function of a permanently inoperative or malfunctioning body part.
Provider	Person or facility providing Medicaid services to recipients.
Psychiatric Hospital	A hospital of more than 16 beds which is primarily maintained for the provision of diagnosis, treatment and care for persons with mental diseases, including medical attention, nursing care, and related services.
Psychiatric Services	Those services covered under the branch of medicine that treats mental and neurotic disorders and the pathologic or psychopathologic changes associated with them, and that are included in the Medicaid fee schedule.

Glossary, continued

Psychiatrist	A state licensed physician who is certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, or has completed a psychiatry residency accredited by the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada.
Quality Improvement Organization	A Quality Improvement Organization (QIO) or QIO-like entity is designated through the Centers for Medicare and Medicaid Services to perform utilization review services and to monitor the appropriateness of care provided to individuals through a state Medicaid program. Florida Medicaid contracts with QIO-like entities to safeguard against unnecessary utilization and to assure the quality of care provided to Medicaid recipients. These were previously called Peer Review Organizations (PRO).
Remittance Advice (RA)	Remittance advice (RA) is a statement from the fiscal agent summarizing the status of and payment amounts for claims filed (previously called a remittance voucher).
Recipient	A person who is eligible to receive services under Medicaid.
Reference Laboratory	A laboratory used for the performance of pathological tests and services by other than the billing physician or the billing laboratory.
Residential Treatment Facility (RTF)	A residential treatment facility (RTF) is a mental health residential facility that is licensed pursuant to section 394.875, F.S.
RPICC	Regional Perinatal Intensive Care Centers (RPICCs) are specialized units within designated hospitals as defined in sections 383.15-21, F.S. RPICCs provide obstetrical services to women identified as having a high-risk pregnancy and neonatal intensive care services to critically ill or low birth weight newborns.
Screening	A medical examination provided to Medicaid patients designed to detect physical and mental conditions for the provision of treatment and other corrective health measures. Note: For Optometric Services, see the definition in Chapter 1 of the Optometric Services Coverage and Limitations Handbook.

Glossary, continued

Self-Audit	Review of claims a provider conducts on their own to ensure Medicaid compliance.
Service Authorization	The approval required from a designated authority for reimbursement for certain Medicaid services.
Service Limit	Restriction on the maximum amount, duration or scope of a Medicaid covered service.
Share of Cost	A share of cost is the amount of medical expenses that must be deducted from an enrolled Medically-Needy recipient's income to make him eligible for Medicaid.
SIPP	The Statewide Inpatient Psychiatric Program (SIPP) Waiver serves Medicaid-eligible recipients under the age of 18 who require placement in a psychiatric residential setting due to serious mental illness or emotional disturbance.
Specialty Hospital	Any facility that meets the provisions specified in section 395.002, F.S., under the definition of hospital as included in this glossary. A specialty hospital regularly makes available either: • The range of medical services offered by general hospitals, but restricted to a defined age or gender group of population; or • A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders.
Support Coordinator	A support coordinator is a case manager for the Developmental Disabilities (Tiers 1-4), iBudget, and Traumatic Brain Injury and Spinal Cord Injury Waivers.
Targeted Case Management (TCM)	Services to arrange, coordinate, and help access services for children served by Children's Medical Services and children and adults with chronic mental health problems.
Teaching Hospital	Any hospital formally affiliated with an accredited medical school that provides medical education as reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians.

Glossary, continued

Third Party	An individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid.
Third Party Liability (TPL)	Third Party Liability (TPL) refers to any entity other than the recipient or the recipient's responsible party that is liable to pay all or part of the cost of medical care.
Title XVIII	The sections of the federal Social Security Act, 42 U.S.C. s. 1395 et seq., and regulations there under that authorize the Medicare program.
Title XIX	The sections of the federal Social Security Act, 42 U.S.C. s. 1396 et. seq., and regulations there under that authorize the Medicaid program.
Title XXI	The sections of the federal Social Security Act, 42 U.S.C. s. 1396 et. seq., and regulations there under that authorize the Children's Health Insurance Program (CHIP).
TOS	Type of service
Total Parenteral Nutrition (TPN)	An intravenous solution providing complete nutritional needs, including lipids and amino acids, for recipients unable to receive nutrition via the gastrointestinal track.
UR (Utilization Review)	The evaluation of the appropriateness, necessity, and quality of services billed to Medicaid. It also means the evaluation of the use of Medicaid services by recipients, including a recipient's need for continued stay in an institutional care facility.
Urgent Services	Those services needed to immediately relieve pain or distress for medical problems such as injuries, nausea, and fever; and services needed to treat infectious diseases and other similar conditions.
Visit	A clinical staff and recipient interaction at the center, office, hospital, home or other place of service.
Void	A process whereby an original paid claim is refunded to Florida Medicaid.

APPENDIX C
MEDICAID ELIGIBILITY CODES ON THE FMMIS RECIPIENT SUBSYSTEM

APPENDIX C
MEDICAID ELIGIBILITY CODES ON THE FMMIS RECIPIENT SUBSYSTEM

Code	Coverage
5007	Pharmaceutical Expense Program to assist with Medicare Part B coinsurance for persons not eligible for Medicaid or QMB, who were diagnosed with cancer or received an organ transplant and were receiving drugs to treat these conditions in December 2005 under the Medically Needy program, who were and continue to be eligible for Medicare. This is not a Medicaid service; it is funded in full by general revenue.
EBA	Enhanced Benefit Account (EBA) tracks credits earned by recipient for healthy behaviors while in a Medicaid Reform HMO. Benefits are limited to approved over-the-counter, health-related items from pharmacies. Recipients who earn the EBA credit can spend the earned credits for up to three years after losing other Medicaid eligibility. Refer to this Web site for additional information: http://ahca.myflorida.com/medicaid/medicaid_reform/enhab_ben/enhanced_benefits.shtml.
FP	Limited to family planning services for certain women
MA I	Full Medicaid
MA R	
MA U	
MB C	
MCAE	
MCAN	
MCE	
MCFE	
MCFN	
ME C	
ME I	
ME T	
MH A	
MH H	
MH M	
MH P	
MH S	
MI A	
MI I	
MI M	
MI P	
MI S	

*Institutional care is defined as long-term care in facilities such as nursing homes or ICF/DDs; it does not include acute care hospitals.

Code	Coverage
MI T	Limited to non-institutional care*
MK A	Full Medicaid but must be enrolled in managed care to be eligible.
MK B	
MK C	
ML A	Limited to emergency care for non-qualified aliens
ML S	
MM C	Full Medicaid
MM I	
MM P	
MM S	
MM T	
MN	
MO A	
MO D	
MO P	
MO S	
MO T	
MO U	
MO Y	
MP C	
MP N	
MP U	
MREI	
MRHA	
MRHH	
MRHM	
MRHP	
MRIA	
MRII	
MRIM	
MRIP	

*Institutional care is defined as long term care in facilities such as nursing homes or ICF/DDs; it does not include acute care hospitals.

Code	Coverage
MRIT	Limited to non-institutional* care
MRMC	Full Medicaid
MRMI	
MRMP	
MRMS	
MRMT	
MRN	
MROT	
MRPN	
MRR	
MRTA	
MRTC	
MRTD	
MRTW	
MS	
MT A	
MT C	
MT D	
MT S	
MT W	
MU	Limited to outpatient, office, transportation, and emergency room services. Does not cover inpatient or delivery services.
MW A	Full Medicaid
MW C	
MX	
NA I	Must meet Share of Cost. Eligible for all services except: • Assistive Care Services; • Intermediate Care Facilities for the Developmentally Disabled (ICF/DD); • Home and Community Based Services Waiver Programs; • Nursing Facility Services; • Regional Perinatal Intensive Care Center Services; • State Mental Hospital Services; and • Statewide Inpatient Psychiatric Program (SIPP) services.
NA R	
NA U	
NCAE	
NCAN	
NC E	
NCFN	
NL A	Limited to non-institutional* emergency care for non-qualified aliens; must meet Share of Cost.
NL S	

*Institutional care is defined as long term care in facilities such as nursing homes or ICF/DDs; it does not include acute care hospitals.

Code	Coverage
NM P	Must meet Share of Cost. Eligible for all services except skilled nursing facilities and ICF/DD.
NN	Full Medicaid for birth month and two postpartum months only, if mother met Share of Cost on or before the newborn's date of birth.
NO Y	Must meet Share of Cost. Eligible for all services except skilled nursing facilities and ICF/DD.
NP C	
NP N	
NP U	
NRMP	
NRN	Full Medicaid for birth month and two postpartum months only, if mother met Share of Cost on or before the newborn's date of birth.
NRPN	Must meet Share of Cost. Eligible for all services except skilled nursing facilities and ICF/DD.
NRR	
NRS	
NS	
QMB	Limited to Medicare premiums, deductibles, and coinsurance
QMBR	
QI1	Limited to Medicare Part B premium only
SLMB	Limited to Medicare Part B premium only
WD	Limited to Medicare Part A premiums only

APPENDIX D
MEDICAID OUT-OF-STATE PRIOR-AUTHORIZATION FORM

MEDICAID OUT-OF-STATE PRIOR-AUTHORIZATION REQUEST FORM

A Florida Medicaid enrolled primary care or specialist physician may refer a Medicaid recipient for out-of-state care to obtain medically-necessary services that cannot be provided in Florida. The physician must request and obtain prior-authorization before the recipient receives out-of-state services.

Approved authorizations do not guarantee payment, but are contingent upon recipient eligibility on the date of service and the servicing provider's willingness to enroll with Florida Medicaid.

General Information			
Medicaid Recipient ID – 10 digits	Last Name	First Name	Date of Birth

Required Documentation (checklist attach to this form)

Requesting Physician Information	Agency Use Only
Medicaid Provider Number: _____	Approved P.A. Number: _____
I certify that the information submitted in this packet is a true and accurate medical indication for the procedures requested. All other treatment available in Florida to correct this problem has been exhausted.	CPT Code(s): _____
	Amount: _____
	Denied Reason : _____
_____ _____	_____
Signature of Provider Date	_____
Provider Name: _____	Additional Info. Specify: _____
Address: _____	_____
_____	Reviewed by:
_____	_____ _____
Contact Name: _____	Signature Date
Contact Phone Number: _____	

Incorporated by reference in 59G-5.020, F.A.C., January 2012 AHCA Med Serv Form 2000-0016

OUT-OF-STATE REQUEST CHECKLIST

- Completed Out-of-State Prior-Authorization Request Form, 2000-0016 filled out by the recipient's Florida Medicaid enrolled primary care or specialist physician;
- Letter from the requesting physician certifying that the requested service is not available in the state of Florida;
- Contact information for the requesting primary care or specialist physician;
- Documentation that justifies the need for the service, such as medical history, lab reports, etc.;
- A referral from a specialty hospital or subspecialist in the area specific to the recipient's diagnosis certifying the requested service is not available in Florida;
- The Current Procedural Terminology (CPT) codes for the procedure(s) being requested;
- Name and address of the out-of-state provider;
- Name and telephone number of the out-of-state provider's contact person.

Note: See the Provider General Handbook for additional requirements when requesting behavioral health and home health services.

AHCA Med Serv Form 2000-0016