MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Bulletin

Program and Policy Information

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NECS for UB-92 Now Available

EDS NECS software for UB-92 billers is now available and ready for shipping. The NECS software allows the submission of both inpatient and outpatient hospital claims electronically using a personal computer and a modem. Electronically submitted claims normally adjudicate in less than ten days, with a higher pay rate and fewer pended claims than paper claims.

Any provider interested in submitting claims electronically must complete an EDI Submitter Agreement which can be obtained by contacting EDS at 1-800-884-3222 or 601-960-2901. Upon approval, EDI Services will issue a submitter ID number and password so that the provider can submit claims electronically. EDI Services will mail the new NECS software to the provider free of charge. EDS offers technical assistance for installing and operating the NECS program upon request. An approved agreement must be on file before the provider can transmit data.

Anyone interested in filing claims electronically must first complete an EDI Submitter Agreement.

Interested providers must meet the minimum system hardware requirements listed on page 2 in order to successfully install and run the NECS program. Please note that this software is designed to be installed on an individual personal computer and not on a file server or network.

(article continued on page 2)

EDS

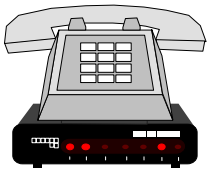
Inside This Issue

NECS for UB-92 Now Available (Continued)

NECS software is now available free of charge for UB-92 billers.

The minimum system hardware requirements for NECS are:

- A personal computer with a 386 or higher central processing unit (CPU)
- 4 or more megabytes of random access memory (RAM)
- 8 or more megabytes of available hard disk space
- Color VGA monitor
- Hayes compatible modem
- Data quality phone line
- MS DOS 5.0 or higher
- 3.5" or 5.25" Double Density or High Density floppy drive.



EDI Services, EDS
1-800-884-3222 or 601-960-2901

Nursing Home Reporting Requirement for SSI Recipients

On October 26, 1994, Congress passed Public Law 103-287 which requires nursing home administrators to report admission of a patient with Supplemental Security Income (SSI) to the Social Security Administration (SSA). Effective October 1, 1995, Title XIX nursing facilities must report to the local Social Security District Office within two weeks of admission when an SSI recipient enters a nursing home. The following SSI recipient identifying information is to be reported to SSA:

Recipient's Name
Recipient's Social Security Number
Date of Entry to the Nursing Facility
Address of Nursing Facility

Public Law 103-287 is the result of a 1990 recommendation from the Office of the Inspector General. Because nursing home admissions are not always reported promptly to SSA, some SSI recipients receive more benefits than they are entitled to in the months following their admission. When an SSI recipient enters a nursing home for an extended period and payment for the recipient's care is being provided by Medicaid, the amount of the recipient's SSI cash benefit is reduced to no more than $30 per month. SSA will use the information provided by the nursing facilities to update its residence address records and to take action to prevent SSI overpayments.

Division of Medicaid
1-800-421-2408 or 601-359-6050

Perinatal High Risk Management/Infant Services

The Perinatal High Risk Management/Infant Services System (PHRM/ISS) program is a multidisciplinary enhanced services case management program for certain Medicaid-eligible pregnant/postpartum women and infants. Services for this target population include risk assessment, case management, psychological and nutritional assessments, home visits and health education. All physician providers are encouraged to complete a Risk Screening Examination on this target population, to refer patients with a positive risk screen to an appropriate PHRM case management provider and to submit a claim for reimbursement. Both the maternal (W9350) and infant (W9353) risk screening examinations generate a fee-for-service reimbursement for private providers for both positive and negative screens.

For more information please call:
EPSDT Unit, DOM

PHRM Success Story

Since the inception of the Perinatal High Risk Management (PHRM) program in August 1988, Medicaid has enrolled 20 private providers and 47 county health department providers of PHRM services in our state. Recent reports show that birth outcomes for infants of women receiving PHRM have increased gestational ages and higher Apgar scores at one and five minutes.

For the name of a PHRM case management provider in your community, please call the EPSDT Unit at DOM.

EPSDT Unit, DOM
1-800-428-4201 or 601-359-6050

Recent reports show that birth outcomes for infants of women receiving PHRM have increased gestational ages and higher Apgar scores at one and five minutes.

PHRM and HealthMACS

The current HealthMACS Primary Care Provider Agreement states that the HealthMACS provider is to "provide and/or work to ensure that essential preventative services (e.g., EPSDT, immunizations and Perinatal High Risk [Case] Management) are obtained by enrollees as appropriate." It is the responsibility of the primary care physicians to provide PHRM services or be sure that women and their unborn children who qualify for PHRM receive the services from an appropriate provider, if one is available in the community.

If you have any questions concerning your responsibility for PHRM services to your HealthMACS recipients, please contact:

EPSDT Unit, DOM
1-800-421-4208 or 601-359-6050

Periapical Films

Effective October 1, 1995, periapical films will require a tooth number. The addition of a tooth number for codes D0220 and D0230 will allow DOM and EDS to distinguish between first and second films on a per tooth basis.

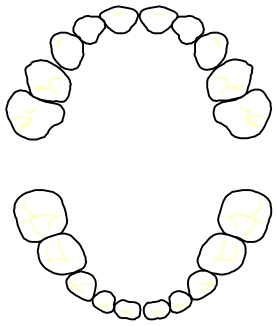
The effected HCPCS codes are defined as follows:

D0220 Intraoral - periapical - first film
D0230 Intraoral - periapical - each additional film

Effective October 1, 1995, D0220 "Intraoral - periapical - first film" will be interpreted as the first periapical film taken for a particular tooth.

Effective October 1, 1995, "first film" will be interpreted as the first film taken for a particular tooth. The term "each additional film" will apply only for any additional views taken of the same tooth. Therefore, if a dentist takes two distinct periapicals, then (s)he may bill D0220 with the corresponding tooth number for each radiograph and will be paid $6.35 for each film. Please note that total reimbursement for periapicals must not exceed $34.30, which is the Medicaid reimbursement for a full mouth series.

Medical Services, DOM
1-800-421-2408 or 601-987-3912



Unspecified Restorations

Effective October 1, 1995, procedure code D2499 will be closed. Providers must use specific procedure codes for four-surface resin restorations and sedative fillings. To make this transition easier, the definition of D2332 has been changed to cover three or more surfaces and a new code has been opened for sedative fillings. The 1995 HCPCS code for unspecified restorative procedures, D2999, may only be used when no specific code applies and, as a by report code, always requires the prior approval of DOM.

Therefore, providers must bill D2332 and indicate the appropriate surfaces for four-surface resins and D2940 for sedative fillings. Please note that sedative fillings will require the prior approval of DOM.

Medical Services, DOM
1-800-421-2408 or 987-3912

Periodontal Services

Due to the over-utilization of periodontal services, DOM will now limit the following covered periodontal procedures to once per quadrant per fiscal year:

D4210 Gingivectomy or gingivoplasty - per quadrant
D4220 Gingival curettage, surgical, per quadrant, by report
D4260 Osseous surgery (including flap and closure) - per quadrant
D4341 Periodontal scaling and root planing, per quadrant

Providers who think that a particular patient's condition requires more than one periodontal service per quadrant per fiscal year may submit a Dental Services Authorization Request along with an x-ray to the DOM Medical Services Unit. Each request for additional periodontal services will be reviewed by the DOM Dental Consultant. Please note that unless it is specifically indicated that the periodontal benefit has already been exhausted, an approved dental treatment plan will not override the once per fiscal year restriction.

Due to over-utilization of periodontal procedures, DOM has now established a one per quadrant per fiscal year limit on these services.

Periodontal services are only allowable for patients between the ages of 10 and 20, with the following exceptions:

⇒ Peridontal services are only allowed for children under age 10 with prior approval of DOM. NOTE: An x-ray demonstrating significant calculus must be submitted along with the the Dental Service Authorization Request.

⇒ Medicaid will cover procedure codes D4210 and D4260 for recipients age 21 and over who are on Dilantin therapy. Providers are required to write "patient receiving Dilantin therapy" across the face of the claim for periodontal services, then submit it to DOM Medical Services for special handling. Periodontal claims for recipients age 21 and over that are submitted directly to EDS will deny for edit code 438 (recipient is 21 or older).

Medical Services, DOM
1-800-421-2408 or 987-3912

Oral Examinations

The current DOM reimbursement for D0110 (initial oral exam for recipients under the age of 21) and D0130 (emergency oral exam) includes compensation for the actual oral exam and sterilization. Sterilization as a separate charge is not covered and must not be billed under the code D9999. It is important for providers to remember that since sterilization is included in the reimbursement for oral exams, the patient can not be held liable for any part of the exam or sterilization fee. Also, providers billing procedure code D0110 are responsible for charting the patient's dentition and should maintain adequate records to support this procedure.

Medical Services, DOM
1-800-421-4208 or 601-987-3912

Revised Criteria for Orthodontic Services

Orthodontic services are restricted to Medicaid-eligible recipients with specific pre-qualifying conditions. Each case will be reviewed by the Orthodontic Consultant for DOM and is subject to his/her approval. Providers must submit casts, x-rays and records along with a completed revised Orthodontic Services Authorization Request (Form MA-1099) to Medical Services at DOM for consideration.

The orthodontic provider is responsible for evaluating the attitude of the patient and/or guardian toward the orthodontic treatment and their ability and/or willingness to follow treatment instructions and meet appointments. This evaluation should precede the taking of any orthodontic records.

For all orthodontic services, the child must complete the course of treatment by their twenty-first birthday.

Medicaid will only consider orthodontic authorization requests for children who meet at least one of the following pre-qualifying conditions.

⇒ Patients with syndromes or craniofacial anomalies such as cleft palate, Down's syndrome, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy or other documented craniofacial anomalies.

⇒ Patients with a full cusp Class III malocclusion.

⇒ Patients with a full cusp Class II malocclusion, only where it can be demonstrated that the patient has an impinging overbite into the palate.

⇒ Patients with documented psychological or emotional problems, failure to thrive or TMJ pathology with medical corroboration and complete documentation. A specialist qualified to assess the patient's condition must write a letter detailing the exact status, diagnosis and previous attempts at therapy and/or remediation. A copy of this letter must accompany the orthodontic authorization request.

⇒ Patients with simple Phase I problems (anterior or posterior permanent tooth crossbites, etc.) in the mixed dentition phase. There will be a cap of $450 for this treatment. This fee will apply toward the child's lifetime orthodontic cap if they qualify for further orthodontic services at a later date.

If a patient does not meet the pre-qualifying criteria, providers are encouraged to counsel the patient and his/her family prior to submitting records to DOM. Please note that a patient with a pre-qualifying condition may not display sufficient need to have the orthodontic services funded by Medicaid. All cases will be reviewed by the Orthodontic Consultant for DOM. A provider who has a patient with one of the pre-qualifying conditions must submit adequate models and records for review along with a detailed course of treatment. It is incumbent on the provider to demonstrate the benefit to the patient relative to their specific pre-qualifying condition.

The following treatment modalities will not be covered:

⇒ Class I malocclusions regardless

⇒ Class II malocclusions without an impinging overbite

⇒ Any functional appliance therapy such as bionators, Frankles, Jasper jumpers, etc.

⇒ Congenitally missing, supernumerary or impacted teeth (unless it is concurrent with treatment qualified as outlined above)

Medical Services, DOM
1-800-421-2408 or 601-987-3912

Attention Laboratories and Radiologists

Effective immediately, laboratories and radiologists must have the referring provider's Medicaid identification number in field 17a of the HCFA-1500 billing form. If the referring provider is affiliated with a rural health clinic (RHC), then the RHC's group number must be used in field 17a. **Failure to comply may result in non-payment of claims**.

Verification of NET Services

DOM provides limited non-emergency transportation (NET) assistance to eligible Medicaid clients to receive services from Medicaid-enrolled providers. To control the cost of these services and the possibility of fraud and abuse experienced by other state Medicaid programs, DOM has instituted several procedures to ensure that NET services are provided only to transport eligible Medicaid clients to Medicaid-enrolled providers.

DHS will call Medicaid providers to verify that appointments are scheduled and NET drivers will verify that appointments are kept by clients receiving NET assistance.

The Department of Human Services (DHS) is responsible for making Medicaid NET arrangements for Medicaid clients which includes verifying that the Medicaid client who requested NET assistance has an appointment with a Medicaid-enrolled provider and that the client kept the appointment. In order to verify that the client has an appointment, the DHS NET Coordinator assisting the client will call the medical provider to verify that an appointment has been scheduled. When the client is transported to the medical provider, the transportation provider will ask the medical provider to sign a service verification form indicating that the appointment was kept by the client. These verifications are required to ensure that clients who receive NET assistance were transported only to Medicaid-enrolled providers.

Also, to further contain the costs of NET services, written medical certification is required in some instances, such as when a client wishes to travel out of his/her community for medical care when a suitable provider is located within the client's community or when the client, such as an individual on dialysis, requires on-going NET assistance. In these instances, the DHS NET Coordinator will ask for a written medical certification from the attending or referring medical provider which includes the client's name, age, and Medicaid identification number, a summary of condition including prognosis, an explanation of medical necessity, the mode of travel required (for example, does the client require a vehicle with a lift), assistance which the client may require during transport, and the date(s) of travel. For clients who require repetitive treatment, the medical certification should include the number of times a week the client will be required to travel and the number of weeks such travel will be necessary.

Questions may be directed to:

NET Services Coordinator, DOM
1-800-421-4208 or 601-987-3905

Checkwrite Schedule

September 04, 1995	October 02, 1995
September 11, 1995	October 09, 1995
September 18, 1995	October 16, 1995
September 25, 1995	October 23, 1995
	October 30, 1995

Checkwrites and Remittance Advices are dated every Monday. However, funds are not transferred until the following Thursday and Remittance Advices usually arrive the following Friday.

ESC Cut-Off Schedule

September 07, 1995	October 05, 1995
September 14, 1995	October 12, 1995
September 21, 1995	October 19, 1995
September 28, 1995	October 26, 1995

The deadline for transmissions to be included in the current week's claim processing cycle is 5:00 p.m., but transmissions can be accepted 24 hours a day, 7 days a week.

Mississippi Medicaid Bulletin

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Jackson, MS 39201-2121

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