MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Bulletin

Program and Policy Information

Volume 2, Issue 4 October 1995

HealthMACS Changes

HealthMACS is changing and growing. Please make note of the following changes effective October 1, 1995.

Effective October 1, 1995, the Division of Medicaid (DOM) is implementing the changes described below to the HealthMACS primary care managed care program.

Hospital Admitting Privileges

Physicians who wish to participate in the HealthMACS program as a primary care provider (PCP) will no longer be required to have hospital admitting privileges. Physician PCPs will be required to have a written agreement with a physician who has hospital admitting privileges. PCPs with such a written agreement must provide the DOM with a copy of the agreement for provider file.

After-Hours Telephone Calls

The PCP is responsible for arranging for 24-hour, seven (7) days per week access by telephone for HealthMACS recipients who have emergency medical needs after office hours.

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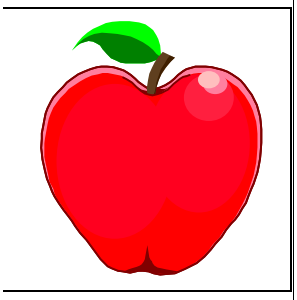
HealthMACS Changes
(Continued)

The telephone access for after-hours coverage can include:

(1) A "live voice", which can be an employee of the PCP, or coverage by an answering service. The "live voice" will need to know how to immediately contact the PCP or the medical professional on call for the PCP.

(2) An answering machine or other electronic device which directs the recipient to the telephone number of the after hours medical personnel.

(3) An answering machine or other electronic device which will immediately page an on-call medical professional.



Referral/Authorization Process

When making a referral, the PCP contacts the referred physician/provider and provides his/her Medicaid provider ID number to the referred provider. When the provider receiving the referral files a claim, (s)he must enter the PCP's Medicaid provider ID number as the referring provider in field 17A and in field 19 of the HCFA-1500 claim form and in field 11 of the UB-92 claim form.

If the referred provider needs to refer the HealthMACS recipient for laboratory, radiology or other services, his/her provider number is used as the referring physician in field 17A on the HCFA-1500 **BUT** the provider number of the PCP is used in the fields listed above when filing claims.

It is important that the referred provider share written information with the PCP about the treatment plans, referrals and other essential health information. This keeps the PCP informed about what is happening with the patient for whom (s)he is the primary care case manager.

DOM and EDS are finalizing reports which will be sent to PCPs. The reports will provide the PCP and DOM managed care staff information regarding services provided to recipients by the PCP and services provided by providers other than the PCP.

If additional information is needed regarding these changes to the HealthMACS program, please contact DOM Managed Care staff.

Managed Care Division, DOM
1-800-421-2408 or 601-359-6050

Change in POS Eligibility Response Information

Effective October 2, 1995, point of service (POS) eligibility verification transaction responses for managed care recipients will no longer display provider ID numbers in the lock-in and managed care information sections. The provider identification number will be crossed out and appear as a series of "Xs." This will not affect eligibility verification or managed care status. Providers should contact the Managed Care Hotline at 1-800-627-8488 if they have any questions or concerns.

Claims Submission Limitation

A recent review of old claims (over one year old) sent to the DOM with requests for payment indicates that providers are not filing timely and/or not following up timely. The workload for DOM and the expense to the agency for refiling these claims is costly to the program.

The policy of DOM regarding timely filing of claims is as follows:

> **Claims MUST be filed within <u>one year</u> from the date of service. The <u>only</u> exception to this policy is for retroactive eligibility. Providers will be allowed one year from the date of the retroactive letter to the recipient to file a claim. A copy of the retroactive letter must be attached to the claim upon submission.**

Claims will no longer continue to be processed after the one-year timely filing limit. **If the claim is not filed within a year of the date of service, the claim will be denied.**

Questions regarding timely filing of claims may be directed to the EDS Communications Unit at 601-960-2800 or 1-800-884-3222.

Claims will no longer continue to be processed after the one-year timely filing limit. If the claim is not filed within a year of the date of service, the claim will be denied.

Additional Coverage of Maternity Anesthesia Services

Effective July 1, 1995, for maternity cases in which a surgeon inserts the epidural and later the services of an anesthesiologist or CRNA are required because the patient has a Cesarean section and/or tubal ligation, DOM will reimburse for the services of the anesthesiologist **OR** CRNA. DOM will not reimburse an anesthesiologist for the supervision of a CRNA in these instances. DOM will also reimburse the surgeon for insertion of the epidural and monitoring until the time of the Cesarean section and/or tubal ligation.

In filing claims for reimbursement, the anesthesiologist or CRNA must bill the same as (s)he does for any other maternity anesthesia service (refer to the Maternity Anesthesia Reimbursement Table on page 5 of this bulletin). The Medicaid reimbursement rate will be the same as that outlined for the anesthesiologist billing under Modifier AA.

Medical Services, DOM
1-800-421-4206 or 601-987-3912

Mental Health Diagnosis Coding

The Medicaid Management Information System (MMIS) will not recognize a DSM code unless it is also an ICD-9 code.

Although the mental health diagnosis coding standard has recently changed from the Diagnostic and Statistical Manual of Mental Illness, Third Edition, Revised (DSM-III-R) to the Fourth Edition (DSM-IV), all Medicaid mental health claims must be submitted with the appropriate ICD-9-CM diagnosis code. The new DSM-IV codes are identical to the ICD-9 code in most cases, but for those exceptions where the codes do not match exactly, the ICD-9 code must be used. The Medicaid Management Information System (MMIS) will not recognize a DSM code unless it is also an ICD-9 code.

Community mental health centers can refer to a recent memo produced by the Department of Mental Health (dated August 23, 1995) for conversion tables from DSM-III-R codes to DSM-IV codes and their ICD-9 equivalent. Please note that this memo specifically states that the ICD-9 “remains the standard used by most reimbursement sources.” The conversion from DSM-III-R codes to DSM-IV codes does not affect your Medicaid billing. If you have questions regarding the memo, please call Mr. Larry Swearengen at 601-359-1288.

Private mental health providers are encouraged to obtain or seek access to an ICD-9 coding manual if one is not already being used for billing Medicaid. Appendix E of all Medicaid provider manuals lists sources for obtaining an ICD-9 manual.

Lew Smith, DOM
1-800-421-4208 or 601-359-6050

Maternity Anesthesia Reimbursement Table

Procedure Description	Effective Dates	Modifier AA Anesthesiology	Modifier 23 90% of AA CRNA	Modifier 47 Surgeons Delivering Physicians
62279	10/01/92	$ 175.00	$ 157.50	$ 85.00
Epidural for	02/01/93	180.00	162.39	87.64
Vaginal Delivery	01/01/94	240.51	216.47	116.82
62276	10/01/92	$ 75.00	$ 67.50	$ 35.00
Saddleblock for	02/01/93	77.33	69.60	36.09
Vaginal Delivery	01/01/94	103.08	92.78	48.11
59515	10/01/92	$ 225.00	$ 202.50	$ 115.00
59514	02/01/93	231.98	208.78	118.57
Anesthesia for C-Section	01/01/94	309.23	278.30	158.05
58600	10/01/92	$ 200.00	$ 180.00	$ 100.00
Anesthesia for Tubal Ligation (**At same time as delivery**)	02/01/93	206.20	185.58	103.10
56301, 56302	02/01/93	$ 206.20	$ 185.58	$ 103.10
58611, 58615	01/01/94	274.86	247.38	137.43

NOTE: Use type of service "B" for all procedures in order to bypass PRO. No time units should be used with these procedure codes.

Exceptions to the table:

Procedure	**Anesthesiologist**	**CRNA**	**TOS**
General Anesthesia for Vaginal Delivery 59409 59410	Use time units	Use time units	7
Anesthesia for Tubal Ligation (at separate setting) 58605-98	Use time units	Use time units	B

This is the Maternity Anesthesia Reimbursement Table that was referenced in the article on page 4.

Dental Update

Effective November 1, 1995, providers who bill for extractions may not bill for surgical removal of residual tooth roots (cutting procedure) on same date of service.

Effective November 1, 1995, providers who bill for extractions may not bill for surgical removal of residual tooth roots (cutting procedure) on same date of service. The code D7250 is intended to cover the surgical removal of residual roots when a tooth has been broken off by natural means or when the recipient seeks follow-up care from a practitioner other than the dentist or oral surgeon who performed the extraction.

The reimbursement for extractions is considered to be global. It covers the actual extraction, local anesthesia and routine post operative care. Sutures are considered to be routine post operative care and may not be billed separately. DOM only covers sutures for repair of recent small wounds - up to five cm (D7910) or more complicated suturing of lacerations (D7911 and D7912). Neither D7910, D7911 nor D7912 should be billed for sutures placed after an extraction.

In the case of a surgical extraction, DOM does not cover the cost of alveoplasty. However, alveoplasty in conjunction with the simple extraction of a permanent tooth is an allowed cost. Please note that when multiple teeth are extracted from the same quadrant, if any of the extractions within that quadrant are surgical, then the alveoplasty can not be billed by the quadrant. In this instance the provider must bill for the alveoplasty by individual tooth number for each simple extraction.

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

Completion of Sterilization Consent Forms at SDH Clinics

On an increasing frequency, the fiscal agent is receiving multiple sterilization consent forms with conflicting information for patients whose pregnancies and plans for subsequent sterilization are handled through the State Department of Health (SDH) clinics.

SDH clinics should initiate completion of the Sterilization Consent Form early enough to allow for the 30-day waiting period. (Please remember that the completed form is only valid for 180 days.) Upon completion by the SDH clinic, the signed form must be forwarded to the delivering physician. The delivering physician must sign and date the physician's statement on the Sterilization Consent Form on the day of the sterilization procedure or some date after the date of the procedure. If a physician signs and dates the consent form prior to the performance of the sterilization procedure, the form is invalid, and the claim will not be paid.

SDH Clinics are encouraged to coordinate completion of these forms with the delivering physician/surgeon in an effort to eliminate submission of multiple forms.

Medical Services, DOM
1-800-428-4201 or 601-359-6050

Periodontal Services Update

There has been a change to the policy for **periodontal services** highlighted in last month's Medicaid bulletin. The age restriction for gingivectomy or gingivoplasty — per quadrant (D4210) and osseous surgery (including flap entry and closure) — per quadrant (D4260) has been changed back to allow for services for children under the age of 10 without the prior approval of DOM and for patients 21 and older when on Dilantin therapy.

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

Requests For Additional Bulletins

As fiscal agent for the Medicaid program, EDS is responsible for disseminating information regarding policy changes and mandates to the provider community. For this reason, a copy of the monthly Medicaid Bulletin must be sent to every active provider. If you are receiving multiple copies because there are several providers who use your mailing address, please forward the bulletin to the addressee. The bulletin contains policy and program information that is pertinent to all active providers.

If you are receiving multiple copies because there are several providers who use your mailing address, please forward the bulletin to the addressee.

EDS maintains a separate mailing list for additional copies requested by both active providers and other interested parties. Additional Medicaid Bulletins and back issues may be requested by phone, mail or fax. Please be sure to include the following information:

First Name: _____ Last Name: _____

Title: _____

Company: _____

Address: _____

City: _____ State: ____ Zip: _____-_____

By completing this information, you are requesting that your name be added to our mailing list for monthly bulletins. Please note that this mailing list is not used for distribution of any other material.

One mailing label will be generated for each request, unless otherwise specified.

Publications Coordinator, EDS
111 East Capitol, Suite 400
Jackson, MS 39201-2121
Phone: 601-960-2805 or Fax: 601-960-2807

Checkwrite Schedule

October 02, 1995	November 06, 1995
October 09, 1995	November 13, 1995
October 16, 1995	November 20, 1995
October 23, 1995	November 27, 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

October 05, 1995	November 02, 1995
October 12, 1995	November 09, 1995
October 19, 1995	November 16, 1995
October 26, 1995	November 23, 1995
	November 30, 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.

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