Mississippi Medicaid Bulletin

Program and Policy Information

Volume 2, Issue 5 November 1995

A N N I V E R S A R Y I S S U E

Important Changes for Durable Medical Equipment Suppliers

The Division of Medicaid (DOM) will be implementing new changes in policy and procedure in the durable medical equipment (DME) program for children. These changes will affect reimbursement for all orthotic and prosthetic devices and additions for children.

Effective January 1, 1996, all DME suppliers will be reimbursed in accordance with the "L codes" in the 1995 HCPCS Manual. This means that DME providers will be reimbursed at a percentage of the Medicare maximum allowable for the State of Mississippi.

Beginning January 1, 1996, all DME suppliers will be required to submit the appropriate L codes on each Plan of Care/DME submitted to DOM. Additionally all claims with dates of services January 1, 1996 and after must be submitted with the appropriate L codes in order to receive payment.

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Important Changes for Durable Medical Equipment Suppliers (Continued)

If you have any questions or would like additional information, please contact EDS at 960-2800 or 1-800-884-3222, or contact Medicaid DME staff at 359-6050 or 1-800-421-2408. Watch for further information in the December issue of the Mississippi Medicaid Bulletin.

Providers should use the Plan of Care Addendum Form instead of completing a new Plan of Care for previously approved services and goods.

New Antepartum Codes for 1996

The current antepartum code, 59420, will be closed on December 31, 1995. Starting January 1, 1996, DOM will require the following codes to be used for all antepartum care:

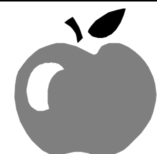
W6130 - antepartum care in the first trimester
W6140 - antepartum care in the second trimester
W6150 - antepartum care in the third trimester

These codes will not decrease a recipient's office visit limits.

If you have any questions, please call the EPSDT Unit of DOM at 1-800-421-2408 or EDS at 1-800-884-3222.

Did you know that HealthMACS is currently in 12 counties? These counties are: Claiborne, Copiah, Covington, Harrison, Jefferson, Jefferson Davis, Lawrence, Lincoln, Simpson, Sunflower, Washington and Warren.

HealthMACS Billing Tips



Effective 10/1/95, the 11-digit HealthMACS authorization number (HAN) was shortened to the primary care provider's (PCP's) Medicaid provider number. The 7-digit PCP Medicaid provider number replaces the 11-digit HAN in field 19 of the HCFA-1500 and box 11 of the UB-92. The 7-digit PCP Medicaid provider number is considered the authorization number for treating and billing for Medicaid HealthMACS clients. The authorization number is not required when billing for HealthMACS clients that are on the PCP's HealthMACS caseload as of the date of service.

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 one year from the date of service. The only 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.

Provider Visit Requests

Provider representatives are available to help you with any billing problems you may have. To request a provider representative to visit your office, please call 1-800-884-3222 and speak with an EDS representative. A provider representative will call you within two working days to schedule an appointment.

To ensure that you receive quality service, a Provider Visit Survey will be left at your office each time a provider representative visits your facility.

HealthMACS NECS Update

HealthMACS providers who submit their claims electronically using NECS should add four (4) zeros to the end of the seven (7) digit Medicaid provider number which is now used as the HealthMACS authorization number. Claims submitted using NECS without the additional zeros will deny. **This only affects providers submitting electronically using NECS software provided by EDS.**

ESC Update

Since June, nursing facilities have been able to submit their claims electronically.

If you submit HCFA-1500, Dental, Pharmacy or UB-92 claims or you bill on a nursing facility roster, you can submit Medicaid claims electronically by using a PC and a modem. Submitting claims electronically has many benefits. Among them are reduced postage cost, faster claim adjudication, and fewer pended claims. Most claims submitted electronically adjudicate in less than ten days. Of the 1,143,855 claims submitted electronically during September, 86 percent paid and only 4 percent pended.

In September, UB-92 billers who chose to use NECS began billing with their new software. The software allows providers to bill both inpatient and outpatient hospital claims.

Currently, you may choose to use a billing agency/clearing house to submit claims for you, have a software vendor write software to suit your needs, or obtain the NECS program free of charge from EDS. In addition to the Nursing Facility and UB-92 software, NECS will also allow you to key your HCFA-1500, Pharmacy and Dental claims for electronic submission. To use the NECS program, your hardware must meet the requirements listed below. It is strongly recommended that NECS be used on a stand-alone PC and not on a file server/network (LAN) or under Windows.

EDI representatives are available to help you.

The minimum system hardware requirements or 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

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. An approved agreement must be on file before the provider can transmit data. 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 NECS software, if requested, to the provider free of charge. EDS offers technical assistance for installing and operating the NECS software upon request.

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

Prospective Drug Utilization Review

Prospective Drug Utilization Review will be added to Point of Service (POS) during the month of November. This enhancement to POS will be phased in with one edit at a time throughout the month of November. The first edit to be activated will be Drug to Drug interaction. The following are the error codes and corresponding conflict codes for the new edits:

Error	Conflict Code
345	DD - Drug to Drug Interaction: This code detects drug combinations in which the net pharmacological response may be different from the result expected when each drug is given separately.
346	TD - Therapeutic Duplication: This code detects simultaneous use of different primary generic chemical entities that have the same therapeutic effect.
347	ID - Ingredient Duplication: Detects simultaneous use of drug products containing one or more identical generic chemical entities.
350	ER - Early Refill/Overuse: Detects prescription refills that occur before the days supply of the previous filling should have exhausted.

The following outcome codes can be used to override an alert message when appropriate:

1A	Fill as is, false positive
1B	Fill prescription as is
1C	Fill with different dose
1D	Filled with different directions
1E	Filled with different drug
1F	Filled with different quantity
1G	Filled with different prescriber approval

Watch for additional information in upcoming bulletins regarding prospective drug utilization review.

For more information please call EDS at 960-2800 or 1-800-884-3222.

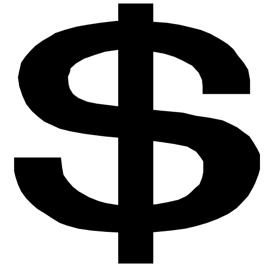
Before rendering services to Medicaid recipients, always verify eligibility.

For additional bulletins, please call 601-960-2805 or write to :

EDS Publications
111 East Capitol
Suite 400
Jackson, MS 39201

Checkwrite Schedule

November 06, 1995	December 04, 1995
November 13, 1995	December 11, 1995
November 20, 1995	December 18, 1995
November 27, 1995	December 25, 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

November 02, 1995	December 07, 1995
November 09, 1995	December 14, 1995
November 16, 1995	December 21, 1995
November 23, 1995	December 28, 1995
November 30, 1995	

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

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