MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Bulletin

Program and Policy Information

Volume 2, Issue 6 December 1995

The Division of Medicaid and EDS will be closed December 25 and 26 1995, and January 1, 1996 for the holidays. However, the 24-hour Point of Service (POS) System will remain operational during these breaks.

DOM and EDS hope that you have a safe and happy holiday season.

EDS

Durable Medical Equipment (DME) Suppliers of Prosthetic and Orthotic Devices and Additions for Children

On October 18, 1995, a meeting was held by the Division of Medicaid (DOM) with the above-mentioned DME suppliers in which reimbursement methodology was discussed. Effective January 1, 1996, Medicaid reimbursement for prosthetic and orthotic devices for children will be 80 percent of the allowable set by Medicare. **Please note this only applies to DME suppliers of prosthetic and orthotic devices and additions for children.**

Beginning January 1, 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 (continued on page 2)

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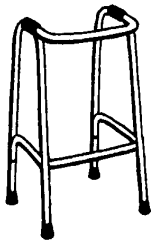

Durable Medical Equipment (DME) Suppliers of Prosthetic and Orthotic Devices and Additions for Children

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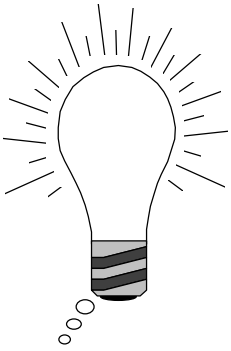
dates of services January 1, 1996, and after must be completed with the appropriate L codes in order to receive payment.

If you have any questions or would like additional information, please contact EDS at 601-960-2800 or 1-800-884-3222, Medicaid DME staff at 601-359-6050 or 1-800-421-2408.

Signed Receipts Needed for DME Providers

Effective January 1, 1996, all DME providers for children will need to send in a receipt/ invoice/delivery slip signed by the Medicaid recipient to the EPSDT Unit verifying delivery of the item. Please call the EPSDT Unit, Division of Medicaid, 1-800-421-2408 or 601-359-6150 with any questions. The address is 239 North Lamar Street, Suite 404, Jackson, MS, 39201.



Reminder to Physicians

Durable medical equipment (DME) and supplies for children requested on a Plan of Care form should be signed and submitted promptly to the Medicaid EPSDT Unit. Delays can result in ill-fitting equipment/devices or can mean the patient's condition has changed during the delay. The patient then does not get the maximum use or benefit from the prescription. If the physician has a concern about the Plan of Care on any patient, he or she can write that on the Plan of Care, or call the EPSDT Unit of the Division of Medicaid at 1-800-421-2408 or direct at 601-359-6150.

New Antepartum Codes for 1996

The current antepartum code, 59420, will be closed on December 31, 1995. Starting January 1, 1996, the 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.

Billing personnel should be aware of this change. If you have any questions, please call the EDS Correspondence Unit at 601-960-2800 or 1-800-884-3222, or the EPSDT

Provider Enrollment at EDS

To better assist providers, EDS has three enrollment specialists who each have been assigned specific sections of the alphabet by the provider's last name. Please refer to the following list when calling or sending correspondence to the Provider Enrollment Unit at EDS:

First letter of provider's last name	Direct Dial Phone
A - G	601 960-2897
H - O	601-960-2896
P - Z	601-960-2813

Address all Provider Enrollment correspondence to:

EDS Provider Enrollment
111 E. Capitol Street, Suite 400
Jackson, MS 39201-2121

If you have any questions, please call the Provider Enrollment Unit at 601-960-2800 or 1-800-884-3222.

Please refer to the phone list for the Provider Enrollment Unit in order to expedite your calls and correspondence.

HealthMACS Billing Tips

Effective October 1, 1995, 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.

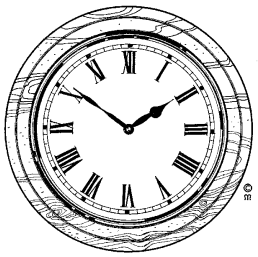
If you have questions concerning HealthMACS, please call 1-800-627-8488.

Automated Response System (ARS) Menu

When calling the EDS toll free 1-800 number, you may expedite your call by taking advantage of the following options. You can make your choice at any time during the message. Just press 1,2,3,4 or 0 to access information!

"1": Eligibility, Check Amount, Drug Coverage and or Managed Care Information
"2": Drug Prior Authorization
"3": Recipients
"4": Point of Service Help Desk
"0": EDS Representative

The ARS can save you time.



IMPORTANT LONG TERM CARE FACILITY POLICY UPDATES

Long Term Care Facilities Policy Updates

The following are policy updates for nursing facilities, ICF-MRs and psychiatric residential treatment facilities. If you should have any questions, please contact the party listed at the end of each section.

I. Long-Term Care Facilities' Hair Hygiene Supplies and Services

A facility's hair hygiene policy must include the provision of combs, brushes, shampoos, trims and simple hair cuts by the facility at no charge to the residents. Hair hygiene services include trims and simple hair cuts provided by facility staff as part of routine grooming care. Trims and simple hair cuts include all haircuts that maintain or enhance each resident's dignity and respect in full recognition of his or her individuality.

Included in allowable costs for Medicaid purposes are all hair hygiene supplies and services not charged to the resident. A facility may charge only for hair hygiene supplies and services requested in addition to or in place of those normally supplied or offered by the facility. Haircuts, permanent waves, hair coloring, and relaxing performed by barbers and beauticians not employed by a facility may be charged to a resident requesting these services. However, if the facility's policy is to use licensed barbers and/or beauticians for trims and simple hair cuts, then residents may not be charged for these services. The resident must be informed of the charge for the supplies and services in advance and an authorization form must be signed by the responsible partyand/or resident.

Each facility must maintain written hair hygiene policies that describe what supplies and services are included in the per diem rate.

Hair hygiene supplies, such as combs, brushes and shampoo, are allowable costs on Line 3-21, Supplies-Care Related, of the cost report. Allowable barber and beauty services should be reported on line 3-12 of the Care-Related category of the cost report.

Questions may be directed to Margaret King, Reimbursement Division, Division of Medicaid, 601-359-6155.

II. Medical Waste is Direct Care

The cost of medical waste for long-term care facilities is allowable in the Direct Care cost category of the cost report. Formerly, the cost of medical waste was allowable under the Administrative and Operating category. A separate line number has been created for reporting these costs under direct care expenses.

Questions may be directed to Margaret King, Reimbursement Division, Division of Medicaid, 601-359-6155.

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III. Resident Fund Account Authorization

Every Medicaid-participating long-term care facility is required to maintain resident's personal funds in a resident fund account if requested by the resident. Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility. The facility must have authorizations for withdrawals of funds from each resident's account. A written authorization form must be kept on file for the following disbursements:

A. Items and services charged by the facility and requested by a resident, such as telephone, television, private room, and privately hired nurses or aides, etc.
B. Beauty and barber charges
C. Pharmacy charges and pharmacy freedom of choice
D. Insurance premium payments (i.e., burial and health)
E. Authorization to pay outside bills. (i.e., utilities for an outside address.)

Questions should be directed to Margaret King, Reimbursement Division, Division of Medicaid, 601-359-6155.

IV. Revision to Reasonable Alternatives to a Surety Bond for Resident Fund Accounts.

The resident right to assurance of financial security is found at 42 CFR 483.10 (c) (7). The facility must purchase a surety bond or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. The surety bond is the commitment of the facility in an objective manner to meet the standard of conduct specified in 483.10 (c) (7), that the facility will hold, safeguard, manage and account for the funds residents have entrusted to the facility. The facility assumes the responsibility to compensate the obligee for the amount of the loss up to the entire amount of the surety bond.

The Health Care Financing Administration (HCFA) defines an article acceptable alternative to a surety bond in their guidance to surveyors as revised March 31, 1995. *Please note the alternatives reflect a change by HCFA from what was reported in our June, 1995 issue of the Mississippi Medicaid Bulletin*.

Reasonable alternatives to a surety bond must:

A. designate the obligee (the resident individually or in aggregate, or the State on behalf of each resident) who can collect in case of a loss;

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IMPORTANT LONG TERM CARE FACILITY POLICY UPDATES

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B. specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or ommission, to hold, safeguard, manage, and account for the resident's funds; and

C. be managed by a third party unrelated in any way to the facility or its management

The facility cannot be named as a beneficiary. Self-insurance is not an acceptable alternative to a surety bond. Likewise, funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entity, also are not acceptable alternatives.

If a corporation has a surety bond that covers all of its facilities, the corporation's surety bond must be sufficient to ensure that all of the residents in the corporation's facilities are covered against any losses due to acts or errors by the corporation or any of its facilities. The intent of focus is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.

Questions should be directed to the Mississippi State Department of Health, Division of Licensure and Certification, (601) 354-7300.

V. <u>Deposit of Resident Funds</u>

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account(s) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident(s)' funds to that account.

CPT CODES FOR VACCINE REIMBURSEMENT

Influenza and Pneumococcal Vaccine Reimbursement

The Mississippi Medicaid program will reimburse physicians for the influenza and pneumococcal vaccine for high risk patients. To file a claim for these injections, please refer to the following coding directions.

Influenza: Use HCPCS Code J6020 for dates of service through 10/31/95.
Use CPT Code 90724 for dates of service on and after 11/01/95.

Pneumococcal: Use HCPCS Code J6065 for dates of service through 10/31/95.
Use CPT Code 90732 for dates of service on and after 11/01/95.

If you have a patient who has Medicare/Medicaid coverage, you must file with Medicare first.

If you should have any questions, please call the EDS Correspondence Unit at 601-960-2800 or 1-800-884-3222.

DO YOU HAVE MEDICARE CROSSOVER PROBLEMS?

Notice to Providers about Medicare Crossovers

If you are having payment problems with Medicare crossover claims, please contact the EDS in-house representatives, Armin Thomas or Shonda Outlaw at 1-800-884-3222.

Upon calling, please be prepared to provide your Medicaid and Medicare provider numbers. Additionally, please provide group affiliation information, if applicable.

In order to make a change to your provider file, you must submit written documentation requesting the specific change you would like made.

For more information, please call Armin Thomas or Shonda Outlaw at 1-800-884-3222 or 601- 960-2800.

IMPORTANT TIMELY FILING INFORMATION

Claims Submission Limitation

A recent review of old claims (over one year old) sent to 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.**

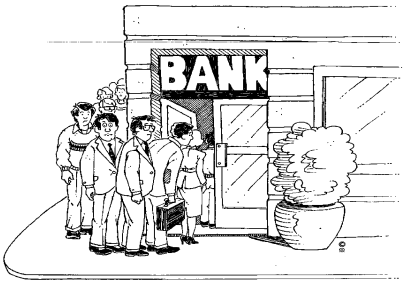
Claims will no longer continue to be processed after the one-year timely filing limit. **If the claim is not filed within a year of the date of service, the claim will be denied.**

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

If you would like to receive additional bulletins please call 1-800-884-3222 to speak with an EDS representative.

EDS Publications
111 East Capitol Street
Suite 400
Jackson, MS 39201
601-960-2805

Checkwrite Schedule

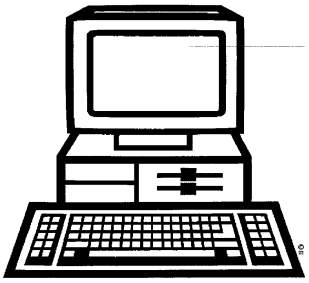


December 04, 1995
December 11, 1995
December 18, 1995
December 25, 1995*
January 01, 1996

*NOTE: Due to the December 25, holiday, Electronic Funds Transfer (EFT) will not be deposited into bank accounts until December 29, 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



December 07, 1995
December 14, 1995
December 21, 1995
December 28, 1995
January 04, 1996

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HAPPY HOLIDAYS