Mississippi Medicaid Bulletin

Program and Policy Information

Volume 2, Issue 10 April 1996

Retroactive Medicare Recovery Program to go into effect April 1, 1996

EDS

Retroactive Medicare Recovery

In response to 42 CFR 433.139.(d)(2) (**see page 3**), and in order to avoid federal sanctions, the Division of Medicaid is implementing the Retroactive Medicare Recovery program effective April 1, 1996.

By federal mandate, if the Medicaid agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party source after a claim is paid, the agency must seek recovery of reimbursement within a specified time period. This includes Medicare coverage when it is determined retroactively.

The methodology for retroactive Medicare recovery has been included in the Medicaid Provider Manual, Chapter 3.0, Section 3.02.8 (**see page 2**) since January 1992.

Normally, the Medicaid agency submits subrogated claims directly to the insurance company involved in order to recover Medicaid payments. However, Medicare will not accept a Medicaid subrogated claim. Medicare will only accept the claim from the provider.

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When Medicare eligibility for a Medicaid recipient is determined retroactively, the Medicaid claims payment system will identify the Medicare-eligible claims with dates of service back to the beginning date of Medicare.

Retroactive Medicare Recovery (Continued)

Therefore, when Medicare eligibility for a Medicaid recipient is determined retroactively, the Medicaid claims payment system will identify the Medicare-eligible claims with dates of service back to the beginning date of Medicare eligibility (not to exceed one year) that have been paid with straight Medicaid payment. On the next provider Remittance Advice, the associated claim payments will be voided. The following message will appear: "Recipient retroactively eligible for Medicare. Please re-bill Medicare." Also included on the Remittance Advice, in the Medical Record's Number field ("Med Rec No."), will be the appropriate recipient's HIC number to aid the provider in billing Medicare.

This ongoing process will occur once a month after the Medicaid claims payment system (MMIS) is updated with the new Medicare coverage. The Medicare updates are affected in the MMIS during the third week of each month. Therefore, the Medicare-eligible claims will be identified by the MMIS during the fourth week of March 1996 and will appear on the provider's Remittance Advice during the first week of April 1996.

The services that will be identified as covered by Medicare are Inpatient and Outpatient Hospital, Home Health, Inpatient and Outpatient Psych, Hospice, Lab/X-ray, Physician, Eyeglass (for recipients 21 and older), Rural Health Clinic, DME, and Ambulatory Surgical Center.

We are also in the process of investigating, and will be recovering the Medicaid payments made for recipients who were added to the Medicaid files prior to March 1996 with Medicare retroactive effective dates. We are attempting to determine how this federal requirement can be accomplished in the least burdensome manner for the provider.

The provider will initially have the straight Medicaid payments taken from his cash flow, but, in most instances, he/she will be reimbursed a much larger percentage of their charges when the Medicare/Medicaid payments are received.

* * * * *

The Mississippi Medicaid Provider Manual Chapter 3, Section 3.02.7 reads, "When a recipient is found to have Medicare coverage after straight Medicaid claims have been paid, the fiscal agent will automatically recoup the payments from the provider and print a message on the Remittance Advice that explains the action to the provider with instructions to bill Medicare. This process will be performed on a monthly basis."

(42 CFR 433.139(d)(2) on following page)

42 CFR 433.139(d)(2) reads, "If the agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, the agency must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party or benefits become available."

Mississippi Change in the Resident Assessment Instrument for SNFs and NFs

The State of Mississippi is changing its Resident Assessment Instrument (RAI) for Medicaid certified nursing facilities (NFs) and Medicare skilled nursing facilities (SNFs). Facilities will be required to convert to the MDS 2.0 effective July 1, 1996. Data specifications have been provided to all vendors that have been approved by the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification, Case Mix Project.

The MDS 2.0 that will be used by the State of Mississippi is the nationally approved instrument including Sections S, T and U. Section S contains state specific information including the resident state identification number, the RN assessment coordinator name, information on hospital and therapeutic home leave days and information on treatments given inside the facility. Sections T and U contain data that will be used by HCFA in the national case mix demonstration project.

MDS 2.0 forms will be available from EDS in June 1996.

Training will be conducted by the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification, Case Mix Project for Facilities on the MDS 2.0 in June 1996. Training will be in different geographic locations of the state and will be free to the facilities.

Questions regarding the conversion to the MDS 2.0 should be addressed to the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification, Case Mix Office at (601)354-7200.

Certified nursing facilities (NFs) and skilled nursing facilities (SNFs) will be required to convert to the MDS 2.0 effective July 1, 1996.

New 1996 ICD-9-CM Diagnosis and Surgical Procedure Codes

The new 1996 ICD-9-CM Diagnosis and Surgical Procedure Codes have been added to the Mississippi Medicaid system files and will be accepted effective April 1, 1996. The codes that have been deleted will no longer be accepted after March 31, 1996.

Billing Maternity-Related Services

Medicaid Billing for Maternity-Related Services

The following CPT codes will be closed and will not be reimbursed by the Mississippi Medicaid program effective April 8, 1996.

59410	These are delivery codes which include postpartum care.
59515	
59614	
59622	

Maternity-related services are to be billed as described below. This revision in billing allows the Medicaid program to track and report the various aspects of maternity care provided to Medicaid recipients.

Antepartum care is to be billed with the appropriate code from below.

W6130:	First Trimester Antepartum Care
W6140:	Second Trimester Antepartum Care
W6150:	Third Trimester Antepartum Care

Delivery is to be billed with the appropriate CPT code from below which is specific for delivery only:

59409	These codes **do** include the immediate postpartum care.
59514	
59612	
59620	

Follow-up postpartum care is to be billed with code 59430.

Psychosocial Rehabilitation Services

Effective January 1, 1996, claims filed with procedure codes **W3015**, **W3016**, and **W3038** that have more than 100 units or dates of service spanning more than 7 days **will deny** for EOB 509. These procedure codes **MUST** be billed as weekly services with dates of service spanning each week of treatment listed on a separate line on the claim form. In addition, the maximum allowed is 25 hours (100 units) per week with one unit equaling 15 minutes.

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39201

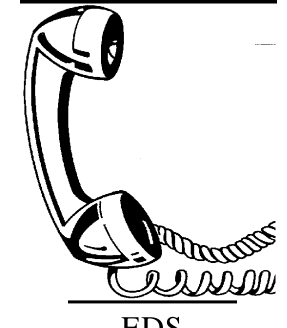
If you would like to receive additional bulletins, please call 1-800-884-3222 to speak with an EDS representative.

Additional Non-Covered Medicaid Procedures

As a result of the ongoing review of the Division of Medicaid's policies and their application and relevance to each CPT code, the following CPT codes will be closed and will not be reimbursed by the Mississippi Medicaid program.

Effective March 25, 1996	99082	
Effective April 8, 1996	90887	(The services represented by this code are considered inclusive in treatment and E & M codes.)

EDS Correspondence Unit
1-800-884-3222 or 601-960-2800



EDS
Correspondence
Unit
1-800-884-3222
or
601-960-2800

Quality Indicators Training

The Mississippi State Department of Health, Division of Health Facilities Licensure and Certification, Case Mix Project will conduct facility training on the Quality Indicators in April 1996. Training will be conducted at the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification office on each Tuesday of the month. Facilities must attend a training session in order to receive the Quality Indicator reports for their facility. Reports will then be sent to the facilities on a regular basis after the training.

If you have not signed up or need additional information, please call the Case Mix Office at (601) 354-7200.

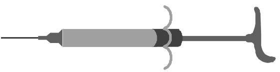
Hospital Reimbursement for Outpatient Radiology

Effective for dates of service on and after March 1, 1996, the Division of Medicaid will convert reimbursement for outpatient radiological services from the usual 75% of billed charges to a fee schedule allowance for the technical components.

Hospitals will be required to list the usual revenue code with the corresponding CPT codes in the 70000 through 79999 range. This is the same process currently used to bill for outpatient laboratory services.

Should there be any questions or if your billing department needs billing instructions, please contact the EDS Correspondence Unit at 601-960-2800 or 1-800-884-3222.

State Medicaid agencies are required by Section 1950(r)(1) of the Social Security Act to provide appropriate immunizations under the EPSDT program.



Important Changes in Childhood Immunization Schedule Effective April 4, 1996

The Department of Health and Human Services has advised of changes in the Recommended Childhood Immunization Schedule developed by the Advisory Committee on Immunization Practices (ACIP). State Medicaid agencies are required by Section 1950(r)(1) of the Social Security Act to provide appropriate immunizations under the EPSDT program according to the ACIP schedule.

The major changes, effective 4/4/96, in the new schedule and how they relate to the Vaccines for Children Program (VFC) are as follows:

- Varicella vaccination is recommended for all children 12-18 months of age. It is also recommended at 11-12 years of age for those children who have not previously received the vaccine and have no history of having had chicken pox. **Varicella vaccine is currently not provided through the VFC program**. However, it is anticipated to become available in the future.

- The three-dose series of hepatitis B vaccine should be initiated or completed for adolescents at 11-12 years of age who have not previously received three doses of hepatitis B vaccine. Hepatitis B vaccine for this age group, as well as for infants and those who are at high risk for the disease (as defined by the ACIP), are **available through the VFC program**.

If you or your staff have questions about the vaccines or the schedule, please call Letitia Thompson or Phylis Hoggatt with the State Department of Health Immunization Program at 1-800-634-9251.

Quick List of Automated Response System (ARS) Options

Dial 1-800-884-3222.
Don’t wait until the end of the message to make your choice.
Just press 1, 2, 3, 4 or 0 to access this information!

“1”: Eligibility, Check Amount, Drug Coverage and/or HealthMACS information
“2”: Drug Prior Authorizations
“3”: Recipients
“4”: Point of Service Information
“0”: EDS Representative

Electronic Processing of Medicare Crossover Claims

The information required to make electronic processing of Medicare crossover claims possible comes from several different sources in a variety of formats. EDS extracts the applicable information from the Medicaid provider file and provides it to the Medicare intermediaries in a tape format, thereby eliminating the need for paper claims. This format allows the Medicare intermediaries to provide EDS with claim payment dates and deductible/coinsurance amounts applicable to eligible Medicaid recipients.

Under the best of circumstances, information that is passed between the Medicare intermediaries and EDS may contain information that is missing or invalid due to unreported or unprocessed information resulting from any number of reasons. At the time the tapes are created, information considered to be invalid or missing results in the electronic records being impossible to identify. In this situation, it is necessary for a paper crossover claim to be submitted. Providers will need to submit a paper claim if Medicaid reimbursement has not occurred within 30 days of receipt of their Medicare EOMB.

Providers are encouraged to notify EDS of all changes in the information which is reflected on the provider file, i.e., change of address, Medicare provider number, bank account information. All changes must be in writing and should occur in a timely manner.

The Division of Medicaid and EDS have been working with the Medicare intermediaries to streamline differences in the format of information used to process crossover claims. A number of problems with Medicare crossover claims have been identified and corrected. There is an outstanding issue regarding Blue Cross Blue Shield of Tennessee, and resolution of this issue is anticipated within the next month.

Your patience regarding these problems is appreciated. If you have questions or experience additional problems regarding crossover claims, please contact the EDS Correspondence Unit at 1-800-884-3222 or 601-960-2800.

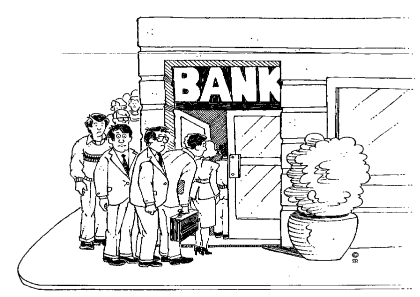
Providers will need to submit a paper crossover claim if Medicaid reimbursement has not occurred within 30 days of receipt of their Medicare EOMB.

Please notify EDS of all changes in the information reflected on the provider file.

Pharmacy Claims Must Contain Valid Numbers

The Prescribing Physician field on the pharmacy claims must contain valid Medicaid provider numbers. Alphabetic characters will no longer be accepted as of April 1, 1996.

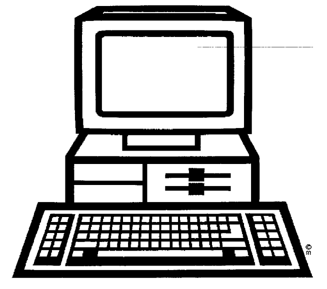
Checkwrite Schedule



April 01, 1996
April 08, 1996
April 15, 1996
April 22, 1996
April 29, 1996

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



April 04, 1996
April 11, 1996
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April 25, 1996

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