Mississippi Medicaid Bulletin

Program and Policy Information

Volume 2, Issue 11 May 1996

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

The EPSDT Unit within the Division of Medicaid would like to clarify the implementation of the new procedures using HCPCS "L" codes that began on January 1, 1996. When a provider uses an "Unlisted Procedure Code" on a DME Authorization Request, the provider will itemize whatever is proposed to be included under that code along with the usual and customary price. This applies to any "Unlisted Procedure Code" within the HCPCS "L" codes. When requesting L3649 (Unlisted Procedures for Foot Orthopedic Shoes), justification will be necessary. Justification includes, but is not limited to, body measurements, photographs, catalogue descriptions, as well as written descriptions.

If you have any questions regarding this information, please contact the EPSDT Unit at 601-359-6150 or 1-800-421-2408.

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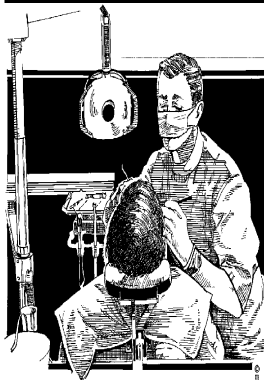
Additional Non-Covered Medicaid Procedures

As a result of the ongoing review of the Division of Medicaid's policies and their application and relevance to each CPT Code, procedure codes 96400, 96405, 96406, and 96423 will be closed and will not be reimbursed by the Mississippi Medicaid program effective May 13, 1996. These procedures are considered inclusive in other CPT and/or HCPCS codes.

Payment Under Locum Tenens/Reciprocal Billing Arrangements for Dentists

The following Medicaid policies relate to payment under a reciprocal or locum tenens billing arrangement.

Under the reciprocal billing arrangement, the patient's regular dentist may submit the claim and receive Medicaid benefits for covered services which the regular dentist arranges to be provided by a substitute dentist on an occasional reciprocal basis if:



In a "locum tenens" arrangement the regular dentist retains a substitute dentist to take over his/her practice during absence. The patient's regular dentist may submit a claim and receive Medicaid benefits for covered services of a locum tenens.

1. The regular dentist is unavailable to provide the services; **and**

2. The Medicaid patient has arranged or sought services from the regular dentist; **and**

3. The substitute dentist does not provide the service to the Medicaid patient over a continuous period of longer than 60 days.

In a "locum tenens" arrangement, the regular dentist retains a substitute dentist to take over his/her practice during an absence. The substitute dentist generally has no practice of his/her own and moves from area to area as needed. The regular dentist generally pays the substitute dentist a fixed amount per diem, with the substitute dentist having the status of an independent contractor rather than of an employee.

The patient's regular dentist may submit a claim and receive Medicaid benefits for covered services of a locum tenens dentist who is not an employee of the regular dentist and whose services for patients of the regular dentist are not restricted to the regular dentist's office, if:

1. The regular dentist is unavailable to provide services; **and**

2. The Medicaid recipient has arranged or sought to receive the services from the regular dentist; **and**

3. The regular dentist pays the locum tenens from his/her services on a per diem or similar fee-for-time basis; **and**

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(Continued from page 2)

4. The substitute dentist does not provide the services to the Medicaid patient over a continuous period of longer than 60 days.

When the regular dentist bills for services performed on a reciprocal or "locum tenens" arrangement, the following guidelines apply:

1. For the reciprocal and "locum tenens" billing, the substitute dentist must write in the recipient's chart, or provide a letter to the regular dentist that can be placed in the chart, that due to the regular dentist's absence, he/she performed the following procedures on this date. This must be signed by the substitute dentist.

   By placing this information in the chart, the regular dentist is certifying that the services performed are covered services furnished by the substitute dentist. These services must be available for inspection and are services for which the regular dentist is entitled to submit.

2. For both the reciprocal and "locum tenens" arrangement, the regular dentist must indicate the name and Medicaid provider number or license number of the substitute dentist on the face of the dental claim form.

The identification of the substitute dentist is for purposes of providing an audit trail to verify that the services were furnished.

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Automated, Multichannel Laboratory Test

For CPT code 80019, the Mississippi Medicaid program will retain the 1995 CPT definition of: 19 or more clinical chemistry tests. This becomes effective May 6, 1996.

Clinical chemistry tests are frequently performed as groups and combinations. When one or more of the automated, multichannel clinical chemistry tests are performed on the same day, the appropriate automated, multichannel test procedure code (80002-80019) must be used.

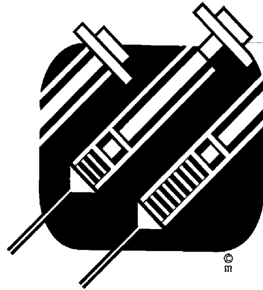
Each test in the automated profile must be related to specific complaints, symptoms, diseases, or injuries. The documentation in the medical records must support the medical necessity for each test and must include the test results. If the documentation does not support the medical necessity, a refund of payments will be requested.

Automated, multichannel clinical laboratory tests are not covered by the Mississippi Medicaid program when performed for routine screening purposes.

Documentation in the medical records must support the medical necessity for each automated, multichannel laboratory test, and must include the test results.

Billing Codes for Allergists

ALLERGY TESTING
Allergy testing is a covered service under the Mississippi Medicaid program. CPT codes 95004 - 95052 are to be used when billing for allergy testing procedures. The number of tests performed must be specified in the "units" field of the claim.



When billing the antigen/antigen preparation codes, the number of doses per vial must be specified in the "units" field of the claim.

ALLERGEN IMMUNOTHERAPY
Allergen immunotherapy is a covered service under the Mississippi Medicaid program. CPT codes 95144 - 95170 are to be used when billing the professional service for the supervision and provision of antigens for allergen immunotherapy in single or multiple dose vials without actually administering the substance.

When billing the antigen/antigen preparation codes, the number of doses per vial must be specified in the "units" field of the claim.

CPT code 95144 is not to be used by allergists providing both the injection and antigen/antigen preparation services. Single dose vials are to be billed only when the allergist is preparing extract to be injected by another physician.

CPT code 95115 (single injection) **or** CPT code 95117 (two or more injections) is to be used when billing for the administration injection of an allergenic extract alone. Use the appropriate code for the number of injections administered and enter one in the "units" field of the claim.

Thus, allergists providing both the antigen/antigen preparation services and the injection must do component billing as specified above.

Effective April 29, 1996, only the following diagnoses will be allowed for allergen immunotherapy:

477.0 - 477.9	Allergic Rhinitis
493.0 - 493.9	Asthma
495.0 - 495.9	Extrinsic Allergic Alveolitis
989.5	Toxic Effects of Venom

Billing Codes for Orthodontics

Effective June 1, 1996, DOM will open three new Orthodontic HCPCS codes:

D8030	Limited ortho treatment of the adolescent dention
D8080	Comprehensive ortho treatment of the adolescent dention
D8670	Periodic ortho treatment visit (as part of contract)

For cases that have been previously approved under different codes, please continue to use those codes until cases are completed. Please remember that **ALL ORTHODONTIC CODES REQUIRE PRIOR APPROVAL.**

Loaner Personal Computers Available

The EDI Services Department of EDS is loaning out personal computers (PCs) to providers who currently submit their claims hard copy. The PCs will be loaned out for a four-week trial period on a first-come, first-serve basis. Interested providers can use the PCs to determine if it would benefit them to bill their claims electronically instead of paper. Use of the PCs and software is free, and there is no fee to submit claims electronically. Providers who already have a PC and would like to obtain the free software should make sure that their system meets the requirements listed below.

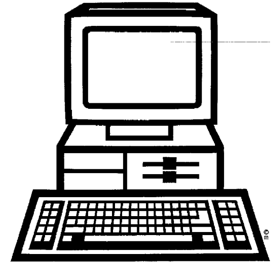
System Requirements

- 386 or better Central Processing Unit (CPU) on a stand-alone PC
- At least 4 megabytes of Random Access Memory (RAM)
- At least 8 megabytes of available hard disk space
- Color VGA monitor
- Microsoft DOS version 5.0 or better
- 1200 to 14400 bps Hayes compatible modem
- 3.5” or 5.25” Double Density or High Density floppy drive

The NECS software is not designed to transmit via modem on a network system. The following two lines must be included in the system’s CONFIG.SYS file:

```
DEVICE=C:\DOS\ANSI.SYS
FILES=40
```

If you wish to sign up for the Loaner PC program or are interested in obtaining additional information about submitting claims electronically, contact the EDI Services Department at EDS at 601-960-2901 or 1-800-884-3222.



If you wish to sign up for the Loaner PC program contact the EDI Services Department at EDS, 601-960-2901 or 1-800-884-3222.

HealthMACS and Pharmacy Claims

Pharmacy claims submitted for a HealthMACS recipient are submitted like all regular Medicaid pharmacy claims with one exception. The valid seven (7) digit provider number of the prescribing physician must be entered in the appropriate field. Claims will not pay if the 1999999 number is entered. The prescribing physician does not have to be the recipient’s HealthMACS provider.

Therapeutic Phlebotomy

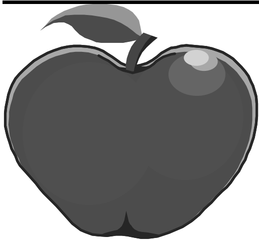
CPT Code 99195, Phlebotomy, Therapeutic (separate procedure), is not an interchangeable code for CPT Code 36415, Routine Venipuncture.

The medical necessity for a therapeutic phlebotomy must be documented on the claim by the use of the appropriate ICD-9 Diagnosis Code. Also, the medical necessity for the procedure must be documented in the patient’s medical record.

Billing for HealthMACS Referrals or Authorized Services

Non-emergent services provided to Medicaid recipients enrolled in the HealthMACS program by a provider other than the recipient's primary care provider (PCP) must be prior authorized and/or referred by the PCP. Emergent services must be post-authorized by the PCP following administration of services. The recipient's PCP can be determined upon verification of recipient Medicaid eligibility using one of the following methods:

1. Using a point of service eligibility "swipe card" device
2. Calling 1-800-884-3222 and using the Automated Voice Response System (AVRS)
3. Calling 1-800-884-3222 and verifying Medicaid eligibility through a Medicaid Correspondence Clerk
4. Calling 1-800-627-8488 and requesting specific PCP information for a client from a HealthMACS Hotline Representative



Emergent services must be post-authorized by the PCP following administration of services.

PCPs may participate in the HealthMACS program as individual providers or as a group. After determining the PCP as outlined above, if the PCP name given is a group, the authorization numbers needed will be the seven (7) digit group provider number and the seven (7) digit individual provider number of the individual within the group making the referral or authorization. If an individual name is given as the PCP, only the individual's seven (7) digit provider number is needed as the authorization number. For a third referral, when the PCP has authorized a referral and the referred provider in turn makes an additional referral such as lab work, or admits the recipient to the hospital, the provider number of the referred physician will then be used as the referring provider, and the referred physician has the responsibility of passing the authorization number to the next provider. The referring provider and attending physician numbers do not necessarily have to be a PCP's Medicaid provider number or linked to a group in anyway; however, they both must be a valid individual Medicaid provider number.

Enter the authorization number on the claim prior to submitting for payment. The authorization number must be entered in field 19 on the HCFA-1500 claim form and enter the referring physician Medicaid provider number in field 17a. On the UB-92 claim form, enter the attending physician's Medicaid provider number in field 82.

If you want more information regarding individual/group PCPs referral, billing procedures, and information regarding electronic billing specifications for HealthMACS, please call the Managed Care Hotline at 1-800-627-8488 and request detailed information sheets.

If your staff or another facility requires additional education in order to ensure that the referral process is effective, please contact the Managed Care Hotline at 1-800-627-8488 and request a visit from a Managed Care Provider Representative.

Important Notice Regarding Nebulizers and Apnea Monitors for Children under 21

Nebulizers and apnea monitors for children under 21 do not require a Plan of Care (MA-1148) but do require a statement of medical necessity signed by a **PHYSICIAN.** The medical necessity statement must be attached to the DME (MA-1103) form. Continue to submit requests for nebulizer supplies for children on a Plan of Care (MA-1148).

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

Provider Based Rural Health Clinics

The following list of procedure codes for provider based rural health clinics will be pulled out of the percentage of charges reimbursement and set up to pay as per the fee schedule. This change is effective for service dates beginning July 1, 1995.

The procedure codes are as follows:

W9010, W9011, W9013, W9014, W9016, W9041, W9042, W9127, W9350,

W9351, W9352, W9353, W9356, W9357, W9358, W9360, W9363, W9364,

W9365, W9366, W9368, W9369, W9370, W9371, W9372, W9373, W9374,

W9375, W9376, W9377, W9382, W9383, W9386, W9410.

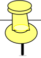
The recovery will be from July 1, 1995 to present. Provider based rural health clinics that provide EPSDT services will be included in the recovery.

New ESC Manuals Ready

New ESC manuals are ready for Dental, HCFA-1500, Nursing Facilities, and UB-92 billers. These manuals contain the technical specifications needed to bill claims electronically. Manuals will be sent to current electronic claims submitters. If you do not receive a manual and would like a copy, contact EDI Services at EDS at 601-960-2901 or 1-800-884-3222.

Orthoptic and/or Pleoptic Training Code

Effective May 13, 1996, procedure code 92065 will require prior authorization which may be obtained through the Division of Medicaid Medical Services.



Checkwrite Schedule

May 06, 1996
May 13, 1996
May 20, 1996
May 27, 1996
June 03, 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

May 02, 1996
May 09, 1996
May 16, 1996
May 23, 1996
May 30, 1996

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

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