MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Bulletin

Program and Policy Information

Volume 3, Issue 2 August 1996

Ambulance Transportation To and From Dialysis Treatments

Effective July 1, 1996 the Division of Medicaid will no longer authorize Medicaid ambulance benefits for Medicare eligible patients who are being transported to and from non-approved Medicare dialysis facilities.

If the patient is covered by both Medicare and Mississippi Medicaid, Mississippi Medicaid will only pay the deductible and coinsurance based on Medicare's allowed charges on cases approved by Medicare. If Medicare benefits are denied because (1) the patient is being taken to a non-approved Medicare dialysis facility or (2) the medical necessity criteria for ambulance transport is not satisfied, Medicaid will not approve benefits for the ambulance transport.

The Division of Medicaid will no longer authorize Medicaid ambulance benefits for Medicare eligible patients who are being transported to and from non-approved Medicare dialysis facilities.

If the patient is only covered by Medicaid, the ambulance provider must<u>continue to obtain prior approval by submitting the Medical Certification Form for Transport of Kidney Dialysis Patients to the Division of Medicaid</u>.

For those cases currently being transported based on past approval obtained from Patsy Crews at the Division of Medicaid, Medicaid will continue to pay for at least 30 more days to avoid any retroactive denials and to provide a reasonable transition period. Ambulance providers should contact the Division or Medicaid for the termination dates on their active cases.

Questions relating to this bulletin should be directed to Patsy Crews, R.N., C.C.M. at 1-601-987-3939 or Peter Montgomery at 1-601-987-3938.

Inside This Issue

EDS

Failure to comply with Medicaid requirements could result in suspension from the Medicaid Program.

Claims Filing Limitation for Medicare/Medicaid Crossover Claims

Effective June 13, 1996, all Medicare/Medicaid crossover claims **must** be submitted within six (6) months from the Medicare payment date listed on the Medicare payment register. Any claims received after the 6-month filing limitation will be denied.

Compliance with Medicaid Pharmacy Requirements

The following are Medicaid policies which require immediate attention. Medicaid's Program Integrity Unit has identified non-compliance with the following Medicaid policies through ongoing pharmacy audits. Pharmacists are reminded that failure to comply with these or any other Medicaid requirements could result in suspension from the Medicaid Program, recoupment of all monies paid for any misrepresented and/or undocumented claims, plus any applicable interest or penalties (please refer to pages 1-8 through 1-11 of the Mississippi Medicaid Pharmacy Manual under the heading **1.05 ADMINISTRATIVE HEARING PROCEDURES).**

1. **National Drug Code (NDC)** - The **EXACT** eleven digits of the NDC identifying the product's source container, including the product's bottle size, **MUST** be used on every claim submitted for payment. The pharmacist is responsible for determining that the **EXACT** NDC number of any product he/she dispenses is indicated on the computer's drug selection screen. This has been Medicaid policy since June 15, 1991, as mandated by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90).

2. **MAC Overrides** - A prescription signed "**Brand Medically Necessary**" by the prescribing physician **MUST** be on file for audit to substantiate any claim submitted with the Federal Maximum Allowable Cost Override Code.

3. **Recipient Signatures** - With the exception of recipients in Long Term Care Facilities, a recipient signature **MUST** be obtained for each individual prescription dispensed (e.g., if four prescriptions are dispensed, four signatures must be obtained). The signatures must be kept in date order, with the recipient signing by each serial number listed. Delivered prescriptions are **NOT** exempted from this requirement.

4. **Nursing Home Residents' Medicine** - Maintenance medication dispensed for recipients residing in a Long Term Care Facility **MUST** be in one month minimum quantities.

Orthoptic and/or Pleoptic Training

As a result of the ongoing review of the Division of Medicaid's policies and their application and relevance to each CPT code, procedure code 92065 will be closed in all programs and will not be reimbursed by Mississippi Medicaid effective August 20, 1996.

Nursing Home Rates

The Mississippi Medicaid State Plan requires that per diem rates for Medicaid participating nursing facilities, ICF-MRs and PRTFs may not be calculated until all of the prior year cost reports are received. We are still waiting to receive several 1995 cost reports at this time. In addition, many of the 1995 cost reports were submitted without the documentation required by the Mississippi Medicaid State Plan and/or the cost report forms and instructions. We appreciate the effort made by those facilities that submitted their cost reports timely and in compliance with Medicaid regulations.

As a result of the quality of most of the cost reports received, it was necessary to utilize many Division of Medicaid and EDS Corporation resources to review the cost reports for completeness and to request additional information. In the future, facilities that do not submit the required information with their cost reports should expect to see the related costs disallowed for Medicaid purposes.

Facilities that do not submit the required information with their cost reports should expect to see the related costs disallowed for Medicaid purposes.

Due to the delay in receiving complete cost reports from so many facilities and since some facilities have not complied with this request or have not submitted their cost reports, we will be unable to compute the FY 1997 rates prior to July 31, 1996. The earliest date you should expect to receive your FY 1997 rates is the end of August. All rates will be retroactive to July 1, 1996. We apologize for any inconvenience as a result of the delay in rates.

Requirements for Reporting Changes for HealthMACS Providers

Should any of the information supplied on your HealthMACS application (Medicaid provider number, clinic address, telephone number, etc.) change at any time during your enrollment in the HealthMACS program, you must notify the Managed Care Division of these changes in writing as soon as possible.

For groups/clinics participating as Primary Care Providers (PCPs), the Managed Care Division must be notified when physicians and/or nurse practitioners enrolled as PCPs leave the group/clinic. When new physicians and/or nurse practitioners associated with the group/ clinic wish to enroll as PCPs, the Managed Care Division should be contacted regarding information needed to enroll them as PCPs.

HealthMACS providers choosing to terminate their HealthMACS provider agreements must notify the Managed Care Division in writing no less than 45 days prior to the requested termination date. This allows time for arrangements to be made for HealthMACS recipients currently assigned to these providers so they do not experience problems accessing services. According to HealthMACS policy, the primary care provider (PCP) must also give patients 30 days notice that he/she will no longer be his/her PCP.

Should any of the information supplied on your HealthMACS application change at any time during your enrollment in the HealthMACS program, you must notify the Managed Care Division of these changes in writing as soon as possible.

If you have questions regarding the HealthMACS program, please contact the Managed Care Division at 601-359-6133.

Special Bulletin Regarding the Medicaid Anesthesia Policy

A special bulletin dated July 15, 1996 regarding the revised Medicaid Anesthesia Policy was distributed to anesthesiologists and CRNAs. If you would like to receive a copy of this revised policy, please call the EDS Correspondence Unit at (601)960-2800 or 1-800-884-3222.

If you would like to receive additional bulletins, please call 1-800-884-3222

Checkwrite Schedule

August 05, 1996
August 12, 1996
August 19, 1996
August 26, 1996
September 02, 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

August 01, 1996
August 08, 1996
August 15, 1996
August 22, 1996
August 29, 1996

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