MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Bulletin

Program and Policy Information

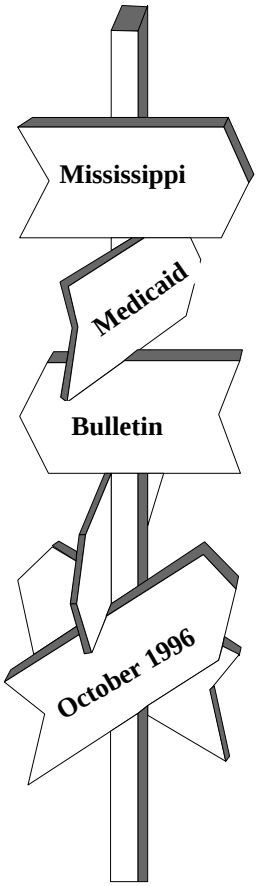
Volume 3, Issue 4 October 1996

HMO Contracts Approved

EDS

HCFA Approves Contracts with HMOs

The Division of Medicaid (DOM) has been notified by the Health Care Financing Administration (HCFA) that the contracts with Apex Healthcare of Mississippi, Inc., and AmeriCan Medical Plans of Mississippi, Inc. have been approved. DOM will finalize these contracts and begin making immediate plans to implement the capitated managed care project in Warren County. Enrollment of Medicaid recipients will begin the first week of November. DOM will notify Medicaid providers in Warren County and surrounding counties of plans for provider workshops as arrangements are finalized. Also, contracts for Mississippi Managed Care Network, Inc. and Family Health Care Plus have been submitted to HCFA for review.



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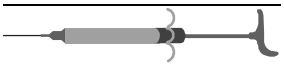

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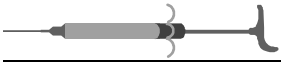


Additional Immunizations for the Vaccines for Children Program

The Vaccines for Children (VFC) Program will begin distributing two additional immunizations to VFC providers. The effective date for Medicaid reimbursement for administration of these vaccines is October 1, 1996.

W6106	Influenza - pediatric high risk	$10.00
W6107	Pneumococcal - pediatric high risk	$10.00

Contact Letitia Thompson at the State Department of Health Immunization Program (601) 960-7751 or Bertha Williams at the Division of Medicaid EPSDT Program (601) 359-6150 if you have questions.

Schedules for Administration of Hib Conjugate Vaccines

The ACIP Recommended Immunization Schedule lists two schedules for administration of Hib conjugate vaccines. Medicaid has assigned administration codes for both schedules.

Hib Schedule A: HbOC (HibTITER), PRP-T (ActHIB) or DTP/HbOC (TETRAMUNE).

W6055	Administration of Hib schedule A first dose
W6060	Administration of Hib schedule A second dose
W6065	Administration of Hib schedule A third dose
W6070	Administration of Hib schedule A fourth dose

Hib Schedule B: PRP-OMP (PedvaxHIB)

W6075	Administration of Hib schedule B first dose
W6080	Administration of Hib schedule B second dose
W6085	Administration of Hib schedule B third dose

CORRECTION - Reimbursement for a Surgical Tray

Last month's article regarding reimbursement for a surgical tray was incomplete. Please note the correction in bold below.

System modifications have been made to allow payment of a surgical tray, procedure code A4550, **along with the same surgical procedures allowed by Medicare when the procedure is performed in the physician's office.**

When billing for a surgical tray, procedure A4550, it is imperative that the surgical procedure be billed on the claim form BEFORE the surgical tray is billed. Failure to do so may result in an inappropriate denial of payment.

Allowable Board of Directors Fees for Nursing Facilities, ICF-MRs and PRTFs

1996 Cost Reports

The Division of Medicaid has computed the allowable Board of Directors Fees that will be used in the desk reviews and audits of 1996 cost reports filed by nursing facilities, ICF-MRs and Psychiatric Residential Treatment Facilities (PRTFs). The computations were made in accordance with the Mississippi Medicaid State Plan by indexing the amounts in the plan using the consumer price index. The amounts listed below are the per meeting maximum with a limit of four (4) meetings per year. The allowable Board of Directors Fees for 1996 cost reports are as follows:

Category	Allowable Cost for 1996
0-99 Beds	$2,641
100-199 Beds	$3,962
200-299 Beds	$5,283
300-499 Beds	$6,603
500 Beds or More	$7,924

1996 New Bed Values for Nursing Facilities, ICF-MRs and PRTFs

The new bed values for 1996 for nursing facilities, ICF-MRs and Psychiatric Residential Treatment Facilities (PRTFs) have been determined by using the R.S. Means Construction Index. These values should be used by facilities to determine if they have purchased assets that exceed the new bed value for the 1996 calendar year. Assets purchased in 1996 that exceed the new bed value, when added together, should be depreciated on the cost report in Section 5 of Form 6. If a facility's total fixed assets purchased is less than the new bed value for 1996, the 1996 acquisitions should be depreciated over three (3) to five (5) years and the depreciation should be expensed under Section 4 on Form 6.

The 1996 new bed value for nursing facilities is $28,233. The 1996 new bed value for ICF-MRs and PRTFs is $33,880.

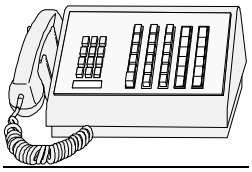
Nursing Home Patients Admitted to Hospitals

Hospitals must indicate the 'N' copay exception indicator on any claim for a nursing home patient admitted to a hospital.

Hospitals

If you have questions regarding any information in this bulletin or would like to receive additional bulletins, please call the EDS Correspondence Unit at:

1-800-884-3222
or
601-960-2800.



Medicare/Medicaid Crossover Claims

Until October 30, 1996, providers have six months from the Medicare payment date to submit original crossovers and up to twelve months from the Medicare payment date to **resubmit** a previously denied crossover claim. As of November 1, 1996, providers have up to six months from the Medicare payment date to submit a crossover claim to Medicaid. Claims filed after the six-month timely filing limitation will be denied.

Closure of Codes

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 codes will be closed and no longer reimbursed by Medicaid.

Effective October 1, 1996

76948 Q0115	These fertility related codes represent procedures which are not covered by the Mississippi Medicaid program.

Effective October 14, 1996

99217	Because Medicaid's observation period is never more than 23 hours, discharge management is considered inclusive in observation care.

Effective November 1, 1996

These codes represent procedures which are considered outmoded under prevailing medical standards.

30210	51605	55705	78891	93528
51020	52250	55720	82965	
51030	52325	55725	93514	

Medicaid Drug Federal Upper Limit Changes

Effective August 9, 1996, the following drug product has been **temporarily discontinued** from the marketplace and should be deleted from the Medicaid Federal Upper Limits Listing (MAC):

Generic Name

Clotibrate
500 mg., Capsule, Oral 100

EDS Publications
111 E. Capitol St.
Suite 400
Jackson, MS
39201

New NECS Software Available for UB-92 Billers

NECS, the free software provided by EDS, can now bill more UB-92 bill types. This software supports the following UB-92 bill types: inpatient (111, 112, 113, 114); outpatient (131); swing bed (181, 182, 183, 184); dialysis (721); hospice (811, 821); and PRTF (891, 892, 893, 894). In addition to the UB-92 claims, the NECS software allows the submission of HCFA-1500, dental, pharmacy, and nursing facility roster claims electronically. Electronically submitted claims normally adjudicate in less than ten days, with a lower denial rate and fewer pended claims.

Providers interested in submitting claims electronically must complete an EDI submitter agreement obtained by contacting EDS at (800)-884-3222 or (601)-960-2901. EDI Services will mail the software, upon approval, with installation instructions, a submitter ID and password. EDS offers assistance for installing and operating the NECS system upon request. An approved agreement must be on file before the provider may transmit data.

Providers must meet the minimum system hardware requirements in order to run the NECS system. Please note that this software is designed to be installed on an individual (stand-alone) personal computer. EDS cannot offer technical assistance if the program is installed on a file server or network.

System Requirements:

- 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, or Windows95
- 3.5” or 5.25” Double Density or High Density floppy drive

FREE
New NECS software is available. Providers interested in this software to submit their claims electronically must complete an EDI submitter agreement obtained by contacting EDS at 1-800-884-3222 or 601-960-2901.

NECS Enhancements on the Way!

EDS is enhancing features of the NECS software program for submitting claims electronically. Some of the enhancements include print abilities, electronic remittance advices, and screens that are more user-friendly.

EDS needs providers/submitters willing to test new software. The software testing must be done in addition to your regular billing; it will not affect your usual adjudication of claims. Claims must be keyed in the provider/submitter’s office, and not by EDS. In order to test, you must meet the minimum system requirements. Testing will begin later this fall.

Providers interested in participating in the testing should contact EDI Services at (800)-884-3222 or (601)-960-2901 for more information.

Anesthesiology Reimbursement for Tubal Ligations NOT Performed Within 8 Hours of Delivery

Specific instructions were included in the bulletin dated January 1, 1996 regarding the Mississippi Medicaid Anesthesia Policy for tubal ligations NOT performed within 8 hours of delivery. These instructions are as follows:

> If the tubal ligation is NOT performed within 8 hours of the delivery, the anesthesiologist/CRNA must file for the tubal ligation in accordance with guidelines established for anesthesia for surgical (non-maternity) procedures.

The appropriate CPT procedure code must be filed with the number of anesthesia time units in field 24G and TOS 7 in field 24D. **Additionally, these claims must be submitted hard copy to:**

Medical Services
Division of Medicaid
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399

The appropriate CPT procedure code must be filed with the number of anesthesia time units in field 24G and TOS 7 in field 24D.

This will prevent your claims from denying for PRO and is effective for dates of service between March 1, 1996 and July 31, 1996 **ONLY.**

Identification of Prescribers on Pharmacy Claims

A computer analysis of Medicaid claims from pharmacy providers submitted in July 1996 determined that a substantial number of providers submitted more than ten percent of the claims with either an invalid prescriber number or the unknown prescriber number, 0019999.

The use of the unidentified prescriber number is appropriate in some instances (see Section 6.01, item 7 of the Mississippi Medicaid Pharmacy Manual). However, the Division of Medicaid provides all pharmacy providers with a list of all participating Medicaid providers and their prescriber numbers as a supplement to the provider manual. This list is periodically updated and distributed. Also, prescriber information may be obtained from the Correspondence Unit at EDS or the office of the prescriber.

Pharmacy providers are requested to reduce the number of pharmacy claims filed with an unknown prescriber number.

Pharmacy providers are requested to reduce the number of pharmacy claims filed with an unknown prescriber number. The Division of Medicaid will continue to monitor this situation. Failure to reduce the number of claims with an unidentified prescriber number may result in prepayment review of all future claims using the unidentified prescriber number and a compliance audit by the Program Integrity Division.

Filing Claims for Patients Enrolled in HealthMACS

The Managed Care Division has recently received calls from providers who are having problems with HealthMACS edits when the initial claim had HealthMACS information on it. Extensive research has been conducted and determined that the majority of claims were submitted with incorrect information entered in the HealthMACS fields. In an effort to avoid future problems, below are some pointers to follow when filing a claim for a patient who is enrolled in HealthMACS.

The recipient's Primary Care Provider (PCP) can be determined by verifying Medicaid eligibility. Be sure to enter the correct dates of service to determine the correct PCP at the time the service was rendered. When a HealthMACS enrollee receives services from a provider other than the assigned PCP, the provider must get both a HealthMACS authorization number (a seven (7) digit number) and the referring physician's individual Medicaid ID number. These numbers may not be the same. Please refer to the May 1996 Mississippi Medicaid Bulletin, page 6, or the HealthMACS section of your provider manual for more information about filing claims.

Be sure to enter the correct HealthMACS 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 in form locator 11 on the UB-92 claim form. On the HCFA-1500 claim form, also enter the referring physician's Medicaid provider number in field 17a; and on the UB-92 claim form, enter the attending physician's Medicaid provider number in form locator 82.

If you are having problems processing HealthMACS claims, have questions regarding the HealthMACS program, or if you would like to attend a HealthMACS educational workshop near you, please call the Managed Care Hotline at 1-800-627-8488.

Laboratory Procedures Waived by CLIA

In conjunction with the CLIA Release No. 29, only the following CPT codes will be reimbursed by the Mississippi Medicaid program without CLIA certification:

81002	82273	82951	83718	85013	87072
81025	82465	82952	83986	85018	
82044	82947	82962	84478	85651	
82270	82950	83026	84830	86588	

All previously waived Q codes will no longer be reimbursed. This is effective October 1, 1996.

HealthMACS

All previously waived Q codes will no longer be reimbursed.

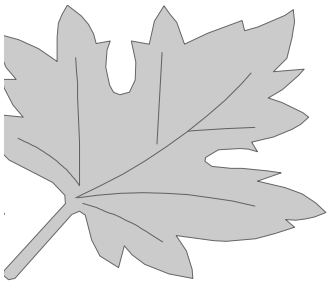
Checkwrite Schedule

October 07, 1996
October 14, 1996
October 21, 1996
October 28, 1996
November 04, 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

October 03, 1996
October 10, 1996
October 17, 1996
October 24, 1996
October 31, 1996



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