MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Bulletin

Program and Policy Information

Volume 4, Issue 8 February 1998

Federally Qualified Health Center Cost Reports

It is imperative that providers make every effort to file complete cost reports in a timely manner.

Medicaid cost reports received from Federally Qualified Health Centers are reviewed by Medicaid personnel prior to being forwarded to EDS for desk review. The purpose of this initial review is to determine if the cost reports are complete and if supporting schedules tie to the cost report. Unfortunately, 77% of the cost reports filed for 1997 required at least one request for additional information. Providers that do not submit the required information on the second request will have the cost associated with the requested information disallowed. If this happens, providers will not be allowed to submit the information at a later date for inclusion in their rate, to amend the cost reports to include the requested information, or to appeal the disallowance of the costs associated with the requested information. The requests for additional required information are very time-consuming and result in a time delay for cost settlement. It is imperative that providers make every effort to file complete cost reports in a timely manner.

Providers should ensure that their preparer is notified of all requests for information as well as all desk review adjustments. This will allow the preparer to be apprised of the Medicaid cost report filing requirements.

Inside This Issue

EDS

Settlement Dates for Claims in 1998

To eliminate any uncertainty as to the settlement dates for claims in the upcoming year, disbursements are to be made on Thursday of each week, including weeks with a Monday holiday, as follows:

Week of	Payment on
February 16	Thursday, February 19
April 27	Thursday, April 30
May 25	Thursday, May 28
July 6	Thursday, July 9
September 7	Thursday, September 10

For the weeks with non-Monday holidays, disbursements are to be made as follows:

Week of	Holiday	Payment on
November 9	Wednesday, November 11	Thursday, November 12
November 23	Thursday, November 26	Wednesday, November 25
December 21	Friday, December 25	Thursday, December 24

These payment dates have been determined using our Claims Payment Processing Procedures for Holiday Weeks and are based on the anticipated State holiday schedule for calendar year 1998. You will be informed of any changes during the course of the year.

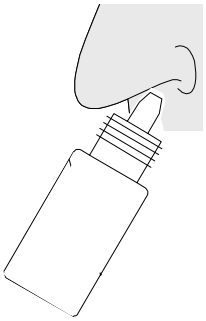
Billing Crossovers for Skilled Nursing Facilities

Facilities filing hard copy crossover forms must use the date the resident was first admitted for skilled nursing facility care.

Facilities filing hard copy Mississippi Crossover Forms to claim Medicare coinsurance days for services provided to Medicaid recipients must use the date the resident was first admitted for skilled nursing facility care in the "Admit Date" block (field #7) on the crossover form. If a Skilled Nursing Facility resident is transferred from a SNF to a second SNF, the second SNF must use the admit date of the first SNF in field #7 of the crossover form.

Medicare coinsurance is calculated from day 21 through day 100 of the resident's stay in a SNF. Medicaid will pay the coinsurance for those recipients who qualify for Medicare Part A. The correct admit date is necessary to determine the number of coinsurance days payable by Medicaid.

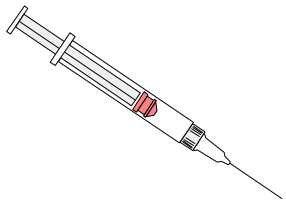
R e m i n d e r



Change in Billing for Stadol Nasal Spray - A Reminder

Pharmacy providers are reminded that beginning **February 1, 1998**, Stadol Nasal Spray is to be billed on a per bottle basis (e.g., bill one bottle dispensed as "1", two bottles as "2", etc.). Until that date, pharmacy providers should continue to bill Stadol Nasal Spray in milliliters (e.g., one bottle dispensed to be billed for the number "3"). Pharmacy providers should take steps to ensure that all employed pharmacists and pharmacy clerks or technicians are aware of this new billing procedure for Stadol Nasal Spray beginning on **February 1, 1998**.

Venipuncture No Longer Qualified as Skilled Nursing Service



The Balanced Budget Act of 1997 includes a provision eliminating venipuncture as a qualifying skilled nursing service for Medicare home health benefits as of February 5, 1998. The purpose of this notice is to advise that the Division of Medicaid will also apply this policy immediately for those individuals who are dually eligible and, as of April 1, 1998, for persons eligible for Medicaid only. All appeals relating to this issue should be directed to the Senator or Congressman representing your district for review in Congress.

Medicaid Patients in Emergency Rooms
(Effective April 1, 1998)

1. Emergency rooms (ER) should follow hospital policy and procedure as established for COBRA.
2. COBRA requires an appropriate and adequate medical screening of all who present to the ER.
3. COBRA requires stabilization and/or treatment of true medical emergencies and of pregnant women. COBRA does not require treatment of "anyone who walks in the door."
4. **Medical Screening**

   Facility Billing: If the patient's medical condition is determined by the hospital ER not to be an emergency or one which does not require treatment for stabilization, the facility should bill revenue code 451 - EMTALA Emergency Medical Screening Services.

   No other codes can be billed for this recipient for the visit.

   Physician/Nurse Practitioner Billing: The ER physician/nurse practitioner providing the medical screening is to bill procedure code W4100, Emergency Medical Screening, on the HCFA-1500.

   No other codes can be billed with procedure code W4100.

5. **Beyond Screening**

   Facility Billing: If the patient's medical condition is determined by the hospital ER to need treatment for stabilization but is not an emergency, the facility should bill revenue code 452 - ER Beyond EMTALA Screening.

   No other ER revenue code in the 450 - 459 range may be billed. However, other services, as appropriate, may be billed with this revenue code.

   Physician/Nurse Practitioner Billing: The ER physician/nurse practitioner is to bill the appropriate CPT E&M codes on the HCFA-1500 for the services provided.

NOTES:

1) When using revenue codes 450, 451, 452, 456, or 459, only one of the codes in this series can be billed at a time. Only one can be billed per patient, per day and place of service.
2) Billing of revenue codes 450, 451, 452, 456, or 459 count against the 6-hospital outpatient visits per year.

Emergency rooms (ER) should follow hospital policy and procedure as established for COBRA.

HealthMACS Patients in Emergency Rooms

HealthMACS Patients in Emergency Rooms
(Effective April 1, 1998)

1. Emergency rooms (ER) should follow hospital policy and procedures as established for COBRA.
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   No other codes can be billed for this recipient for this visit.

   Physician/Nurse Practitioner Billing: The ER physician/nurse practitioner providing the medical screening is to bill procedure code W4100, Emergency Medical Screening, on the HCFA-1500.

   No other codes can be billed with procedure code W4100.

   HealthMACS Authorization: **Post authorization*** from the primary care provider (PCP) is required to bill revenue code 451 and for the physician/nurse practitioner to bill W4100.

   The medical screening (451 and W4100) includes the following services:

   a. whatever the hospital ER determines to be necessary for an appropriate and adequate medical screening to determine whether or not the patient has an emergency medical condition or one that needs treatment for stabilization;
   b. instructions to the patient which may include but are not limited to what to do until s/he can be seen by a PCP the next working day and the need to contact a PCP for appointment time;
   c. discharge of patient to HealthMACS PCP or other appropriate medical personnel with ER notes or summary of ER screening and instructions given to the patient sent to the PCP the next working day, **and** contact of the PCP regarding need for the patient to be seen the next working day by the PCP or other appropriate medical personnel due to ER discharge to the PCP or other medical personnel. The ER and PCP will need to determine how to get ER information to the PCP timely as the PCP will need information early the next working day;
   d. documentation of services rendered to the patient, including what was done for medical screening, instructions to the patient, discharge arrangements, and information sent to the PCP.

(Continued on page 5)

(Continued from page 4)

5. **Beyond Screening**

   Facility Billing: If the patient's medical condition is determined by the hospital ER to need treatment for stabilization but is not an emergency, the facility should bill revenue code 452 - ER Beyond EMTALA Screening.

   No other ER revenue code in the 450-459 range may be billed. However, other services, as appropriate, may be billed with this revenue code.

   Physician/Nurse Practitioner Billing: The ER physician/nurse practitioner is to bill the appropriate CPT E&M codes on the HCFA-1500 for the services provided.

   HealthMACS Authorization: **Post authorization*** from the PCP is required to bill revenue code 452 and for the physician/nurse practitioner billing.

   The billing of revenue code 452 includes:

   a. documentation of services rendered to the patient, including what was done for medical screening, instructions to the patient, discharge arrangements, and information sent to the PCP; and if appropriate,

   b. instructions to the patient which may include but are not limited to what to do until s/he can be seen by PCP the next working day, medication or prescription for medication to last until the next working day when s/he can be seen by PCP; patient will need to be instructed to contact PCP for appointment time;

   c. discharge of patient to HealthMACS PCP or other appropriate medical personnel with ER notes or summary of ER screening and instructions given to the patient sent to the PCP the next working day, **and** contact of the PCP regarding need for the patient to be seen the next working day by the PCP, or other appropriate medical personnel due to ER discharge to the PCP or other medical personnel. The ER and PCP will need to determine how to get ER information to the PCP timely as the PCP will need information early the next working day.

7. Notify the Division of Medicaid (DOM), Managed Care Division, of any reports of COBRA violations regarding HealthMACS patients as DOM is documenting information to send to HCFA regarding discrepancies in managed care requirements and COBRA requirements.

8. The ER is to notify DOM, Managed Care Division, of HealthMACS patients who continuously misuse the ER. DOM will arrange for recipient education regarding appropriate use of the ER and medical resources for these patients.

* **Post authorization - The time period for obtaining post authorization is 24 hours on weekdays and 48 hours for weekend days.**

NOTES:

1) When using revenue codes 450, 451, 452, 456, or 459, only one of the codes in this series can be billed at a time. Only one can be billed per patient, per day and place of service.

2) Billing of revenue codes 450, 451, 452, 456, or 459 count against the 6 hospital outpatient visits per year.

Effective April 1, 1998

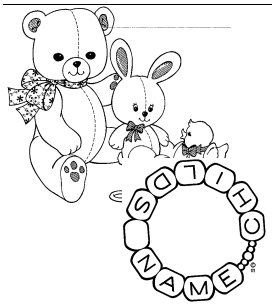
Newborn Hearing Screens

Effective April 1, 1998, the Division of Medicaid will apply the following policies relating to Newborn Hearing Screens.

1. The initial screening must be done within 6 months of the infant's birth.
2. It is expected that the initial screening will be done during the same admission as the baby's birth if the hospital has the equipment or contracts with an outside source to perform the screening. If initial screening is done during the same admission as the birth, payment is included in the hospital's per diem rate.

   Such charges must be billed on the facility's inpatient claims under Revenue Code 470 on the UB92.

   If the hospital contracts for the screening to be done by an audiologist or other qualified provider, the hospital is responsible for payment to that source.
3. If the initial screening is done after discharge in the outpatient department of a hospital, the facility must charge under Revenue Code 470 on the UB92 as an outpatient hospital service. Again, if the hospital contracts for the screening to be done by an audiologist or other qualified provider, the hospital is responsible for payment to that source.
4. If the baby fails the initial screening and the second screening is done during an admission or in the outpatient department of the hospital, the above policies apply.
5. If the first or second screening is done in the office of a physician or audiologist, the provider must bill Code W9523 on the HCFA-1500 claim form. The Medicaid allowance will be $30.00.



It is expected that an initial hearing screening be done during the same admission as the baby's birth if the hospital has the equipment or contracts with an outside source to perform the screening.

For Mississippi Medicaid purposes, the local code W9523 will identify the initial screening or the subsequent screening if the baby fails the initial screening. This code may be billed only by physicians or audiologists performing the service in their office.

Revenue Code 470 must be used to report the screening tests and Revenue Code 471 must be used to report the diagnostic testing when billed by a hospital. This is applicable to both inpatient and outpatient services.

Under Mississippi Medicaid, CPT Codes 98585 and 92587 may be used only for diagnostic testing of newborns who have failed the initial and second screening. CPT 92588, which specifies diagnostic testing, may also be applicable. These CPT codes may be billed only by physicians and audiologists.

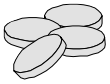
Questions relating to this policy should be directed to the EDS Correspondence Unit at 1-601-960-2800 or 1-800-884-3222.

1998 CPT Codes

The additions, changes, and deletions to the 1998 CPT codes were loaded into the Medicaid Management Information System (MMIS) on January 31, 1998. The new codes are effective for dates of service beginning January 1, 1998. The discontinued CPT codes will not be accepted after March 31, 1998.

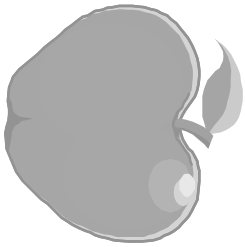
Proper Billing for Helidac Therapy

Helidac Therapy, NDC 00149-0495-01, is a carton of fourteen (14) blister packs, each divided into four (4) doses of four (4) different capsules or tablets. Since each carton totals 224 tablets, some pharmacy providers have been mistakenly billing the quantity **224** for one carton of Helidac Therapy. One carton of Helidac Therapy dispensed should be billed for the quantity **56**, the total number of doses supplied. Providers must reverse any claims for this drug that have been filed to date with incorrect amounts. A follow-up claims review will be done in 30 days to ensure that all needed corrections have been made.



One carton of Helidac Therapy dispensed should be billed for the quantity **56.**

HealthMACS Workshop



The Mississippi Division of Medicaid and EDS will be conducting the final workshop for information of the managed care program Health Through Medicaid Managed Access to Care and Services (HealthMACS). HealthMACS, a primary care case management program for AFDC/AFDC-related Medicaid eligibles, will be implemented **Statewide** by **April 1, 1998.** HealthMACS links Medicaid eligibles with a PCP who is responsible for managing the health care needs of Medicaid eligibles assigned to him/her. HealthMACS offers better patient care by providing continuity of services and encouraging more appropriate use of the health care system.

The purpose of the workshop is to discuss the policies of the HealthMACS program, how it changes the way HealthMACS enrollees access care and services, and how medical care provided by health care specialists other than the PCP must be authorized by the PCP for Medicaid to reimburse for the services. Some Medicaid services are excluded from HealthMACS and do not require authorization by the PCP. These services include: podiatry, dental, psychiatry, ophthalmology, eyeglasses, hearing aids, nursing home, ICF/MR, and emergency/non-emergency transportation.

Medicaid providers who can be PCPs for HealthMACS are: family practitioners, general practitioners, pediatricians, obstetricians (OB), gynecologists (GYN), internists, and nurse practitioners (pediatric, adult, family, OB-GYN, and certified nurse midwives). **If you provide health care to AFDC/AFDC-related Medicaid eligibles in Mississippi, or you are one of the provider types listed and are interested in being a PCP for HealthMACS, you and/or a representative of your billing staff may want to attend one of the sessions scheduled below.** We will conduct two sessions at **9:00am and 1:00pm.** Each session will contain the same presentation. Detailed information about the HealthMACS program will be given during the workshop. HealthMACS applications and agreements will be available.

This will be your last opportunity to attend a HealthMACS workshop before the program is implemented statewide. If you are not sure if you need to attend a workshop, please call the Managed Care Hotline, 1-800-627-8488, or the Division of Medicaid Managed Care staff, 1-800-421-2408, for additional information about the program and the workshop.

"Last Chance Workshop"
February 4, 1998 - 9:00 a.m. and 1:00 p.m.
Harvey Hotels and Suites North
I - 55 North West Frontage Road
Jackson, Mississippi

Mississippi Medicaid Bulletin

EDS
111 East Capitol, Suite 400
Jackson, MS 39201-2121

Bulk Rate
U.S. Postage
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February 1998

S	*M*	*T*	*W*	*T*	*F*	*S*
1 Stadol Nasal Spray billed on per bottle basis begins	Checkwrite 2	3	4	5 Venipunture no longer qualified as Skilled Nursing Service on crossovers ESC Cut-Off 5 pm	6	7
8	Checkwrite 9	10	11	12  ESC Cut-Off 5 pm	13	 14 **Valentine's Day**
15	Checkwrite  16 **President's Day**	17	18	19 Claims settlement date ESC Cut-Off 5 pm	20	21
 22	Checkwrite 23	24	25	26 ESC Cut-Off 5 pm	27	28
	EDS Correspondence Unit 1-800-884-3222 or 601-960-2800					

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.