MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Bulletin

Program and Policy Information

Volume 4, Issue 9 April 1998

Void/Adjustments of Stadol Nasal Spray Claims

Pharmacy providers should review all claims submitted since February 1, 1998 for Stadol Nasal Spray and void/adjust any claims that were submitted with the quantity in milliliters rather than per bottle (e.g. the quantity "one" for one bottle should be billed instead of "three" milliliters). This change in billing procedure was announced in the Mississippi Medicaid Bulletin in January and February of 1998.

Starting April 1, 1998, claims found to have been submitted for Stadol Nasal Spray with erroneous quantities, i.e., in milliliters instead of per bottle, will be voided by the Division of Medicaid. It will then be the pharmacy provider's responsibility to resubmit these claims with the proper quantity, e.g., "one" for one bottle dispensed, "two" for two bottles dispensed, etc.

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Correction

Newborn Hearing Screens

Newborn Hearing Screens - Correction

On page 6 of the February, 1998 Medicaid Bulletin, the policy on "Newborn Hearing Screens" has an incorrect code.

In the fourth paragraph, providers should change CPT code 98585 to 92585. The sentence should read "Under Mississippi Medicaid, CPT codes 92585 and 92587 may be used only for diagnostic testing of newborns who have failed the initial and second screening."

BBA imposes new federal mandates

HealthMACS Policy Changes

The Balanced Budget Act of 1997 (BBA) has imposed new federal mandates for State Medicaid managed care programs. In an effort to meet these federal mandates, HealthMACS may have some policy changes over the next several months. Please continue to monitor monthly provider bulletins for articles regarding policy changes as required by the BBA.

New HealthMACS eligibles have had a choice of selecting and/or changing their HealthMACS primary care provider (PCP); however, the BBA mandates regulations which will require some modification to this process. New eligibles will be allowed a 90-day window of change once their initial lock-in has begun. These recipients will be identified and notified six weeks before their enrollment period begins to inform them that a PCP has been selected for them and they have a 90-day window to change PCPs if they are not happy with this selection.

Due to the modification of the HealthMACS enrollment process, **HealthMACS providers will not receive any computerized recipient assignment for May**. In May, the only assignments PCPs will receive will be those eligibles who have called the HealthMACS Hotline and selected or changed PCPs or have had their selection submitted by their PCPs. Computerized assignments will resume in June.

The Managed Care Division will be sending all HealthMACS PCPs a letter which will summarize BBA requirements that affect HealthMACS. This letter will also request information from PCPs. Upon receipt of the letter, PCPs are encourage to respond promptly as PCP feedback will assist in ensuring that revisions to HealthMACS policy occur in the most effective manner for participating PCPs and the patients they serve.

Contracts with Health Maintenance Organizations (HMOs)

The Division of Medicaid (DOM) will enter contracts with HMOs at the beginning of each state fiscal year (July 1). No contracts will be entered into during the state fiscal year. Any HMO interested in contracting with the DOM must complete an application and submit it to the DOM Managed Care Division no later than May 1, 1998. Applications may be obtained by contacting the Managed Care Division at (601) 359-6133.

Billing Tips

In order to reduce billing inaccuracies, and assist with questions, the following list of common billing errors is presented.

1. When submitting claims for recipients with a third party payment amount, put the payment amount in **field 29** on the HCFA-1500 and **form locator 54** on the UB92. If the payment amount is less than 20% of billed charges, the claim form should indicate "***LESS THAN 20% PROOF ATTACHED"***.
2. When the third party payment source denies payment, indicate "***TPL DENIAL ATTACHED"*** in the body of the claim form. Please note that an attachment from the TPL source indicating additional information has been requested and the information was not supplied or the conditions of the TPL guidelines for coverage have not been met does not constitute a valid TPL denial.
3. When billing for services denied by Medicare for recipients who are eligible for Medicare and Medicaid, you must indicate "***MEDICARE DENIAL ATTACHED***" on the claim form. Be sure all TPL denial attachments reflect the dates of service being billed.
4. If it has been (30) days from the time a claim was paid by the Medicare intermediary for services rendered to recipients who are both Medicare/ Medicaid eligible and both the deductible and/or coinsurance amounts have not yet been reimbursed by Medicaid, the Mississippi Medicaid Crossover Form should be completed and submitted for processing.
5. Medicaid currently uses one (1) digit "place of service" and "type of service" codes. Please be sure to use the correct place of service and type of service when completing the claim forms. These codes are listed in Appendix M and N in the back of the Physician's Provider Manual. For other provider types, refer to the Table of Contents in the front of the provider manual for the location of the appropriate appendix.
6. Providers completing the Consent for Sterilization Form for planned sterilization procedures should follow the guidelines as established on page 209 of the Physicians Provider Manual (revised 1996 edition). Only one properly completed consent form is required for all providers rendering services for any sterilization procedure.

If you have questions about billing that you would like to have answered, please call the EDS correspondence unit at 1-800-884-3222 or send them to EDS Provider Relations Unit, P O Box 23061, Jackson, MS 39225-3061 or fax them to (601) 960-2807. These questions and others will be answered under "**Billing Tips**" in other issues of the Mississippi Medicaid Bulletin.

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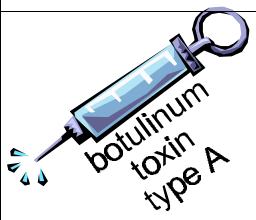
HCPCS Code J0585

HCPCS code J0585 represents an injectable medication defined as *botulinum toxin type A, **per unit***. Please be certain to bill **per unit** for dates of service on and after January 1, 1998 and **per 100 units** for dates of service prior to January 1, 1998.



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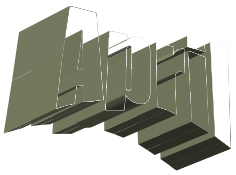

April 1998

S	*M*	*T*	*W*	*T*	*F*	*S*
EDS Correspondence Unit 1-800-884-3222 or 601-960-2800			Claims submitted with erroneous quantities for Stadol Nasal Spray will be voided. 1	2 ESC Cut-Off 5 pm	3	4
5 Daylight Saving Time begins	Checkwrite 6	7	8	9 ESC Cut-Off 5 pm	10	11
12	Checkwrite 13	14	15	16 ESC Cut-Off 5 pm	17	18
19	Checkwrite 20	Professional Secretaries Day 21	22	23 ESC Cut-Off 5 pm	24	25
26	Checkwrite DOM **closed** for Confederate Memorial Day 27	28	29	30 ESC Cut-Off 5 pm		

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.