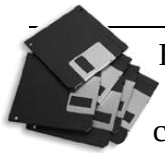
MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Bulletin

Program and Policy Information

Volume 4, Issue 12 June 1998



Facilities **must** continue submitting MDS data via diskettes to the Division of Medicaid for reimbursement.

Case Mix

Facilities **must** continue submitting MDS data via diskettes to the Division of Medicaid for reimbursement.

Any facility errors that need to be corrected (i.e., incorrect or missing discharge dates, incorrect bed hold data, or missing assessments) must be submitted on diskette. Hard copies of MDS forms for data entry will **not** be accepted.

Facilities may start using the 1/30/98 version of the MDS for submissions starting June 1, 1998. It is required that all facilities use this form by June 22,1998.

Do **not** code evaluation time or documentation time for speech, occupational or physical therapy in Section P1b of the MDS. Only the actual time that the resident spends in treatment is recorded in this section. See HCFA's RAI Version 2.0 Q&A, page 31, Question 132 and the RAI Users Manual, Section 3, page 151.

Any questions regarding the electronic submission of MDS data to the National System should be directed to Health Facilities Licensure and Certification Division of the Department of Health at (601) 354-7300.

Inside This Issue

EDS

The Mississippi Crossover Form has been Changed

Mississippi Crossover Form

The Mississippi Crossover Form will be **replaced** effective July 1, 1998.

New forms will be mailed the week of June 22, 1998. Please discard the old Mississippi Crossover Form and begin using the new forms A and B as of July 1, 1998. **When submitting forms A or B, please remember Medicaid requires the Medicare EOB.**

Filing Claims for Medicare/Medicaid Eligibles

Currently, only inpatient hospital crossover days apply toward the Medicaid service limitations for those recipients who are eligible for both Medicare and Medicaid.

Effective July 1, 1998, **ALL** crossover claims will apply toward the Medicaid service limitations for all Medicare and Medicaid eligibles (i.e., 30 inpatient hospital days, 12 office visits, 6 outpatient visits, etc.).

In addition, the payment methodology for crossover claims will change. These changes are in accordance with the Balanced Budget Act of 1997.

Effective July 1, 1998, payment methodology for crossover claims will change.

New Payment Methods

The Medicare payment amount will be compared to what Medicaid would have paid for a Medicaid only claim for the same service.

1. If the Medicare payment is more than the Medicaid allowable charges, the crossover claim will zero pay and be considered paid in full. **THE PROVIDER CANNOT BILL THE PATIENT FOR THE DIFFERENCE.**
2. If the Medicare payment is less than the Medicaid allowable charges, the difference between the Medicare payment and the Medicaid allowable charge will be paid to the provider. **THE PROVIDER CANNOT BILL THE PATIENT FOR THE DIFFERENCE IN THE CHARGES AND PAYMENTS RECEIVED FROM MEDICAID AND MEDICARE.**
3. If the Medicare service is not covered under the Medicaid State Plan, the crossover claim will zero pay and the patient cannot be billed for the difference between the Medicare payment and the Medicare allowed amount.

Questions regarding these changes must be made in writing and directed to:

Helen Wetherbee, J.D., M.P.H.
Executive Director
Division of Medicaid
Office of the Governor
239 North Lamar Street
Suite 801, Robert E. Lee Building
Jackson, Mississippi 39201-1399

Hospice/Managed Care (HMOs)/ Home and Community Based Waivers

Prior to enrolling any Medicaid recipient in a hospice program, the hospice provider is required to verify a recipient's Medicaid eligibility. Medicaid recipients have the option to enroll in Health Maintenance Organizations (HMO) that have contracts with DOM, or one of DOM's three Home and Community-Based Services Waivers. If a recipient has elected to enroll with an HMO, pre-certification for hospice care must be authorized by the HMO. If the proper authorization is not obtained, claims will be denied. The Division of Medicaid will not assume responsibility for payment if the recipient is enrolled in an HMO. If a recipient is enrolled in one of the Home and Community-Based Services Waivers, the recipient must disenroll from the waiver **prior** to enrolling in the hospice program. Hospice providers can call the EDS Correspondence Unit at 1-800-884-3222 to verify eligibility, Managed Care enrollment or Home and Community-Based Services Waiver enrollment.

Hospice providers must check the recipient's eligibility before they are enrolled into the Hospice program.

Submission of Corrected Claims for Services to HMO Recipients

When it is necessary for a provider to submit a corrected claim for services provided to a Medicaid HMO recipient, the provider must utilize the usual adjustment process for Medicaid claims. Providers must void the previous claim paid at zero dollars to avoid receiving the "duplicate claim" denial edit on the corrected claim.

Payment for Multiple Surgeries

Changes have been made to the Medicaid computer system to let providers know how surgical procedure codes (CPT procedure codes 10,000 – 69,999) are processed when more than one surgical code is billed on the same date of service. A modifier will show on the Remittance Advice (RA) which indicates the following:

5A	Primary
5B	Primary Bilateral
50	Secondary Bilateral
51 or Other	Secondary

Changes have been made to the Medicaid computer system to let providers know how surgical procedure codes are processed when more than one surgical code is billed on the same date of service.

When more than one surgery code is billed for a single date of service (multiple surgeries), only one primary surgery will be identified. A primary surgery code is paid at 100% of the Medicaid allowed amount OR billed charges, whichever is the lesser. Only one unit of a primary procedure is paid at 100%. After the first unit, all subsequent units are paid as secondary.

Secondary bilateral procedures should no longer be billed with two units. Please return to billing bilateral procedure codes with the –50 modifier and one unit. Continue to bill surgical procedures as instructed in the May bulletin. NEVER bill with modifier 5A or 5B.

Also, remember that secondary surgery codes are paid at 50% of the allowed amount.

Changes with Non-Emergency Transportation

DOM takes over Non-Emergency Transportation

Effective July 1, 1998, sole responsibility for the Non-Emergency Transportation (NET) program will be transferred to the Division of Medicaid (DOM).

Previously, the NET program has been a shared responsibility of the Department of Human Services (DHS) and DOM.

The purpose of the NET program is to provide transport for routine medical services to NET eligible Medicaid recipients. The program relies on a network of volunteer drivers and group providers located throughout the state. The program is administered on the local level by transportation coordinators located in various offices throughout the state. The primary functions of the coordinators are to screen Medicaid recipients for eligibility for NET services, arrange rides for recipients, and submit claims paperwork to ensure that both volunteer drivers and group providers are paid in a timely manner.

Current plans for the transition of the program to DOM call for two transportation coordinators to be housed in selected DOM regional offices throughout the state. Three coordinators will be located in the NET office in Jackson, and four coordinators will be located in the Gulfport regional office due to the increased number of NET eligible Medicaid recipients in these areas.

At present, Division of Contracts Monitoring-NET staff members are working to ensure that the transition takes place with minimal disruption to providers and recipients of NET services.

An article will appear in next month's bulletin outlining the transition of the program to DOM in greater detail.

Effective January 1, 1998, a per-visit payment limit will apply to ALL rural health clinics, with the exception of clinics owned by rural hospitals with fewer than fifty (50) beds.

Independent and Provider Based Rural Health Clinics

As mandated by the Balanced Budget Act of 1997, effective January 1, 1998, a per-visit payment limit of $57.77 will apply to ALL rural health clinics, with the exception of clinics owned by rural hospitals with fewer than fifty (50) beds. Therefore, claims filed for services with an encounter will be zero-paid, except for the technical component amount of certain x-rays and radiology services. An adjustment will be made on a future remittance advice for claims filed for dates of service January 1, 1998 forward.

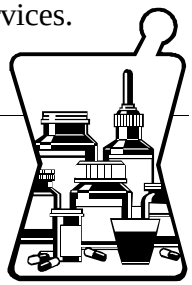
A per-visit payment limit will apply to all rural health clinics

Disease Management Services

On April 1, 1998, the Health Care Finance Administration gave approval to the Mississippi Division of Medicaid to pay qualified pharmacists for disease management services. To qualify, a pharmacist must be registered to practice pharmacy in Mississippi and must be certified by the Mississippi State Board of Pharmacy to provide disease management services as defined by the State Pharmacy Practice Act.

The target date for implementation of this new program is July 1, 1998. Interested pharmacists may contact EDS to inquire about the enrollment packet at (601) 960-2800 or 1-800-884-3222 on or after June 15, 1998.

On April 1, 1998, the Health Care Finance Administration gave approval to the Mississippi Division of Medicaid to pay qualified pharmacists for disease management services.



Change of Ownership

For providers who undergo a change of ownership by Medicaid definition, a new Medicaid application and agreement MUST be completed, and a new Medicaid provider number must be assigned. These forms may be obtained by calling EDS Provider Enrollment at (601) 960-2800 or 1-800-884-3222.

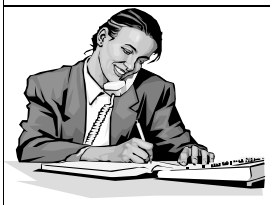
Billing Tips

1. Verify recipient eligibility for Medicaid benefits and services at the beginning of each month or at each visit. Recipients may be enrolled in programs with restricted services (i.e. HMOs or HealthMACS) which require appropriate prior approval for reimbursement. If the recipient is enrolled in a Mississippi Medicaid Managed Care program, be sure to get and use the appropriate authorization numbers. This information may be obtained from the audio voice response system (AVRS), the EDS Correspondence Unit or the eligibility swipe card device.

2. When verifying eligibility for a newborn with a swipe card device, be sure to use the mother's Medicaid ID number and a "K" along with the baby's date of birth. Numbers beginning with 2XX are temporary numbers for newborns only. Do not use a "K" with numbers that begin with 2XX when verifying eligibility.

3. When a recipient receives retroactive eligibility, attach a copy of the retroactive eligibility letter with each claim being submitted. Indicate "***Retroactive Letter Attached***" in the body of the claim form.

If you have questions about billing, 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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Jackson, MS 39201-2121

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June 1998

S	M	T	W	T	F	S
	Checkwrite 1 Facilities may start using 1/30/98 version of MDS software.	2	3	4 ESC Cut-Off 5 pm	5	6
7	Checkwrite 8	9	10	11 ESC Cut-Off 5 pm	12	13
 14 **Flag Day**	Checkwrite 15 Providers may inquire about enrollment packets for Disease Management.	16	17	18 ESC Cut-Off 5 pm	19	20
First Day of Summer 21 **Fathers Day**	Checkwrite 22 Facilities must use 1/30/98 version MDS software.	23	24	25 ESC Cut-Off 5 pm	26	27
28	Checkwrite 29	30	EDS Correspondence Unit 1-800-884-3222 or 601-960-2800			

Checkwrites and Remittance Advises are dated every Monday. However, funds are not transferred until the following Thursday and Remittance Advices usually arrive the following Friday.