Mississippi Medicaid Bulletin

Program and Policy Information

Volume 5, Issue 2 August 1998

Participating HMOs

AMERICAN MEDICAL PLANS OF MISSISSIPPI

CARE3

FAMILY HEALTH CARE +

MISSISSIPPI MANAGED CARE NETWORK

PHOENIX HEALTHCARE OF MISSISSIPPI

Update on Managed Care with HMOs

As of July 1, 1998, the Division of Medicaid has contracts with five (5) health maintenance organizations (HMO). They are: AmeriCan Medical Plans of Mississippi, Care3, Family Health Care +, Mississippi Managed Care Network, and Phoenix Healthcare of Mississippi.

Apex Healthcare of Mississippi did not renew its contract to continue as a Mississippi Medicaid HMO. Apex will continue to process claims through December 31, 1998 for providers who provided services to Mississippi Medicaid recipients who were members of Apex. The dates of service are for claims on or before June 30, 1998, and on or after December 1, 1996. Providers with any claims for Apex members which have not been filed need to file the claims as soon as possible. The claims need to be filed as usual with EDS and EDS will transmit the claims information via electronic bulletin board to Apex to be processed. Providers who have problems with Apex processing claims that have already been submitted need to contact Apex at 1-888-288-2885. If the issue cannot be satisfactorily resolved, the provider may contact the Managed Care Division at the Division of Medicaid for assistance.

The HMO program continues to operate in the following counties: Forrest, Hancock, Harrison, Lauderdale, Warren and Washington. During early August HMO enrollment packets will be sent to Medicaid beneficiaries in Lamar and Perry Counties. HMOs will begin providing services on September 1, 1998, for those Medicaid beneficiaries who enroll with an HMO by August 25, 1998. In September 1998, HMO enrollment packets will be sent to Medicaid beneficiaries in Covington, George, Greene, Jackson, Jones, Pearl River, Stone, and Wayne, Counties. The HMOs will begin providing services in these counties on October 1, 1998.

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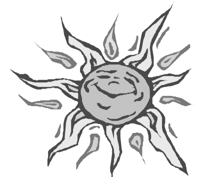


Medicaid Managed Care Workshop

The Medicaid Health Maintenance Organization (HMO) program is expanding to serve Lamar and Perry Counties in south Mississippi effective September 1, 1998. The program will be expanded to Covington, George, Greene, Jackson, Jones, Pearl River, Stone, and Wayne, Counties effective October 1, 1998.

Recipients who choose to enroll in an HMO before August 25, 1998, will begin receiving coverage by an HMO on September 1, 1998.

Medicaid recipients in these counties will begin receiving HMO enrollment information in early August. Recipients who choose to enroll in an HMO before August 25, 1998, will begin receiving coverage by an HMO on September 1, 1998. All Medicaid eligibles except those recipients residing in a long-term care facility are eligible to participate in an HMO. Recipients who receive Medicaid through the Department of Human Services must participate in either a Medicaid HMO or HealthMACS. To prepare for this transition, the Mississippi Division of Medicaid, approved Medicaid HMOs, and EDS invite you to attend a provider workshop. There will be two workshops in south Mississippi focusing on the Medicaid HMO program with two sessions at each location. The first at **9:30 a.m.**, and the second at **1:30 p.m**. You are invited to attend either session. Information presented will be the same for all dates, locations and times. The workshop will provide you with a basis for understanding the HMO managed care program and billing for Medicaid recipients who are enrolled with an HMO. Workshops will be conducted at the following locations:

- **LaFont Inn - August 5, 1998**; Highway 90, Pascagoula, MS
- **Hattiesburg Convention Center - August 6, 1998**; One Convention Center Plaza, Hattiesburg, MS

The following Medicaid approved HMOs will be present at the workshop to assist you with any billing questions: **Family Health Care +, AmeriCan Medical Plans of Mississippi, Inc., Mississippi Managed Care Network, Phoenix Healthcare of Mississippi, Inc., and Care3, Inc.**

For questions regarding this event call 1-800-884-3240.

CLIA Requirements for Mississippi Medicaid Providers

Any provider billing CPT or HCPCS codes for lab services must complete the CLIA Certification Information form since all editing is performed on these codes only.

As of last month, claims for laboratory services, REGARDLESS OF THE DATE OF SERVICE, began denying if the Mississippi Medicaid CLIA Certification Information form had not been received or the CLIA certification was not valid for the services billed. Any provider billing CPT or HCPCS codes for lab services must complete the CLIA Certification Information form since all editing is performed on these codes only. If revenue codes ALONE are billed (such as inpatient hospital claims), the CLIA Certification form is not necessary. All questions should be directed to EDS Customer Service at 1-800-884-3222. Please do not call the State Department of Health, Licensure and Certification or any of the HCFA offices.

Proper Billing for Helidac and Prevpac

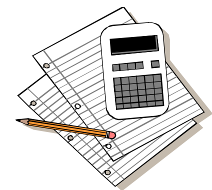
One carton of Helidac Therapy should be billed for the quantity **56** and one Prevpac Patient Pack should be billed for the quantity **14**. Pharmacy providers must reverse any claims for these two drugs that have been filed to date with incorrect amounts. Starting August 10, 1998, the Division of Medicaid will void claims which have been submitted for these drugs with erroneous quantities. It will then be the pharmacy provider's responsibility to resubmit these claims with the proper quantity.

Pharmacy providers must reverse any claims for Helidac and Prevpac that have been filed to date with incorrect amounts.

Completing the Adjustment/Void Request Form for Refund Checks

If you are paid incorrectly on the Remittance Advice (RA) for a Medicaid claim or have received monies from a third party payer after payment by Medicaid, it is necessary to submit an Adjustment/Void Request form.

If money applies to more than one recipient or multiple paid claims for the same recipient, please provide an **Adjustment/Void Request** form for each claim with the actual dollar amount to be applied on each claim. All of the information below can be found on the RA on which the claim paid.



The following information must be completed on the Adjustment /Void Request form:

- Provider Number
- Reason for Refund
- Recipient Name
- Description of Request (Dates of Services)
- Mississippi Medicaid Identification Number
- ICN numbers to which check applies

Please return the completed Adjustment/Void Request form to the following address:

EDS
P.O. Box 23085
Jackson, MS 39225-3085

Electronic Claims Record Layout Upgrades

The Mississippi Division of Medicaid is upgrading the electronic claims record layouts for HCFA-1500, UB92, and Pharmacy. Please direct any questions to EDI services at (800)-884-3222 or (601) 960-2901.

Voice Response Enhancements for Dental Providers

Beginning August 17, 1998, the Automated Voice Response System (AVRS) will include 3 new dental service options. After accessing the Service Limits option, providers accessing option 5 for dental limitations will now be able to obtain the number of comprehensive visits, preventive services (prophy/prplus), and the number of limited oral exams.

For more information, please call the EDS Correspondence Unit at (601) 960-2800 or 1-800-884-3222.

Automated Voice Response Enhancements

Medicaid Payment Methodology

Provider Questions Regarding Medicaid Payment Methodology for Medicaid/Medicare Crossover Claims

The Balanced Budget Act of 1997 eliminated the requirement that state Medicaid programs pay Medicare claims at Medicare rates, even for services not covered by Medicare. This corrected problems in federal law that have been the subject of litigation all over the country. State law provides no authority for reimbursement other than payment in accordance with the Medicaid program.

The Division is particularly concerned about the impact of these changes on professionals reimbursed on a fee-for-service basis. We are committed to seeking increases in these Medicaid rates during the 1999 session, and hope that you will encourage your professional associations to support such legislation.

Below is a compilation of questions received by the Division of Medicaid regarding changes in payment of Medicare crossover claims along with our answers.

1. **Question:** **Will Medicaid pay the Medicare deductible?**

   DOM Response: Yes.

2. **Question:** **Will the 20% co-insurance now paid by Medicaid for Medicare patients still be paid?**

   DOM Response: No. If the Medicare paid amount equals zero or is more than the Medicaid reimbursement rate, the crossover will zero pay. If the Medicare paid amount is less than the Medicaid reimbursement rate, the crossover will pay the difference between the Medicare paid amount and the Medicaid reimbursement amount or the co-insurance amount, whichever is less.

3. **Question:** **For Medicare capped rental items that are Medicaid purchase and rental items, what will be the allowable amount that the claim will be judged by? If Medicare is renting the equipment will it be based on Medicaid's rental allowable amount?**

   After the 20% co-pay on a rental is paid for a certain number of months will it cap like Medicare caps or will it continue to rent as long as the co-pay is within the allowable?

   DOM Response: As long as Medicare makes a payment, the comparison as outlined in the June Medicaid Provider Bulletin will be used to determine if Medicaid will pay zero or an actual payment. If the deductible has been met and the crossover amount is zero (0) then Medicaid will zero pay. Medicaid will no longer pay the 20% Medicare co-pay, as such. If Medicaid covers the service, then the Medicare paid amount will be compared to the Medicaid allowed amount. Medicaid will pay only if the Medicare paid amount is less than the

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Medicaid reimbursement amount, and then Medicaid will pay the difference.

4. **Question:** **Will the new payment method for crossovers apply to all claims submitted to Medicaid on or after July 1, 1998?**

   DOM Response: The new payment methodology will only apply to crossover claims with **dates of services** on or after July 1, 1998.

5. **Question:** **Will Medicaid reimburse ambulance services for IV supplies and solutions?**

   DOM Response: Effective July 1, 1998, Medicaid does not cover IV supplies and solutions billed by an ambulance provider. Such items are included in the base rate. The recipient may not be billed.

6. **Question:** **Will the RA give a specific amount which a provider will need to write off for the contractual adjustment in these cases?**

   DOM Response: This information is not available and cannot be provided on the RA.

7. **Question:** **Can a provider be allowed to bill a patient for Medicare co-insurance if the provider tells the patient initially that they will accept Medicare, but not Medicaid reimbursement?**

   DOM Response: No, see Question #1.

8. **Question:** **If a patient has Medicaid/Medicare will they be limited to the 12 physician visits and 30 inpatient hospital days?**

   DOM Response: Medicaid will continue to cover services up to the service limits as stated in the Medicaid Provider Manual. Please refer to any Medicaid Provider Manual **(Chapter 1 Section 1.02).**

9. **Question:** **Will a patient who has used all of his/her outpatient visits within the first month be allowed to submit a dialysis crossover claim to Medicaid and will this effect the payment of crossover claims submitted for capitation fees for dialysis patients?**

   DOM Response: Crossover claims for dialysis and outpatient visits are billed separately. Outpatient visits are limited to 6 visits, but there is no service limit for dialysis claims.

10. **Question:** **Will CPT codes 90921 (full month) and 90925 (partial month) be effected by these new changes?**

    DOM Response: Yes, if the codes are submitted as crossover claims.

Medicaid/Medicare Crossover Claims

Mississippi Medicaid Bulletin

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August 1998

S	M		T	W	T	F	S
							1
2	3	Checkwrite	4	5	6 ESC Cut-Off 5 pm	7	8
9	10	Checkwrite	11	12	13 ESC Cut-Off 5 pm	14	15
16	17	Checkwrite	18	19	20 ESC Cut-Off 5 pm	21	22
23 / 30	24 / 31	Checkwrite	25	26	27 ESC Cut-Off 5 pm	28	29

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.