Mississippi Medicaid Bulletin

Program and Policy Information

Volume 5, Issue 3 September 1998

Reporting of Prescriber Identification Number on Pharmacy Claims

Monthly analysis of all pharmacy claims indicates that many Medicaid participating pharmacy providers have put forth the effort to accurately identify the prescribers of the drug services rendered. Twenty-two pharmacy providers with a high percentage of non-compliance with this request had their point of service (POS) billing capability suspended by Medicaid while they undertook corrective action procedures. Since they had disposed of alternative billing methods to POS, they were without Medicaid payments for weeks. As these providers learned, if your POS is suspended for non-compliance with billing requirements, it will not be reinstated instantly upon request. Also, more than a dozen pharmacy provider agreements were terminated as a result of failure to comply with requests pertaining to submission of valid information. The Division of Medicaid will verify the validity of prescriber information and other provider information has improved prior to reinstatement.

New edit criteria for the claims processing system are being developed which will deny claims for many of the invalid numbers being submitted in the prescriber identification field. This will not prevent incorrect identification from being filed, and claims processing edits do not release the pharmacy provider from his/her responsibility to submit valid and accurate claims data. As stipulated in provider agreements and the Pharmacy Manual, claims data received by the Medicaid program is accepted as medically necessary, accurate, and complete. Pharmacy audits and retrospective drug utilization review (DUR) by Medicaid's DUR program will identify misrepresentations of the prescribers, which will be dealt with by various methods - including suspension from the Medicaid program and/ or recovery of payments. Monitoring of this problem will continue.

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EPSDT Audit Classifications

EPSDT screening providers are subject to periodic audit reviews. Providers will be classified according to the results of the review. The criteria used for the reviews are based on the policies in the EPSDT manual.

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Provider Classifications:

Class I.
Documentation and/or Clinical Review Audit scored at 93-100%
Next Review Date: 2 years

Class II.
Documentation and/or Clinical Review Audit scored at 85-92%
Next Review Date: 18 months

Class III.
Documentation and/or Clinical Review Audit scored at 76-84%
The facility has a new contract and/or providers
Next Review Date: 1 year

A Class III profile must have an audit in one year. New providers are automatically placed in this class. Technical assistance and an on-site inspection must be completed before any screens can be performed.

Class IV.
Documentation and/or Clinical Review Audit scored 75% or below. A corrective action plan is required within 30 days of the audit. The following EPSDT policy violations will automatically place the provider in a Class IV category:

- Lead Violations;
- Periodicity Violations;
- Documentation and/or Clinical score of 75% or below; or
- Any violations of the Division of Medicaid policies, EPSDT policies, and/or contracts that may jeopardize the program's integrity.

All Class IV providers are placed on probation. During the probationary period, the EPSDT nurse will be available to offer technical support/assistance needed and/or requested by the provider.
Next Review Date: 3-6 months

Failure of a Class IV provider to submit a corrective action plan will result in a reclassification to a Class V.

Class V.
The provider will be immediately referred to the Executive Director of DOM for suspension from the EPSDT program.

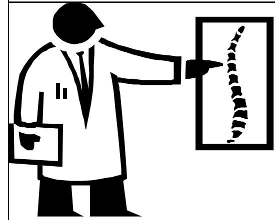
Chiropractic X-ray Services

Effective for **dates of services on and after July 1, 1998**, chiropractors may bill the following codes for x-rays. Payments for these codes along with payments for 98940, 98941, and 98942 will be applied toward the $700.00 per year per recipient limit.

CPT CODE	DESCRIPTION	ALLOWANCE
72010	Radiologic examination, spine, entire, survey study, anteroposterior and lateral	$51.55 Complete $21.84 Professional $30.67 Technical
72040	Radiologic examination, spine, cervical; anteroposterior and lateral	$28.24 Complete $10.68 Professional $18.07 Technical
72070	Radiologic examination, spine, thoracic, anteroposterior and lateral	$29.73 Complete $10.68 Professional $19.55 Technical
72080	Radiologic examination, spine, thoracolumbar, anteroposterior and lateral	$30.32 Complete $10.68 Professional $20.15 Technical
72100	Radiologic examination, spine, lumbosacral; anteroposterior and lateral	$30.32 Complete $10.62 Professional $20.15 Technical

If the chiropractor is billing for only the professional component, the modifier 26 should be used following the code. If the chiropractor is billing for only the technical component, modifier TC should be used following the code.

Codes 72040, 72070, 72080, or 72100 may not be billed with 72010 for the same date of service.



If the chiropractor is billing for only the professional component, the modifier 26 should be used following the code. If the chiropractor is billing for only the technical component, modifier TC should be used following the code.

Enrollment of Disease Management Providers

Pharmacists credentialed to provide disease management services may receive reimbursement using only the individual Medicaid disease management provider number. Pharmacies with multiple individual disease management providers may apply for group provider numbers that will allow them to receive reimbursement for all disease management services under one group provider number.

Services provided by individual disease management providers from different servicing locations may be billed using one group number. A group number is also available for each servicing location, when an enrollment packet for each location is completed.

Please contact EDS Provider Enrollment to request your group enrollment packet at 1-800-884-3222.

Dental Screenings in the School

Dental screenings performed in a school for Medicaid recipients under age 21 must be billed using procedure code W9367 with Place of Service Code zero. Do not use D0140 or D0150 for a location other than the dentist's office or outpatient/inpatient setting.

Payment of Claims for Medicaid Recipients Who Were Enrolled With AmeriCan Medical Plans

Providers may not bill Medicaid recipients for services which are Medicaid covered services or additional services covered by AmeriCan.

Many providers have outstanding claims for Medicaid recipients who were enrolled with AmeriCan Medical Plans. While the Division is aware that many of these claims are now several months old, the provider may not bill the recipients directly for these services. In accordance with the Medicaid provider participation agreements to provide services to Medicaid recipients, the provider agrees to accept, as payment in full, the amounts paid by the Division of Medicaid. Based on a contractual agreement with the Division, AmeriCan is responsible for processing claims for dates of service when Medicaid members were enrolled in that Plan. Providers may not bill Medicaid recipients for services which are Medicaid covered services or additional services covered by AmeriCan. Providers may not bill Medicaid recipients for claims which were denied by Medicaid as these claims were forwarded to AmeriCan for processing.

The Managed Care Division has forwarded to AmeriCan copies of outstanding claims which have been mailed or faxed in by providers. If you have outstanding claims which have not already been sent to the Managed Care Division, you may mail these to the Managed Care Division, Division of Medicaid, 239 N. Lamar Street, Suite 801, Jackson, MS 39201-1399 or fax to 601-359-4185. To forward these outstanding claims to AmeriCan, the Division needs a copy of the claim or information regarding the claim which includes the recipient's name, Medicaid ID number, date of service and procedure code or type of service.

If you prefer to contact AmeriCan Medical Plans directly, you may call 601-968-9000.

The Division of Medicaid has been informed by the Department of Insurance that AmeriCan will soon begin processing outstanding claims.

Electronic Claims Upgrades

Electronic Claims Record Layout Upgrades

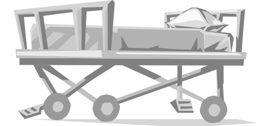
The Mississippi Division of Medicaid is upgrading the electronic claims record layouts for HCFA-1500, UB92, and Pharmacy. Please direct any questions to EDI Services at 1-800-884-3222 or 601-960-2901.

Durable Medical Equipment/Medical Supplies/Orthotics/Prosthetics

Effective October 1, 1998, the Division of Medicaid has authorized HealthSystems of Mississippi (HSM) to determine medical necessity of durable medical equipment, medical supplies, orthotics, and prosthetics supplied by durable medical equipment providers under new coverage criteria. HSM will distribute this coverage criteria to the providers along with their procedures and related forms. HSM will be notifying providers of workshops to introduce the prior approval policies and procedures.

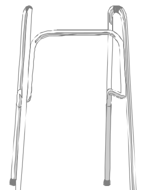
In accordance with the Administrative Procedures Act, a copy of the Division of Medicaid's criteria for durable medical equipment, medical supplies, orthotics, and prosthetics including the reimbursement has been filed with the Secretary of State as public notice of the intent to define the coverage criteria and reimbursement requirements.

Durable

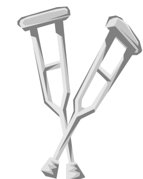


Medical

Equipment



DME



Prior Authorization Termination for Durable Medical Equipment

All prior authorizations (PA) for durable medical equipment with through dates ending in nine (9) or 9999 OR authorized units ending in (9) or 99999 will be closed according to the following schedule.

PAs with begin dates prior to 1984 through 12/31/95 will be closed 10/31/98;

PAs with begin dates 1/1/96 through 12/31/96 will be closed 11/30/98;

PAs with begin dates 1/1/97 through 12/31/97 will be closed 12/31/98.

A new PA request must be submitted to HealthSystems of Mississippi (HSM) if durable medical equipment or medical supplies are needed once the closure dates are effective.

Updating Provider Records

In the ongoing process to ensure that all provider files reflect the most current provider information, providers are asked to update all information on the provider file that may have changed, i.e. Medicare provider number, bank account number, or group affiliations. Also, providers should check pay-to and servicing addresses as the servicing address needs to reflect the physical location where services are rendered, not a post office box.

Changes must be submitted in writing to the Provider Enrollment Unit at EDS. The request for changes must be signed by the provider or individual with legal authority to sign on behalf of the facility or entity.

If there has been a recent change of ownership or change in tax identification number, please contact the EDS Provider Enrollment Unit in order to obtain an enrollment application for a new provider number. Provider enrollment may be reached at 1-800-884-3222 or 601-960-2800.

Please send any updated information to

EDS
Attn: Provider Enrollment
P.O. Box 23082
Jackson, MS
39225-9912

or fax to

601-960-2807.

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

Bulk Rate
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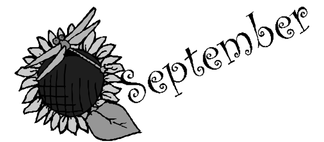

September 1998

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