



Mississippi Medicaid Bulletin

Program and Policy Information

Volume 5, Issue 5

November 1998

Upgrade Re-scheduled

Electronic Claims Record Layout Upgrade Re-scheduled

Electronic Claims Record Layout Upgrade has been re-scheduled for December 4, 1998.

Mississippi's Division of Medicaid has announced that the electronic claims record layouts (NECS formats) will be upgraded for the following **batch** claim form types: UB92, Dental, HCFA-1500, and Pharmacy. A detailed description of changes was sent to you on June 30, 1998. It is your responsibility to inform your billing agency/software vendor of the changes to the format and the new effective date of the changes. Point-of-Service upgrades for electronic claims will be released in early 1999; this is not part of the current NECS upgrade.

Please note:

- **Claims received in the new format before December 4, 1998 will not be processed.**
- **Claims received in the old format after the December 3, 1998 claims input cut-off time will not be processed.**

If you currently use the free Mississippi Medicaid NECS software, an upgraded version (on diskettes) will be mailed to you no later than November 20, 1998.

Please direct any questions to EDI Services at 1-800-884-3222, or 960-2901 in the Jackson area.

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Billing Ambulance Claims on HCFA-1500

Emergency Ambulance providers are now required to file all claims on the HCFA-1500 claim form. This became effective October 1, 1998, and applies to both paper and electronic submissions. Any claims received by EDS after October 15, 1998, submitted on the old claim form are returned to the provider for resubmission on the HCFA-1500.



Emergency Ambulance providers are now required to file all claims on the HCFA-1500 claim form.

The following modifiers indicate origin and destination of the trip and must be entered in Locator 24 D of the HCFA-1500 for proper billing.

<u>Modifiers</u>	<u>Description</u>
D	Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential, domiciliary, custodial facility
H	Hospital
N	Skilled Nursing Facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at physician's office on the way to the hospital

For example, if a patient is transported from his home to the hospital, modifier RH would be entered.

Other required fields are 24 E, Diagnosis Code and, if applicable for non-emergency transport, Locator 23, Prior Authorization.

When completing the ambulance provider portion of the Certificate of Medical Necessity for Non-Emergency Ambulance Transportation, the total number of miles estimated one way should be entered. When completing the claim form, the first 25 miles that are included in the base code should be subtracted from the actual number of miles traveled.

EPSDT Prior Authorization (PA) Notice for Durable Medical Equipment (DME)



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

EPSDT PAs with begin dates of 1/1/98 will be closed 12/31/98.

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

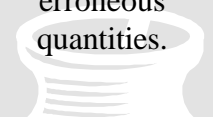
Pulmicort and Avonex Claims

Pulmicort 200 mcg. Turbuhaler (NDC 00186-0915-42) is to be billed to Medicaid on a per each basis, i.e., when one Turbuhaler is dispensed, Medicaid is to be billed for the quantity one (1), two Turbuhalers dispensed is to be billed for the quantity two (2), etc.

Avonex Ad. Pack 30 mcg. vial (59627-0001-03) is to be billed to Medicaid on a per vial basis, e.g., when four vials are dispensed, Medicaid is to be billed for the quantity four (4), etc.

Pharmacy providers should review all claims submitted for Pulmicort 200 mcg. Turbuhaler and Avonex Ad. Pack 30 mcg. vial and void/adjust any claims that were submitted with erroneous quantities. Starting November 18, 1998, all claims found to have been submitted for these drug products with erroneous quantities will be voided by the Division of Medicaid. It will then be the pharmacy provider's responsibility to resubmit these claims billed with the proper quantities.

Pharmacy providers should review all claims submitted for Pulmicort 200 mcg. Turbuhaler and Avonex Ad. Pack 30 mcg. vial and void/adjust any claims that were submitted with erroneous quantities.



Billing Services Performed by Another Provider

The following clarifications relate to the Division of Medicaid's policy regarding Mississippi Medicaid providers billing for services performed by another provider.

1. Providers who submit a provider enrollment application and qualify for a Mississippi Medicaid provider number must bill for their own services.

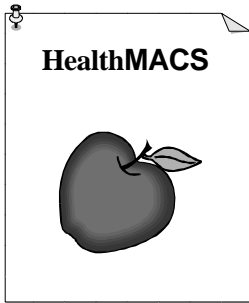
For example, a nurse practitioner must submit the claim under the nurse practitioner's provider number. If the nurse practitioner, for any reason, chooses not to or is unable to obtain a Medicaid provider number, the services performed by the nurse practitioner may not be billed to Medicaid.

Other examples include but are not limited to psychologists and licensed certified social workers (LCSW).

2. Physicians, nurse practitioners, or any other providers may not bill for services performed by other providers unless allowed by specific Federal and/or State laws or regulations governing the Medicaid program. A provider's professional license, certification, practice acts, etc., which may allow for supervision of another provider does not, of itself, justify Medicaid reimbursement.
3. This policy is not applicable to physicians supervising residents or interns in a teaching facility setting. A separate policy governs this practice.
4. This policy is not applicable in locum tenens/reciprocal billing arrangements. A separate policy governs this practice (refer to the March, 1995 Mississippi Medicaid Bulletin).



Clarifications related to the Division of Medicaid's policy regarding billing services performed by another provider.

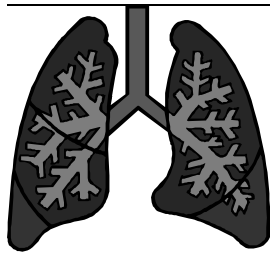


HealthMACS Posters

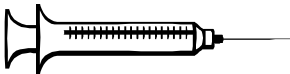
All Medicaid providers with a specialty type for primary care, EPSDT, and hospitals have been mailed or will be mailed by mid-November a supply of the most current HealthMACS educational poster. When you receive your new poster, please replace any previously posted poster with the new one. If you have not received your new poster by November 16, 1998, or if you need additional posters or other HealthMACS educational material, please call toll-free 1-800-627-8488.

Policy and Procedure for Medicaid Reimbursement for Synagis™ (palivizumab) in the Office Setting

SYNAGIS™ (palivizumab) is indicated for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in pediatric patients at high risk of RSV disease. Starting November 1, 1998 the DOM will reimburse physicians for SYNAGIS™ (palivizumab) injections using HCPCS code J3490 (Injection, palivizumab, per 1 mg IM). Medicaid will reimburse \$10.13/mg. Prior authorization is required and certain clinical criteria must be met (see below). All claims must be submitted on the HCFA-1500 (paper claims only) and will pend for review. Claims must be submitted with the diagnosis code V07.2 (Prophylactic immunotherapy) and an appropriate ancillary diagnosis (example BPD, lung/respiratory failure).



Starting November 1, 1998, the DOM will reimburse physicians for SYNAGIS™ (palivizumab) injections using HCPCS code J3490 (Injection, palivizumab, per 1 mg IM).



- Prior Authorization for Synagis™ (palivizumab) must be obtained using the Plan of Care (POC) Authorization Request form (MA-1148). The POC must be submitted to the EPSDT Unit of the Division of Medicaid (DOM) and processed by the DOM prior to administering Synagis to any Medicaid eligible child. If an infant or child is hospitalized, the physician should initiate the prior authorization process before discharge from the hospital. The DOM will not authorize payment for services rendered without proper prior authorization.
- The Certificate of Medical Necessity for Synagis™ (palivizumab), located on the next page, must be attached to the Plan of Care form.
- All potential Synagis™ (palivizumab) recipients must meet criteria in one of the four (4) categories.
- All Authorizations for Synagis™ (palivizumab) will end at age two (last day of the child's birthday month).
- Authorization will be for the RSV season only (November through April).

If the drug is not supplied by the physician's office but is supplied by a pharmacy the same prior authorization limits and clinical criteria will apply. The pharmacist must have a valid, approved prior authorization before supplying the drug.

If you have any questions, please call Rosemary Beason at 601-359-6150.




Mississippi Medicaid Bulletin

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Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 DOM will begin reimbursing Physicians for Synagis™.	2 Checkwrite	3  Election Day	4	5 ESC Cut-Off 5 pm	6	7
8	9 Checkwrite	10	11 DOM Closed  Veteran's Day	12 ESC Cut-Off 5 pm	13	14
15	16 An NECS upgrade will be sent out to those using the electronic software. Checkwrite	17	Pharmacy claims submitted with erroneous quantities will begin being voided by DOM. 18	19 ESC Cut-Off 5 pm	20 All NECS software should be sent out.	21
22	23 Checkwrite	24	25	26 ESC Cut-Off 5 pm 27 DOM and EDS closed for Thanksgiving 	28	
29	30 Checkwrite	EDS Correspondence Unit				

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.