Mississippi Medicaid Bulletin

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Adult Dental Services for Beneficiaries in HMOs

The Division of Medicaid encourages dental providers in HMO counties to continue to provide adult dental services to Medicaid beneficiaries who are members of HMOs. All dental services which are covered by regular Medicaid for adult beneficiaries not enrolled with an HMO are also covered by regular Medicaid for HMO beneficiaries.

Dental providers will not be required to sign a contract with HMOs to provide these services to HMO beneficiaries. HMOs may offer expanded coverage of other dental services to HMO beneficiaries. To receive payment from the HMOs for these expanded adult dental services, it is necessary for you to be a provider in the HMO provider network.

Additions, Deletions, and Changes to the 1999 HCPCS and CPT Codes

The additions, deletions, and description changes to the 1999 HCPCS and CPT Codes will be loaded into the Medicaid Management Information System (MMIS) in the near future. Providers should continue to utilize the 1998 codes until the Division of Medicaid provides further directions for filing the 1999 codes.

All Prior Authorization Numbers and Treatment Authorization Numbers (TANs) with "THRU" dates of 12/31/99

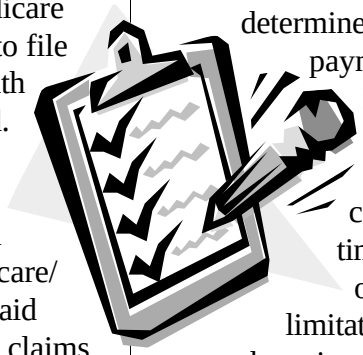
All prior authorizations numbers and Treatment Authorization Numbers (TANs) that are on our computer file with a "THRU" date of 12/31/99 or 99/99/99 will end on 12/31/99. If services or supplies will be needed beyond that date, please submit a request for continuation prior to 12/01/99 as described in your Medicaid provider manual.

MISSISSIPPI DIVISION OF MEDICAID

Medicare/Medicaid Crossover Claim Limitations Reminder

Providers have six (6) months from the Medicare paid date to file a claim with Medicaid. The 6-month limitation for Medicare/Medicaid crossover claims is determined by using the Medicare payment date and the date of receipt by Medicaid. Timely filing ICNs should not be used on crossover claims. Use of timely filing ICNs will not override the 6-month limitation. Claims received more than six months after the Medicare payment date are denied unless they meet the following guidelines.

Providers have six (6) months from the Medicare paid date to file a claim with Medicaid. The 6-month limitation for Medicare/ Medicaid crossover claims is determined by using the Medicare payment date and the date of receipt by Medicaid.



1. Claims over six months old can be processed if the beneficiary's Medicaid eligibility has been approved retroactively by the Division of Medicaid, the Department of Human Services or the Social Security Administration. Proof of the retroactive determination must accompany the claim. Dates of service must be within the eligibility period stated on the eligibility approval document. Providers have six (6) months from the date of the retroactive eligibility notification letter to submit claims.

2. The 6-month filing limitation for newly enrolled providers begins the date the new provider number is assigned. New providers have six (6) months from the date of the notification letter to submit claims for the eligibility period as stated in the notification letter.

If you have EOMB'S (Explanation of Medicare Benefits) stating the claims crossed over to Medicaid and you have no record of payment by Medicaid, or you have paper or electronic claims that do not appear on your remittance advice after thirty (30) days, please call the EDS Correspondence Unit at 1-800-884-3222 for assistance. If no record of the claim is on file you may submit a follow-up claim. To assist the Correspondence Unit, please have your Medicare number, payment dates, and EOMB available when you call.

Crossover Billing Tips

Effective July 1, 1998, all providers filing hard copy crossover claims were required to use the new Mississippi Crossover Claim Form. The EOMB (Explanation of Medicare Benefits) must be attached to the claim form.

The Part A Crossover form must be used if the services were billed to Medicare on the UB-92 form. The Part B Crossover form must be used if the services were billed on the HCFA-1500.

As of July 1, 1998, service limitations set for regular Medicaid will also apply for crossover claims.

If there is a change in your Medicare provider number, it is imperative that EDS be notified immediately to prevent possible non-payment of your crossover claims. In the near future, EDS will be mailing Medicare provider number verification forms to all providers in order to ensure that our records reflect accurate Medicare information.

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Nursing Facility Admission

The Health Care Financing Administration has notified the Division that some Medicaid participating nursing facilities are retaining money they are required to refund to residents when Medicaid eligibility is made retroactive. When a person applies for admission to a nursing facility (NF) pending Medicaid eligibility or if a resident has spent most of his private funds toward the NF and is applying for Medicaid, the NF usually requires a private rate payment until Medicaid eligibility is determined. When Medicaid eligibility is determined, it is most often made retroactive to a time prior to the date that the decision is made. Federal statutory and regulatory requirements mandate that the NF accepts Medicaid payment as payment in full when the person's Medicaid eligibility begins. Thus, NF's are required to refund any payment received from a resident or family member for the period of time that the Medicaid eligibility was pending and the resident is determined eligible for Medicaid.

The policies described above reflect the requirements of the following statutory and regulatory provisions:

- Section 1919(c)(5)(A)(i)(I) of the Social Security Act requires that a NF must not require individuals applying to reside or residing in the facility to waive their rights to benefits under Medicaid or Medicare.
- Section 1919(c)(5)(A)(iii) requires that a NF, in the case of an individual who is entitled to medical assistance for NF services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under Medicaid, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual or the individual's continued stay in the facility.
- Under 42 CFR 483.12(d), a NF:
  - must not require residents or potential residents to waive their rights to Medicare or Medicaid;
  - must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility; and
  - in the case of a person eligible for Medicaid, a NF must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility.

Failure to meet these resident rights requirements could result in an enforcement action against the nursing facility.

Federal statutory and regulatory requirements mandate that the NF accepts Medicaid payment as payment in full when the person's Medicaid eligibility begins. Thus, NF's are required to refund any payment received from a resident or family member for the period of time that the Medicaid eligibility was pending and the resident is determined eligible for Medicaid.

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If you have any questions related to the topics in this bulletin, please contact the EDS Correspondence Unit at 1-800-884-3222 or 601-960-2800.

Mississippi Medicaid Bulletins and Manuals are on the Web !
www.dom.state.ms.us

Contact EDS Publications if you would like to receive the Mississippi Medicaid Bulletin, or have an interest in what you would like to see. Fax EDS Publications at 601-960-2807, or e-mail publications@msxix.hcg.eds.com.

EDS

February 1999

Sunday	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*
	1 Checkwrite	2	3	4 ESC Cut-Off 5 pm	5	6
7	8 Checkwrite	9	10	11 ESC Cut-Off 5 pm	12 	13
	15 DOM & EDS Limited Staff Checkwrite	16	17	18 ESC Cut-Off 5 pm	19	20
21	 22 Checkwrite	23	24	25 ESC Cut-Off 5 pm	26	27
28	Checkwrite					

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.