Mississippi Medicaid Bulletin

Volume 5, Issue 10

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Helpful Hints When Resubmitting Denied Claims

A maximum of ten (10) Explanation of Benefit (EOB) error codes may be provided on a single document or line item when billing for a processed claim. When reviewing denied claims:

1. Check the error codes provided for each claim submitted for possible provider billing errors or keying errors if filed hard copy.

2. Review the denied claim for other common edits that may create a second denial on your resubmission that was not captured the first time.

The following is a list of the most common reasons claims deny.

- 003 Recipient number invalid
- 006 Service from date is invalid
- 007 Service through date is invalid
- 042 Invalid revenue charge
- 045 Surgery date not within dates of service
- 103 Place of service missing or invalid
- 208 Valid referring number required for HealthMACS
- 218 Recipient not eligible on date(s) of service
- 510 Prior Authorization (PA) not on file
- 511 Prior Authorization (PA) does not match claim data
- 746 Inpatient vs. Outpatient Duplication

Please remember that a remittance advice is a tool that can be used for correcting and resubmitting claims in a timely manner. Weekly follow-up is essential.

The Remittance Advice (RA) the Key to Payment

The Remittance Advice (RA) is an excellent report that can assist with weekly postings of submitted claims. This report provides a status on payments, denials, pends, resubmission turnaround documents, financial data, and remit messages.

MISSISSIPPI DIVISION OF MEDICAID

Medical Screening Services for HealthMACS Patients in Emergency Rooms

Effective February 27, 1999, HealthMACS authorization is no longer required when billing procedure code W4100.

Facility Billing: If the patient's medical condition is determined by the hospital emergency room (ER) not to be an emergency or one which does not require treatment or stabilization, the facility should bill revenue code 451 - EMTALA Emergency Medical Screening Services. **Effective January 11, 1999, HealthMACS authorization is no longer required to bill revenue code 451- when the screening is done by the emergency room department, place of service 2.** No other codes can be billed for this beneficiary for this visit. Stand alone usage of revenue code 451 is acceptable when no services beyond an initial screening/assessment are rendered. Services beyond screening will require HealthMACS post authorization.

Physicians/Nurse Practitioner Billing: The ER physician/nurse practitioner providing the medical screening in the hospital emergency room, place of service 2, is to bill procedure code W4100 - Emergency Medical Screening. **Effective February 27, 1999, HealthMACS authorization is no longer required when billing procedure code W4100.** No other codes can be billed with procedure code W4100.

HealthMACS Case Management Fee

Primary Care Providers (PCP) in the HealthMACS program are paid a case management fee of $3.00 per month per enrollee. The exception to this is Medicaid providers that are reimbursed on a cost basis, such as rural health clinics (RHC) and federally qualified health centers (FQHC). For these providers, the case management is covered in the cost report. PCPs who receive notification of the RHC/FQHC status on or after May 1, 1999, will have their monthly case management fee recouped from the date the RHC/FQHC status is made effective.

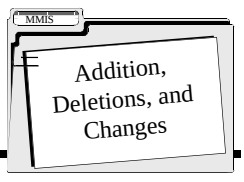
News Regarding AmeriCan Medical Plan (AMP) Payment of Claims

The Department of Insurance (DOI) has begun payment of outstanding claims submitted to AmeriCan Medical Plan (AMP) on behalf of Medicaid beneficiaries enrolled with the plan. Providers who have not received payment for outstanding claims should contact DOI staff at AMP at 601-968-9000 regarding the status of these claims. Any claims that have not been previously submitted to EDS should be submitted as soon as possible.

1999 ICD-9 Diagnosis and Procedure Codes

The addition, deletions, and changes to the 1999 ICD-9 Diagnosis and Procedure Codes have been loaded into the Medicaid Management System (MMIS). The effective date of the new codes is October 1, 1998. The deleted codes will be valid through March 31, 1999.

If providers have already submitted claims on the new codes and have received a denial because of an invalid code, the claims should be resubmitted as soon as possible.



Claims Summary Reports (PS&R)

Providers should request all Claims Summary Reports (PS&R) through the Division of Medicaid's Reimbursement Division. All requests must be in writing and include the following information:

1. Medicaid Provider Number
2. Provider's Name
3. Time Period
4. Summary or Detail Report
5. Address to mail the PS&R

If discharge information is needed, please state the discharge request in the correspondence. All requests should be sent to the following address:

Division of Medicaid
c/o Charissa Wilson
Reimbursement Division
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399

The request may also be faxed to 601-359-4193.

Schedule of Workshops for Hospital Providers

The Division of Medicaid, EDS, and HealthSystems of Mississippi will present workshops for Mississippi Medicaid Hospital Providers.

The following is a schedule of the workshops:

April 28, 1999, from 9 am to 4 pm
Primos Northgate- Convention Hall A, 4330 North State St. Jackson, MS.

April 29, 1999, from 9 am to 4pm
Comfort Inn - On the Hill, 6541 Highway 49 North, Hattiesburg, MS.

May 4, 1999, from 9 am to 4 pm
Holiday Inn - Grenada, 1796 Sunset Dr, Grenada, MS.

All hospital administators, CFO's, business office managers, and billing personnel are encouraged to attend.

Highlights

- **Medicare/Medicaid Crossover Claims**
- **Medicare -- Medicaid Provider Linkage**
- **Billing Instructions**
- **EOB Codes**
- **Billing Tips**
- **Retrospective Review**
- **23 Hour Observation Clarification**

Billing for Psychiatric Therapeutic Procedures

The Division of Medicaid is providing the following clarification for billing CPT codes for Psychiatric Therapeutic Procedures in the range from 90804 through 90899.

Billing for psychiatric therapeutic procedures should be according to the time specified for the CPT code. For those CPT codes in the 90845 to 90865 range where no time is given one unit is equal to one session regardless of the time spent in the therapy session. This policy is consistent with the American Medical Association's Current Procedures Terminology (CPT) Manual (1998) which does not assign time values to group psychotherapy sessions.

CPT codes 90804 through 90899 are limited to one unit per day with the exception of 90853, which is limited to two units. Providers may bill up to two units for CPT code 90853-Group Psychotherapy (other than of a multiple-family group) when: 1) two sessions per day are medically necessary; and 2) two sessions per day are appropriate, and in accordance with the standards of medical practice.

Diagnosis Codes for Laboratory and Radiology Procedures

The appropriate ICD-9 diagnosis code(s) must be recorded in Field 21 of the HCFA-1500.

In the May 1998 Provider Bulletin, independent laboratories and radiologists were notified that diagnosis codes would be required on all HCFA-1500 claims beginning July 1, 1998. All independent laboratories, radiology centers, pathologists and radiologists must be certain to record a diagnosis code that is appropriate for the billed procedure. The appropriate ICD-9 diagnosis code(s) must be recorded in Field 21 of the HCFA-1500. A maximum of two (2) diagnoses codes may be reported (Fields 21-1 and 21-2). Each detail line in Field 24 must reference the appropriate diagnosis code, **EITHER the first or the second,** but not both. Claims submitted electronically and without a diagnosis code will be denied. A Resubmission Turnaround Document (RTD) will be generated for hardcopy claims submitted without a diagnosis code.

Y2K

Automated Voice Response System (AVRS) Changes for Y2K Compliance

As of Monday, March 22, 1999, the Automated Voice Response System (AVRS) has a new format for Y2K compliance for a beneficiary's birthday, All providers will be required to enter Y2K compliant dates for a beneficiary's birthday. The new format is MMDDCCYY (MM=month, DD=day, CCYY=year). Providers must now enter the 4-digit birth year. For example, a beneficiary born February 14, 1970, should be keyed as **"02141970"** or a beneficiary born January 20, 2000, should be keyed as **"01202000**". **"Birthday"** is the only date format change; no other date formats have changed. If you have any questions or concerns, please call EDS at 1-800-884-3222.

Y2K Status

The March 1999 Mississippi Medicaid Bulletin included an article on the status of Y2K compliance. As stated in the previous article, many staff hours are being invested to assure that this task is completed well in advance of the new millennium.

The Division of Medicaid (DOM) is currently implementing and testing changes to its computer systems for compliance with Y2K. Testing of these changes will continue throughout the year to ensure that services will not be interrupted. Please read the Medicaid Provider Bulletins and RA Banner Messages, or visit the web page for the DOM at **www.dom.state.ms.us** for updates on the Y2K initiative.

Disease Management Pharmacist Reminders

Pharmacists billing for Disease Management are required to include the beneficiary's ICD-9-CM diagnosis code when billing a claim (Field #21 on the HCFA-1500 form). Please make sure the ICD-9-CM that you obtain from the referring physician falls within the diagnosis type that is allowed under your specific disease management certification.

If a Disease Management Pharmacist Provider obtains a new certification in any additional disease state(s), a copy of the certification(s) issued by the State Board of Pharmacy should be forwarded to Jack Lee at the Division of Medicaid (fax #601-359-6147).

Viagra Coverage

The prior approval form for Viagra is included on page 5 of this bulletin. Physicians may use photocopies of this form to submit prior approval requests to Medicaid (fax # 601-359-6147).

SILDENAFIL CITRATE (VIAGRA®)
PRIOR AUTHORIZATION REQUEST FORM

FAX OR MAIL TO:
DIVISION OF MEDICAID, PHARMACY PRIOR APPROVAL
229 NORTH LAMAR ST, SUITE 801, JACKSON, MS 39201
FAX # 601-359-6147

Patient's Name:	Prescriber's Name:
Patient's Medicaid #:	Prescriber's Address:
Check one: **Viagra** 25 mg. ☐ 50 mg. ☐ 100 mg. ☐	Prescriber's Medicaid #:
Pharmacy's Name:	Prescriber's Phone #:
Pharmacy's Phone #	Prescriber's FAX #:

Please indicate the medically confirmed etiology, by history **and** physical exam, responsible for erectile dysfunction (impotence).

☐ Spinal cord injury
☐ Diabetic neuropathy
☐ Prostatectomy (radical)
☐ TURP associated neurological damage (irreversible)
☐ Cardiovascular disease (CHD, PVD, HTN)*
☐ Other (specify etiology):_____

***Is this patient using organic nitrates, either regularly and/or intermittently, in any form? yes_____ no_____**

Caution should also be used in prescribing this drug for those with active coronary ischemia, congestive heart failure, borderline low blood pressure, borderline low volume status, retinitis pigmentosa, and those with complicated, multi-drug, antihypertensive programs or taking drugs that may affect the metabolic clearance of sildenafil.

PLEASE NOTE: By signing this form, the prescriber agrees to the best of his/her knowledge that this drug is for this patient's use only. Approval of medical necessity does not guarantee Medicaid eligibility or payment. The pharmacy provider is responsible for verifying Medicaid eligibility and program enrollment (i.e., FFS, PCCM, HMO, etc.).

A physician or other provider who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the ordering prescriber identified above. I certify that the medical necessity information contained herein is true, accurate, and complete to the best of my knowledge. I certify that I am familiar with Viagra package labeling and that this drug is medically necessary for the patient listed above. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution.

Prescriber's Signature: _____ **DATE OF APPLICATION:** _____

(SPACE BELOW FOR MEDICAID USE ONLY)

☐ MEDICAID ELIGIBILITY VERIFIED **P.A. #**_____

☐ Approve request
☐ Deny request
☐ Modify request

Authorization effective dates from _____ through _____ .

_____ _____

Reviewer's Signature Response Date/Hour

Mississippi Medicaid Bulletin

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Jackson, MS 39201-2121

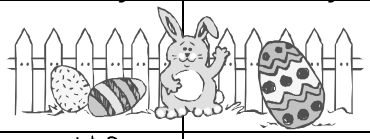
If you have any questions related to the topics in this bulletin, please contact the EDS Correspondence Unit at 1-800-884-3222 or 601-960-2800.

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

April 1999

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1 April Fools ESC Cut-Off 5 pm	2	3
4 Daylight Saving Time Begins	5 Checkwrite	6	7 Home Health Workshops at HSM	8 Home Health Workshops at HSM	9 Home Health Workshops at HSM	10
11	12 Checkwrite	13	14	15 ESC Cut-Off 5 pm	16	17
18	19 Checkwrite	20	21 Remember Secretary's Day!	22 ESC Cut-Off 5 pm	23	24
25	26 Checkwrite	27	28 Hospital Providers Workshop Jackson	29 Hospital Providers Workshop Hattiesburg	30	31

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.