

# Mississippi Medicaid

Volume 5, Issue 12

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## Bulletin

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### Billing for Imitrex and Infergen



**Imitrex kits**, including refill kits, must be billed as a quantity of one (1) for each kit dispensed. The Division of Medicaid does not allow reimbursement for syringes or total milliliters dispensed. All strengths of **Infergen vials and syringes** must be billed for the total milliliters dispensed, not for total syringes or vials dispensed. Pharmacy providers should review

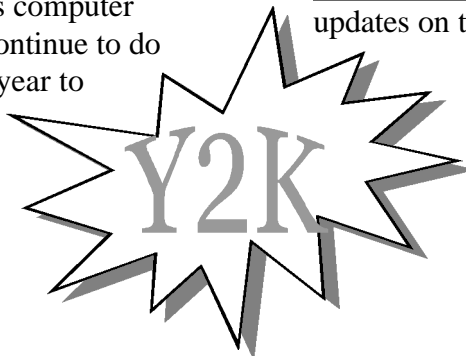
all claims submitted for Imitrex or Infergen and void/adjust any claims that have been billed for the incorrect amounts. Beginning June 7, 1999, claims filed incorrectly for Fiscal Year 1999 not voided/adjusted by the provider will be voided by the Division of Medicaid. It will then be the provider's responsibility to resubmit the corrected claim.

### Y2K Status

The Division of Medicaid (DOM) recently completed its Y2K Medicaid and supporting systems' renovation and implementation.

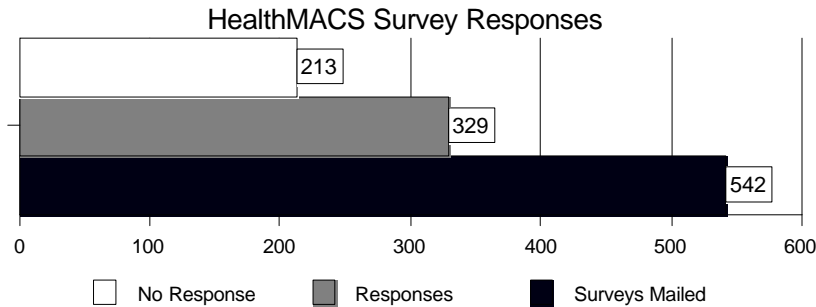
The DOM is currently testing the Y2K changes to its computer systems and will continue to do so throughout the year to

ensure services will not be interrupted during the new millennium. Please read the Medicaid Provider Bulletins and RA Banner Messages, or visit the DOM web page at [www.dom.state.ms.us](http://www.dom.state.ms.us) for updates on the Y2K initiative.

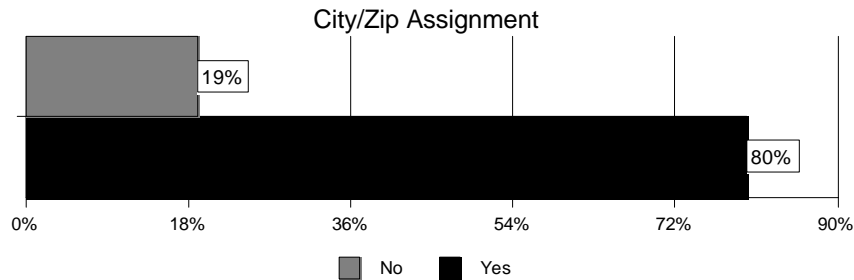


## HealthMACS Survey Results

Last year the Division of Medicaid (DOM), Managed Care Division sent surveys to 542 HealthMACS primary care providers (PCP) in order to elicit input about possible enhancements to the program. PCPs who responded to the survey did not answer all questions. Below are the results of the survey, and the responses by the Division of Medicaid:

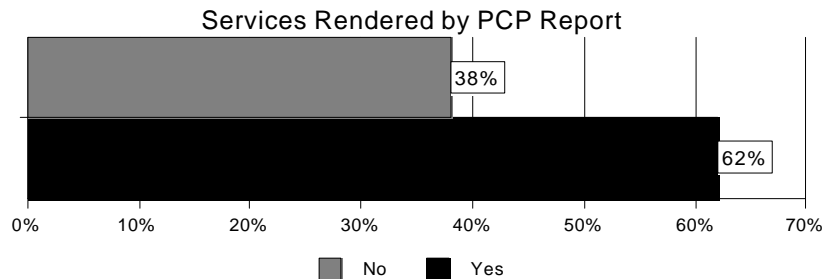


**Question:** Would you like the maximum number of enrollees for the city/zip assignment increased?



**Medicaid Response:** A request has been submitted to make changes to the Medicaid Management Information System (MMIS) to allow a maximum of 35 enrollees to be assigned to PCPs participating in this type of HealthMACS assignment.

**Question:** Would you like to have the “Services Rendered by PCP” report eliminated from the HealthMACS reports you receive?

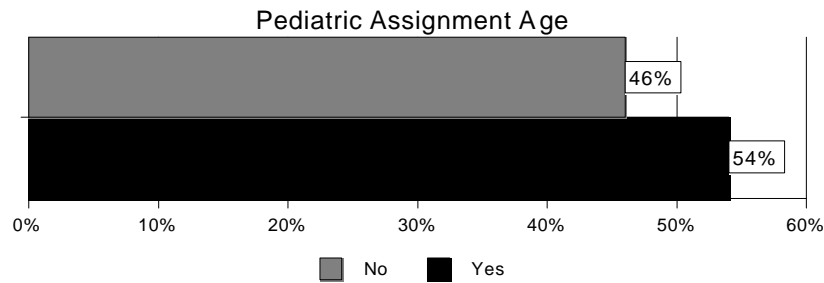


**Medicaid Response:** Plans are being made to discontinue this report from distribution to PCPs each quarter. PCPs will continue to receive the “Services Rendered by Non-PCP” report.

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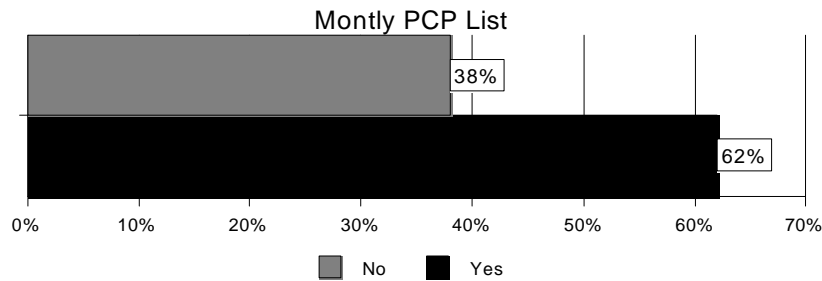
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**Question:** If you are a pediatrician, would you like the maximum age assignment changed from 12 years of age to 18 years of age?



**Medicaid Response:** The Managed Care Division has requested that the Policy Committee consider a request to change HealthMACS policy to allow the age assignment for pediatricians be increased to 18 years of age. If approved by the Policy Committee, changes will be made to the MMIS to allow assignments to pediatricians of children up to age 18. Providers effected by this change will be notified when this change is implemented.

**Question:** If you submit claims electronically, are you interested in having your monthly PCP list and other PCP reports sent to you electronically?



**Medicaid Response:** Changes will be made to the MMIS to allow the monthly PCP list to be received electronically. The change requires extensive systems changes and implementation will take some time. Implementation of this feature will change the date of HealthMACS enrollee assignment to the 25<sup>th</sup> of each month. Providers will be notified prior to this change being implemented.

**Other Questions:**

- \*Would you like more information about participating in the city/zip assignment?
- \*Would you like more information about submitting claims electronically?
- \*Would you like more information about participating in the Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) program and/or the Vaccine for Children (VFC) program?

**Medicaid Response:** The PCPs who indicated an interest have been referred to appropriate staff at DOM or EDS for additional information.

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**Outcome:** The input from the response to the survey is valuable as revisions to the HealthMACS program are considered. DOM thanks the PCPs who responded to the survey and provided comments. The Managed Care Division encourages suggestions for program improvement. The participation of PCPs is essential in making HealthMACS a successful primary care case management program.

If you are interested in participating in HealthMACS as a PCP, please contact the Managed Care Division at (601) 359-6133. If you want other information about HealthMACS, please submit your request in writing to:

Division of Medicaid  
239 North Lamar Street  
Robert E. Lee Building, Suite 801  
Jackson, MS 39201-1399

### **CORRECTION - NECS Software Patch**

The patch for the NECS software for Dental and Pharmacy providers corrects the following errors:

**Dental** - The place of service field, detail line 8 now accepts two (2) digits. This was the only detail line with this problem.

**Pharmacy** - The quantity field now accepts 5.2 (99999.99) rather than 4.2 (9999.99) for all detail lines.

The corrected version of the NECS software is located on the DOM web page at [www.dom.state.ms.us](http://www.dom.state.ms.us) or contact the EDI unit at EDS at 1-800-884-3222.

### **Change in the Number of Therapeutic/Home Leave Days for Nursing Facilities and ICF-MRs**

The Governor recently signed House Bill 57 which passed during the 1999 legislative session. This bill increases the number of therapeutic/home leave days per state fiscal year for both nursing facilities and intermediate care facilities for the mentally retarded (ICF-MRs). The number of therapeutic/home leave days has been increased to 52 days per state fiscal year for residents of nursing facilities. Residents of ICF-MRs are now allowed 84 days per state fiscal year. In addition to those 84 days, ICF-MR residents may be on leave Thanksgiving Day, the day before and after Thanksgiving Day, Christmas Day, and the day before and after Christmas Day.

The Division of Medicaid has prepared an amendment to the State Plan. The amendment allowing these additional days will be effective May 14, 1999 upon approval by the Health Care Financing Administration.

Facilities will be allowed to bill for the additional leave days only for leave days taken on or after May 14, 1999.

## Third Party Liability Casualty Policy Clarification

When treating a Medicaid eligible individual for injuries or illness that may eventually lead to a legal cause of action, the medical provider must decide up front whether to file with Medicaid or to pursue payment through legal settlement. If the decision is to file with Medicaid, the provider is not allowed to accept payment from the legal settlement. Filing with Medicaid shows the provider's intent to accept Medicaid as payment in full. Conversely, if the decision is to take part in the legal settlement, at no time in the future can the provider file with Medicaid for the particular services.

When the provider decides to file with Medicaid and receives a request for medical information from the attorney or third party source, the provider must place three (3) items of information on the medical records submitted:

1) the patient is a Medicaid beneficiary, 2) the Medicaid Identification Number, and 3) the patient's medical bill has been paid by Medicaid or will be billed to Medicaid. The provider must mail a copy of the written request and authorization along with the subpoena, if applicable, to the Division of Medicaid Third Party Liability Unit.

This clarification pertains to the third party liability casualty cases that result in legal cause of action. The Medicaid Provider Manual reference for this policy is chapter 3, sections 3.03 and 3.04.

Please direct any related questions to Mrs. Barbara Rhodes in the Third Party Liability Unit of the Division of Medicaid at (601) 359-6050 or to the EDS Correspondence Unit at (601) 960-2800 or (800) 884-3222.

*This clarification pertains to the third party liability casualty cases that result in legal cause of action.*

## Crossover Part B Form

The new crossover forms introduced in July 1998, are required for any services billed hard copy (paper claims) to Mississippi Medicaid for Medicare services. Minor revisions have been made to the Part B Crossover Form effective 4/1/99. These changes include the elimination of Form Field 1, type of bill, and the elimination of revenue codes in Form Field 9.

It is not necessary to throw away the forms you may have in stock; simply modify your billing to ensure you do not submit the type of bill or revenue codes on a Part B form. The Part A Crossover form should be used when billing services represented by a revenue code.

The latest version is available on the DOM web page at [www.dom.state.ms.us](http://www.dom.state.ms.us).



**If you have any questions regarding any information in this bulletin, please contact the EDS Correspondence unit at 1-800-884-3222.**

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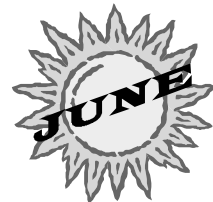
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111 East Capitol, Suite 400  
Jackson, MS 39201-2121



*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.*

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[www.dom.state.ms.us](http://www.dom.state.ms.us)

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Fax EDS Publications at 601-960-2807, or e-mail [publications@msix.hcg.eds.com](mailto:publications@msix.hcg.eds.com).



## JUNE 1999

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3 ESC Cut-Off 5 pm	4	5
6	7 Checkwrite	8	9	10 ESC Cut-Off 5 pm	11	12
13	 Flag Day Checkwrite	15	16	17 ESC Cut-Off 5 pm	18	19
20 Father's Day	 Summer Begins Checkwrite	22	23	24 ESC Cut-Off 5 pm	25	26
27	28 Checkwrite	29	30			

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.