Mississippi Medicaid Bulletin

March 2000 *Volume 6, Issue 9*

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Long Term Care Alternatives Program

Since the inception of the Long Term Care Alternatives Program on November 1, 1999, the Division of Medicaid (DOM) has received over 700 DOM 260 NF forms to be processed. Our social workers across the state report that they are helping "get the word out" about alternatives to nursing home placement, and are having a good response. However, many times the DOM 260 NF form is incomplete when received at the Division of Medicaid. Prior to faxing the DOM 260 NF form to DOM, please ensure that all items on the form are filled out and there are no blank fields. Also, we often have difficulty reaching the sender for additional information when needed because there was no cover sheet. Please always include a cover sheet with the facility's name, location and phone number. All forms should be faxed to the Division of Medicaid, Long Term Care Alternatives Division, at 601-359-1383. If you need additional information about this program, please call 601-359-4283 or visit our web page at www.dom.state.ms.us.

HealthMACS Authorization Numbers are 7 Digits

HealthMACS authorization numbers are 7 digit numbers. The Managed Care Bureau has determined that some HealthMACS claims may have denied because the HealthMACS authorization numbers submitted on the claims were 11 digit numbers. In 1995, the HealthMACS authorization number was changed from an 11 digit number to a 7 digit number. Providers who are still submitting claims with four extra zeros in addition to the 7 digit authorization number may have claims deny with a HealthMACS error, **even when the HealthMACS authorization number is correct**. Only the 7 digit HealthMACS authorization number should be entered in the appropriate HealthMACS authorization fields regardless of whether the claim is submitted electronically or on paper. The HealthMACS authorization fields should **not** contain any slashes, dashes, notations, etc. For more information regarding the HealthMACS program, please contact your Managed Care Specialist at 601-359-6133 or 1-800-421-2408, extension 6133.

MISSISSIPPI DIVISION OF MEDICAID

New Eligibility Office for Rankin and Simpson Counties

The Division of Medicaid, Eligibility Bureau has opened its 25th Regional Office in Brandon, which will serve as a satellite office for the Jackson Regional Office. The Brandon office will handle Rankin county & Simpson county cases while the Jackson office handles Hinds county & Madison county cases.

The new address is:

Brandon Regional Office
1647 W. Government Street
Brandon, MS 39042
Telephone: 601-825-0477
Fax: 825-2184

Working Disabled

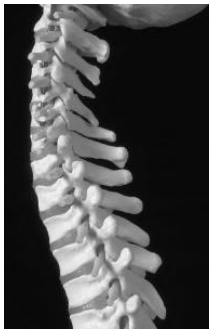
Working disabled individuals who do receive "unearned" income such as disability or pension benefits cannot receive more than the SSI limits of $512 or $769, depending on marital status.

The Division of Medicaid implemented a new eligibility category for the working disabled that was effective July 1, 1999. This new group allows Medicaid coverage for disabled working individuals who, because of relatively high earnings, cannot otherwise qualify for Medicaid. The earnings limit is set at 250% of the federal poverty level which translates to gross annual earnings of $41,988 for an individual and $56,100 for a couple. In order to qualify, an individual (single or married) must be working and earning more than $500 per month but less than the 250% cap. The worker must also be disabled according to SSI criteria, but there is no requirement for the individual to have ever applied for SSI or for their Social Security disability or pension benefits. Working disabled individuals who do receive "unearned" income such as disability or pension benefits cannot receive more than the SSI limits of $512 or $769, depending on marital status. There is a monthly premium to "buy-in" to Medicaid for eligible workers with countable earnings above 150% of poverty.

Individuals who meet the criteria of disabled and working with earnings less than the 250% limit should be referred to the Medicaid Regional Office that serves the county where the individual lives or contact 1-800-421-2408 and ask for the Eligibility Bureau for additional information.

Medicaid no longer requires that chiropractic x-ray services be billed to Medicare when services are rendered to a Medicare/Medicaid eligible beneficiary.

Chiropractor X-ray Billing on Medicare/Medicaid Beneficiaries



Medicaid no longer requires that chiropractic x-ray services be billed to Medicare when services are rendered to a Medicare/Medicaid eligible beneficiary. Since Medicare does not cover these services, the provider may bill Medicaid directly on a HCFA-1500 claim form. The applicable codes are 72010, 72070, 72100, 72040, 72080.

Billing for Radiation Therapy

CPT codes 77419, 77420, 77425, and 77430 have been deleted from CPT 2000 and have been replaced with the new CPT code 77427. The description for this code is "Radiation treatment management, 5 treatments."

CPT codes 77419, 77420, 77425, and 77430 have been deleted from CPT 2000 and have been replaced with the new CPT code 77427.

CPT code 77427 is effective as of January 1, 2000. CPT Codes 77419, 77420, 77425, and 77430 will not be accepted after March 31, 2000.

For Mississippi Medicaid purposes, radiologists must continue to bill one unit for one daily treatment. If two treatments are performed on the same day, the radiologist may bill for two units. The Medicaid allowance is calculated to provide a per treatment payment rather than a weekly payment.

2000 CPT Codes

The additions, changes, and deletions to the 2000 CPT codes were loaded into the Medicaid Management Information System (MMIS) on February 6, 2000. The new codes are effective for dates of service beginning January 1, 2000. The discontinued CPT codes will not be accepted after March 31, 2000.

Balance Billing for Cross-Over Coinsurance

As a reminder, it is not permissible to bill a Medicare/Medicaid beneficiary the difference between the total of billed charges not covered by Medicare and Medicaid payments. Federal Regulations state that the combination of payments from Medicare and Medicaid are to be considered payment in full.

Diagnosis Limitations on HCFA-1500

As stated in the Mississippi Medicaid Provider Bulletin, Special Issue dated November 19, 1996, when filing the HCFA-1500 claim form, only primary and secondary diagnoses (Items 21-1 and 21-2) are to be reported. Each detail line in item 24 must reference the most appropriate diagnosis code, either primary or secondary, but not both. No more than two diagnosis codes may be reported on a HCFA-1500 claim form. Additional diagnosis lines must be billed on a separate claim form with the associated detail lines.

No more than two diagnosis codes may be reported on a HCFA-1500 claim form.

Physician Visit Limit

This is a reminder that psychiatric procedures (90801-90899) count toward the physician office visit limit and additional psychiatric procedures (90801-90899) will not be reimbursed after a beneficiary has met the 12 physician visit limit.

Mississippi Medicaid Bulletin

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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

March 2000

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2 ESC Cut-Off 5 pm	3	4
5	6 Checkwrite	7	8	9 ESC Cut-Off 5 pm	10	11
12	13 Checkwrite	14	15	16 ESC Cut-Off 5 pm	17	18
19	20 Checkwrite	21	22	23 ESC Cut-Off 5 pm	24	25
26	27 Checkwrite	28	29	30 ESC Cut-Off 5 pm	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.