Mississippi Medicaid Bulletin

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Mississippi Medicaid Coverage Criteria for LPN Care of Ventilator Dependent Patients in the Home Setting

Private duty nursing agencies accepting referrals for ventilator dependent patients must be able to provide care at either the RN or LPN level and maintain a sufficient staffing pattern for full service.

Private duty nursing agencies must assume all responsibility for compliance with the regulation of the Board of Nursing including special training or certification requirements for caring for ventilator dependent patients.

Private duty nursing agencies employing LPN's to care for ventilator dependent patients in the home setting must maintain the following documentation in the employee record:

1. Documented experience in caring for ventilator dependent patients (For example, ICU experience).

2. Verification of the above through copies of certificates, work history, etc.

3. Verification that the employee assigned to the ventilator dependent patient has received inservice by the RN Supervisor, a respiratory therapist, an authorized representative of the supplier or manufacturer of the ventilator, or through a hospital training program.

4. Documentation of RN oversight which includes:

   A. Written plan of oversight duties to monitor quality of care and documentation that verifies the oversight activity.

   B. Written plan of oversight duties to monitor service delivery in the home setting and documentation which verifies the oversight activity.

Mississippi Medicaid benefits will be reimbursed at the level of care approved by the Peer Review Organization. Should benefits be approved for services at the LPN level, and at the discretion of the agency, an RN is assigned to the case, Medicaid benefits will only be provided at the LPN payment schedule.

This policy is effective June 1, 2000.

MISSISSIPPI DIVISION OF MEDICAID

Meridia Coverage

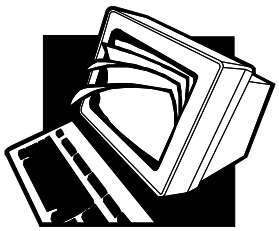
Effective March 22, 2000, Medicaid began reimbursing pharmacy providers for all strengths of the drug Meridia. Prescriptions are limited to a thirty-four (34) day supply. There are no prior approval requirements.

When billing for multiple surgical procedures performed during the same surgical session, providers must bill all procedures on the same HCFA-1500 claim rather than splitting the procedures on separate claims.

Multiple Surgical Procedures Performed During the Same Surgical Session

When billing for multiple surgical procedures performed during the same surgical session, CPT Codes 10000 through 69999, providers must bill all procedures on the same HCFA-1500 claim rather than splitting the procedures on separate claims. The only exception is if the numbers of procedures exceed the limit of lines that can be reported on the HCFA-1500 form. The Division of Medicaid multiple surgery policy applies to multiple procedures performed during the same surgical session. Billing all procedures on the same claim reduces the potential for overpayments and refund requests.

Mississippi Crossover Claim Forms



Download from the Mississippi Medicaid website www.dom.state.ms.us

Providers are required to use current Mississippi Crossover Claim Forms when submitting claims for Medicare beneficiaries that did not crossover electronically to Mississippi Medicaid. You may obtain these forms from EDS or access them on the Division of Medicaid website at www.dom.state.us.ms. Please note that the Medicare Part A Mississippi Crossover Claim Form was revised 7/1/98 and the Medicare Part B Mississippi Crossover Claim Form was revised 4/1/99. All other crossover claim forms are obsolete.

Remember that each Mississippi Crossover Claim Form must have a Medicare EOB attached. Crossover claim forms submitted without a separate attachment will be returned to the provider.

Mississippi Medicaid Website

If you are interested in acquiring Mississippi Medicaid publications, please visit the Division of Medicaid website at www.dom.state.ms.us. Once you are at the site you can click on **provider** allowing you access to bulletins, manuals, fee schedules, Crossover Part A and Part B forms with instructions, Prescribing Provider listings, and Provider Enrollment Applications.

Those interested in billing claims electronically may download the free NECS software by following the directions on the website.

Updating hospice policy and reimbursement methods

Hospice Policy and Reimbursement Methods

The Division of Medicaid is currently in the process of updating hospice policy and reimbursement methods to more closely follow Medicare guidelines. Please watch bulletins closely for additional information. DOM will hold provider workshops as well as send out individual letters to hospice providers to inform them of all changes.

Reimbursement for Corneal Tissue in Ambulatory Surgical Centers

The Division of Medicaid is now reimbursing ambulatory surgical facilities for the cost of corneal tissue used in corneal transplant cases.

Effective April 15, 2000, the Division of Medicaid began reimbursing ambulatory surgical facilities for the cost of corneal tissue used in corneal transplant cases. The reimbursement is 100% of the cost reflected on the invoice from the donor supplier excluding transportation fees. **Transportation fees are not covered under the Mississippi Medicaid program.**

Ambulatory surgical facilities may bill for the cost of corneal tissue by (1) filing a hard copy HCFA-1500, (2) assigning HCPCS code V2785 for the corneal tissue, and (3) attaching an invoice from the donor supplier which lists both the tissue cost and the transportation fees. If an invoice is received without the transportation fees listed, the claim will be denied until an invoice is received with the itemization. The fee for the corneal tissue **must be included** on the same HCFA-1500 claim form as the fees for the corneal transplant.

This policy is applicable only to ambulatory surgical facilities.

Health Insurance Portability and Accountability Act (HIPAA)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) contain a number of requirements that will improve and simplify the administrative demands on providers of health care. Although use of electronic health care transactions has grown significantly, especially for Medicaid, providers have complained that different health plans have different format requirements for transactions. Even when the same format is accepted by multiple plans, those plans usually have different coding or other completion requirements for the formats. This forces providers to respond to the separate requirements of each plan if the providers want to be able to interact electronically with those plans for billing, payment, eligibility, claim status query, and a number of other health care transactions. This is inefficient, expensive, and confusing.

HIPAA will remedy those complaints. Providers who submit electronic claims transactions will recognize the benefits of HIPAA within the next few years. As this may have significant impact on provider operations and planning for billing/practice management systems, Medicaid plans a series of educational efforts to furnish providers the information needed to make informed choices. In addition, information will also be shared with professional associations, their publications, and national media to publicize the impact of these changes.

HIPAA Administrative Simplification Summary Background

HIPAA requires that the Secretary of the Department of Health and Human Services adopt standards for electronic transactions and data elements for those transactions, standard code sets to be used in the transactions, unique health identifiers, and security standards and safeguards for electronic information systems involved in those transactions. This article is limited to information on the HIPAA transaction standards. Unique health identifiers, standard code set, and security issues will be addressed in later updates.

The following health care transaction standards are specified:

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H *Health*

I *Insurance*

P *Portability*

A *Accountability*

A *Act*

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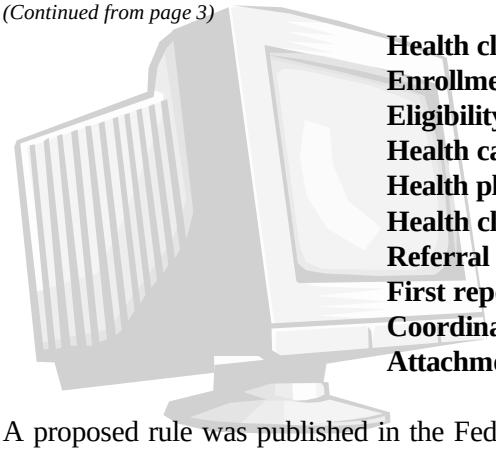

Health claims or equivalent encounter information;
Enrollment and disenrollment in a health plan;
Eligibility for a health plan;
Health care payment and remittance advice;
Health plan premium payments;
Health claim status;
Referral certification and authorization;
First report of injury;
Coordination of benefits; and
Attachments

A proposed rule was published in the Federal Register on May 7, 1998. It proposed the adoption of version 4010 of the X12N standards for each of the transactions as well as the National Council for Prescription Drug Program (NCPDP) standards for retail pharmacy transactions.

Those X12N standards are the 837 (claims, encounters, and coordination of benefits), 834 (enrollment and disenrollment), 270/271 (eligibility, query and response), 835 (payment and remittance advice), 820 (premium payments), 276/277 (claim status inquiry and response), and 278 (referral certification and authorization). Publication of the final rule for those transactions is expected later this year. The attachments transactions proposed rule is also expected to be published later this year. A first report of injury transaction proposed rule will be published when an industry consensus standard emerges. Although the NCPDP standards are for real time and batch transactions, Medicaid is not required to support other real time health care transactions at this time. Medicaid agencies are not precluded from offering real time and direct data entry (DDE) after implementation of the Administrative Simplification transaction standards, as long as the real time transactions meet the format and content requirements of the Administrative Simplification standards.

HIPAA requires that the adopted standards be implemented by virtually all health plans in the United States (including, but not limited to, Medicare and Medicaid), and health care clearinghouses. This includes any plan that performs the business function related to each standard transaction regardless if that function is performed electronically, in paper form, by telephone or in another mode, and by providers of health care that transmit any of these transactions electronically. Providers that exchange any of these transactions electronically with health plans must either transfer transactions that comply with the implementation guides adopted in the final rule or contract with a clearinghouse to translate their transactions into or from the standard formats. If a provider chooses to contract with a clearinghouse for these translation services, the provider is responsible for the clearinghouse charges and the accuracy of the translations performed by that clearinghouse. Likewise, health plans that conduct these transactions electronically must be able to receive and send standard transactions that comply with the requirements in the published implementation guides. Effective with implementation of these standard transaction formats, a plan may not require an exchange of electronic transactions of these types in any other format. Nor may a provider or a plan use a trading partner agreement to override, substitute or otherwise change any requirement or condition of use of any part of an implementation guide for standard transactions.

A health plan that is unable to directly exchange electronic transactions in a standard format can contract with a clearinghouse to translate incoming and outgoing transactions to comply with the standard format requirements. If a health plan chooses this option, it cannot charge providers or other clearinghouses that choose to use the standards for those translation costs. Nor may a plan delay or disadvantage processing of transactions that are submitted or issued in a standard format.

HIPAA does **not** require that providers submit claims or receive remittance advices electronically. Nor does HIPAA require that providers submit electronic queries and receive electronic responses for claim status and eligibility. Providers may continue to make mail and telephone inquiries if they prefer unless they have trading partner agreements that require

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otherwise. HIPAA does make it easier and more cost-effective to use electronic transactions with the expectation that these improvements will result in greater use of electronic data interchange (EDI). Medicaid may continue to issue free billing software that can be used by providers to electronically bill Medicaid. HIPAA requires that the transaction standards be implemented by most health plans and "electronic" providers within two years of the effective date of publication of the final rule in the Federal Register. Certain "small" health plans will be allowed three years for implementation.

What This Means for Providers

Once the transaction standards are implemented nationally, a provider will be able to submit the same transaction in the same format to any health plan. Likewise, an "electronic" provider will receive transactions of these types from any plan in the same format. This will make it more cost-effective for most health care providers to use software to automatically produce standard transactions to send to plans and to automatically post data directly to accounts receivable. HIPAA will reduce the need for manual processing in the day-to-day processing of patient account information.

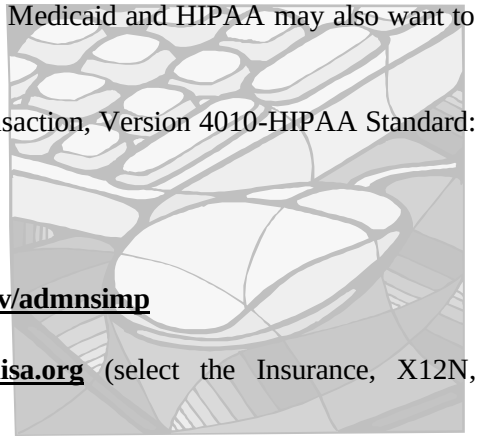
Many providers and plans may need to make significant changes to realize the benefits of HIPAA. Once the HIPAA transaction standards are fully implemented, Medicaid will no longer be able to accept flat-file electronic proprietary Medicaid, UB-92, or National Standard Format (NSF) transactions for claims. Nor will Medicaid be permitted to issue any electronic remittance advice in non-HIPAA format, or exchange any electronic transactions of the type specified by HIPAA, such as eligibility queries/responses, in any version not adopted as a national standard in the transaction and code set final rule.

Providers who currently use a health care clearinghouse to translate outgoing or incoming electronic transactions may continue to use a health care clearinghouse to translate nonstandard transactions into the HIPAA standard transactions or to translate standard transactions into nonstandard transactions. If a clearinghouse is not used, a choice must be made as to whether to install software that can send and receive in the HIPAA transaction standard or contract with a clearinghouse for this service.

Providers that do not currently transmit by electronic means some or any of the transactions affected by HIPAA should re-examine the cost-effectiveness of beginning to use or expanding their use of Electronic Data Interchange. EDI staff can provide information about the advantages of EDI, requirements for EDI, vendors that may be able to help providers become EDI capable, and on the impact of the HIPAA transaction standards. EDI operators at EDS are available weekdays from 9:00 a.m. to 5:00 p.m. at 1-800-884-3222 or 601-960-2800.

How to Get More Information

Medicaid will issue additional information to providers regarding the HIPAA transaction standards as the final rules are published. Providers that would like to obtain more information about EDI under Medicaid and HIPAA may also want to consult the following Web sites:



Map of Medicare National Standard Format to X12 837 Professional Claim Transaction, Version 4010-HIPAA Standard: **www.hcfa.gov/medicare/edi/hipaadoc.htm**

X12N version 4010 transaction implementation guides: **www.wpc-edi.com**

Text of Administrative Simplification law and regulations: **www.aspe.os.dhhs.gov/admnsimp**

X12N meeting and workgroup meeting information and minutes: **www.disa.org** (select the Insurance, X12N, Subcommittee within ASC X12).

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

EDS

May 2000

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
14 Mother's Day	15 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	29 Checkwrite DOM, EDS, and HSM closed for Memorial Day	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.