Mississippi Medicaid Bulletin

Volume 7, Issue 1

July 2000

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Due to the Division of Medicaid being closed the 3rd and 4th of July, bank deposits will be delayed until July 7th.

Changing Banking Information

If you are changing the bank account in which your Mississippi Medicaid Electronic Funds Transfer (EFT) reimbursements are deposited, there are two (2) things that must be taken care of to ensure successful transfer.

First, you must notify the EDS Provider Enrollment Department. Notification must be in writing and signed by the person who is authorized to change your bank account. Notification must contain all pertinent banking information such as the name of the banking institution; the bank's ABA/routing number, and the bank account number. In addition, you must send a copy of a voided check or deposit coupon to verify the accuracy of the information. Please send notification and corresponding information to the following address:

EDS Provider Enrollment Department
111 E. Capitol Street
Suite 400
Jackson, MS 39201

Second, all changes made to your banking information will result in a paper check being issued and mailed to your pay-to address for approximately 2 to 3 weeks. This timeframe is necessary to allow EDS to electronically send test transactions to your bank to validate that your bank account number and ABA/routing number information are correct. Once the testing is completed, you will receive your Mississippi Medicaid reimbursement electronically.

Keep in mind that changes at your bank that result in changes to your bank account number or ABA/routing number may also result in the need for EDS to re-validate that your bank account information is correct. As a result, a paper check will be issued and mailed to your pay-to address for approximately 2 to 3 weeks. Again, once the testing is completed, you will receive your Mississippi Medicaid reimbursement electronically.

It is important to remember that you must notify the EDS Provider Enrollment Department in writing of all pertinent changes in order to accurately maintain your provider file information.

If you have questions, please contact the EDS Provider Enrollment Department at (601) 960–2800 or (800) 884–3222.

MISSISSIPPI DIVISION OF MEDICAID

Ambulance Providers

An analysis of ambulance claims submitted since distribution of the Division of Medicaid (DOM) ambulance policy effective July 1, 1998 shows that mileage codes have been consistently submitted without valid base procedure codes.

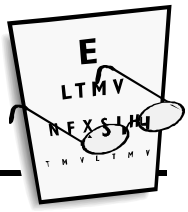
According to the policy, the initial 25 patient -loaded miles of ambulance transports are always included in the base code and rate. Ambulance providers must bill the appropriate mileage code with the base code beginning with the 26th patient-loaded mile. If a mileage code is submitted on a claim without a valid base code, the claim will deny with Edit 111.

If you have any questions, please contact Stephanie Parrish or Margie Mayes at 601-359-6150.

Ambulance Providers must always bill mileage with a base code. All claims submitted without a base code will deny.

Adult Eyeglass Services

Effective July 1, 2000, the Division of Medicaid will reimburse for one pair of eyeglasses for adults e very three years. Corrective lenses must be prescribed by an ophthalmologist or optometrist. This benefit is in addition to eyeglasses that are prescribed following eye surgery. **During the transition from no benefits to the current benefit limits, a prior authorization (PA) process will be required. Providers will be notified within the next 3-6 months when a PA is no longer required.** For more information, please call Jeanette Williams/Maternal Child Health at 1 -800-421-2408 or 601-359-6138.



HealthMACS Meetings

Managed care staff from the Division of Medicaid and EDS will be conducting HealthMACS meetings during the month of August. **Medicaid Managed Care staff will present significant policy changes to the HealthMACS program that will go into effect September 1, 2000.** Beneficiary education specialists will discuss the importance of beneficiary education and the ne w Mississippi Health Benefits program also known as CHIP. After the discussion, staff will be available to answer your questions and address your concerns about HealthMACS. Sessions will begin at 9:30 a.m. at the following locations.

August 2 at the Ramad a Inn Southwest
Conference Center
1525 Ellis Avenue
Jackson, Mississippi

August 3 at the Holiday Inn Northeast
111 US Hwy 11 at US Hwy 80
Meridian, Mississippi

August 8 at the Biloxi Beach Resort
2736 Beach Boulevard
Biloxi, Mississip pi

August 9 at the Hattiesburg Lake Terrace
Convention Center
One Convention Center Plaza
Hattiesburg, Mississippi

These meetings are open to all providers. Primary care providers and hospitals are especially encouraged to have representatives at any one of these me etings. Other times and sites will be available and listed in the August Medicaid Bulletin. If you have any questions please con tact the Managed Care Hotline at 1 -800-627-8488 or the Division of Medicaid Managed Care Division at 1 -800-421-2408.

Third Party Liability Reminders

When an individual is insured under any other private or public insurance plan, in order to be eligible for Medicaid, that person must assign his/her rights to the third party source to the Division of Medicaid. The medical provider, for most services, must file with the third party source and receive payment or denial prior to filing with Medicaid. It is a mandate of federal and state law that, for most services, Medicaid funds be expended only after the liability of the primary payers are utilized.

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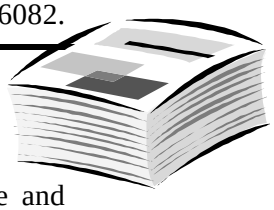
Per federal law, the exceptions to the mandate to file with the third party source prior to filing with Medicaid are prenatal, preventive pediatrics, and services rendered to a child who has medical support that has been obtained through the Child Support Enforcement Agency. Also, Mississippi Medicaid has an approved federal waiver to pay pharmacy claims and seek recovery from the third party source.

Further, in casualty cases involving the treatment of injuries or illness arising out of vehicular collision, industrial accident, products or malpractice-type cases, etc., in which collection from the third party source may involve legal action, the medical provider must decide at the time of treatment whether to file with Medicaid or to take part in any later legal settlement. When the claim is filed with Medicaid, the provider is then required to accept Medicaid as payment in full. He/she cannot at a later date refund Medicaid's payment and receive payment from the legal settlement.

See chapter 3 of the Provider Manual for more detailed explanations of third party liability-related requirements in the Medicaid program.

If it is determined by the provider that the third party source contained in the Medicaid claims payment system is no longer in effect, verification of this information can be sent by FAX to the Division's Third Party Liability Unit at (601) 359-6632 or it can be given by telephone to Mrs. Darlene Branson at (601) 359-6082.

Non-Emergency Transportation (NET) Group Providers Submit Claims Directly to EDS



Beginning September 1, 2000, all NET group providers will be required to submit their claims directly to EDS for payment. The Division of Medicaid held training sessions and explained the new claims process.

Providers must submit their HCFA-1500 claims to EDS either electronically or by paper. Electronic submission is the preferable format. EDS provides NECS software needed to submit claims electronically at no cost to the provider. Medicaid NET Coordinators will still arrange and approve transportation requests for group providers as they have done in the past. However, NET group providers should submit their claims directly to EDS only *after* the NET Coordinator has approved the transport. After the claim has been processed, EDS will generate the remittance advice directly to the group provider.

For questions, please call Sharon Terry-Daniels at 601-987-6875 or Linda McCune at 601-987-6876.

Psychiatric Therapeutic Procedures

Effective July 1, 2000, psychiatric therapeutic procedures (CPT codes 90801-90865) do not count toward the physician office visit limit. This applies to private practitioners and clinics. When the physician office visit limit is exhausted, these procedures will continue to be reimbursed by Medicaid. However, service limits will be developed and set for psychiatric therapeutic procedures. When service limits become effective, providers will be notified in the provider bulletin.

Internal Control Numbers and Timely Claims Filing

An Internal Control Number (ICN) is assigned to each Medicaid claim that is submitted to the fiscal agent for processing. The ICN contains information that is useful to providers, the fiscal agent, and the Division of Medicaid (DOM). One of the most important uses of the ICN is that it tells the date the claim was originally filed. This is important as DOM will not pay straight Medicaid claims with dates of service over one (1) year.

Any time a claim is resubmitted, it is important to put the original ICN on the claim. If a claim is resubmitted after one year from the date of service, it must have an ICN indicating the original date the claim was received by the fiscal agent. The ICN is available to providers on the remittance advice (RA) that gives information about why a claim denied. It is recommended that you put the ICN in the upper right corner of the claim and highlight it. Using the ICN can prevent a claim from denying because of timely filing or duplicate claim.

The ICN consists of 13 digits that provide information regarding when the claim was received. Each digit of the ICN has meaning as shown below.

Y D D D M B B B P P P (L L)

Y = The last digit of the year in which the claim was received by the fiscal agent, i.e., 2000 = 0.

D = The Julian calendar day the claim was received by the fiscal agent, i.e., July 15 = 197.

M = The media code which denotes the manner in which the claim is filed with the fiscal agent.

- 0 = paper claim
- 1 = electronic claim
- 2 = paper with attachment
- 3 = point of sale (pharmacy)
- 4 = special batch (paper - done internally)
- 5 = RTD sent back from provider
- 6 = internal special run (mass adjustment)
- 9 = internal special run (recovery/systematic reprocess)

When resubmitting claims, using the ICN can prevent a claim from denying because of timely filing.

B = The internal batch number.

P = the page number within the batch.

L = The line number from the claim form/transmission.

HIPAA Update

Frequently Asked Questions About Administrative Simplification

The purpose of Administrative Simplification is to improve the efficiency and effectiveness of the health care system by standardizing the electronic data interchange of certain administrative and financial transactions while protecting the security and privacy of the transmitted information. *Administrative Simplification* (AS) provisions were passed into law as part of Public Law 104-191 on August 21, 1996 by the signing of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which amended Title XI of the Social Security Act by adding Part C - Administrative Simplification (42 U.S.C. 1329d). During the upcoming months, there will be bulletin articles regarding questions that have been raised about the interpretation and implementation of these AS provisions.

NOTE: This information was taken from the Health Care Financing Administration's web site at **www.hcfa.gov** .

(Continued on page 5)

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Who must comply?

The HIPAA law was passed at the request of the health care industry, and the standards to be adopted by the Secretary apply to the whole industry, not just Medicare and Medicaid.

All health plans, all payers, and all clearinghouses that process health data must comply. This is not optional. It applies for every transaction that these organizations conduct for which such a standard has been adopted. Health plans, payers, and clearinghouses must be able to send or receive the designated transactions in standard electronic form no later than 24 months after the standard is adopted by the Secretary (36 months for small plans). Health plans and payers that cannot perform these standard electronic transactions may comply by contracting with a clearinghouse to perform them. However, the responsibility for compliance remains with the primary entity.

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All health care providers who elect to conduct these specific transactions electronically must conduct them according to the standards as well. Health care providers may also contract with a clearinghouse to conduct standard transactions for them.

When employers act in the roles of a health plan or a health care provider, they too must comply with the standards and may contract with a clearinghouse or third party administrator (TPA) to conduct the standard transactions for them.

Health plans may not refuse to accept standard transactions submitted electronically (on their own or through clearinghouses). Further, health plans may not delay payment because the transactions are submitted electronically in compliance with the standards.

There are a few exceptions:

Non-standard transactions. The standards for the designated transactions apply when those transactions are transmitted electronically, but not to transactions conducted by paper, telephone or personal interactive systems. Specific programs such as Medicare may elect to extend the standard requirements to paper-based transactions, but this is not required by HIPAA.

Transmissions within corporate entities. Clearly, electronic transmission of any of the specified transactions **between** corporate entities must comply with the standards adopted by the Secretary. However, transmissions of these transactions **within** a corporate entity are not required to comply with the standards. For example, a hospital that is wholly owned by a managed care company would not have to use the standards to pass encounter information back to the home office, but it would have to use the standard claim transaction to submit a claim to another payer.

Small health plans. HIPAA gives small health plans 36 months from the date of adoption of a standard to come into compliance. We are proposing to define a small plan as one with fewer than 50 participants.

Workers Compensation. The HIPAA definition of a health plan does not specifically include Workers Compensation programs or carriers. However, the list of designated transactions for which the Secretary must adopt standards for electronic transmission includes "First Report of Injury" which is the primary transaction used to initiate Workers Compensation actions. For this reason, the Secretary will be proposing a standard for First Report of Injury and will be considering different ways of achieving compliance with this standard.

Health Plan Sponsors. Health plan sponsors, including employers when they act in the role of a sponsor, are not covered explicitly by the law but may benefit from the adoption of standards and electronic transactions. Sponsors may elect to use standard enrollment, disenrollment, and premium payment transactions, which must be accepted by all health plans when submitted electronically. Market forces may move health plans to require sponsors to use the standards for electronic transactions, although this is not mandated by the law.

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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

July 2000

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				**July 1, 2000** • Therapeutic procedure codes do not count toward physician office visits. • The Division of Medicaid will reimburse for 1 pair of eyeglasses for adults every 3 years.		1
2	3 DOM, EDS and HSM closed for the 4th of July Holiday Checkwrite	4 DOM, EDS and HSM closed for the 4th of July Holiday	5	6 ESC Cut-Off 5 pm	7	8
9	10 Checkwrite	11	12	13 ESC Cut-Off 5 pm	14	15
16	17 Checkwrite	18	19	20 ESC Cut-Off 5 pm	21	22
23 30	24 31 Checkwrite	25	26	27 ESC Cut-Off 5 pm	28	29

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.