Mississippi Medicaid Bulletin

Volume 7, Issue 2

August 2000

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Provider Enrollment Information
Social Security Numbers vs. Employer Identification Numbers

When an individual Medicaid provider number is assigned, it is entered into the Medicaid system with that provider's social security number (SSN) assigned to it. If this number is used as a Medicaid billing provider number, income or earnings information is reported to the IRS for this SSN. **All physicians, nurse practitioners, CRNAs, nurse midwives, dentists, psychologists, chiropractors, podiatrists, occupational therapists, physical therapists, speech/language therapists, and social workers must have an individual Medicaid provider number.** There may be restrictions on whether or not some of the providers can bill Medicaid as a billing provider, but any services rendered by these types of providers must indicate the providers as servicing providers.

Example: John Doe, MD, has an individual Medicaid provider number, and he wants to use this number as both the servicing provider number and the billing number; the Division of Medicaid (DOM) will report all Medicaid income/ earnings to the IRS on his SSN. The only Medicaid application needed is for John Doe, MD.

In order for income or earnings information to be reported to the IRS using an employer tax ID number (EIN), that entity to which the EIN is assigned must be a Medicaid group provider. This may be a sole proprietorship, an incorporated individual, other incorporated entity, partnership, etc. DOM refers to this as a group number even when there is only one individual affiliated with the "group." The Medicaid provider number for this entity is entered into the Medicaid system with the EIN assigned to it. All services billed using this group provider number must indicate an individual Medicaid servicing provider number. All income or earnings information for the group provider number is reported to the IRS for this EIN.

Example: John Doe, MD, owns Doe Medical Center. The EIN is issued to Doe Medical Center. An application must be submitted for a group number for Doe Medical Center. The group application should be completed to indicate that Dr. Doe is affiliated with Doe Medical Center. Dr. Doe must submit an application for

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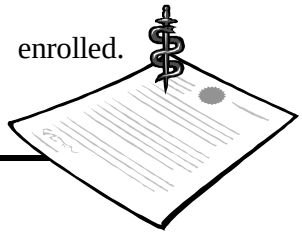
an individual Medicaid provider number for himself. He will indicate on his application that he is affiliated with Doe Medical Center. Doe Medical Center will bill claims indicating Dr. Doe as the servicing provider. Billing in this manner allows monies earned for services provided by Dr. Doe to be reported on the EIN of Doe Medical Center. However, if Dr. Doe bills claims using only his individual provider number, these monies will be reported on Dr. Doe's SSN.

Effective September 2000, DOM will begin contacting Medicaid providers who are incorrectly enrolled. These providers must complete new Medicaid provider enrollment packets



Physician Fees Updated

In accordance with House Bill 1332, passed during the 1999 Legislative Session, effective July 1, 1999, the Division of Medicaid has updated the physician fees as of July 1, 2000, in compliance with the following language that requires that these fees be adjusted annually:

"All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the adjusted Medicare payment established on January 1, 1994."

Case-Mix Master Roster Report Changes

Effective the third quarter, 2000 DOM will send only two case-mix interim roster reports to each nursing facility prior to the close of each quarter.

The first interim roster report will be mailed on or around the fifteenth day of the last month of the quarter, and the second interim roster report will be mailed on or around the fifteenth day of the month following the end of the quarter. For third quarter 2000, the first interim roster will be mailed on or around September 15, and the second interim roster will be mailed on or around October 15. The third quarter will not close until November 5, allowing the facility approximately three weeks to submit any additional data that impacts the quarter and was not included on the second interim roster report. If you have any questions concerning this change, contact the Case Mix Help Line at 601-359-5191.

Hospice Workshop Scheduled

A hospice provider workshop/training session has been scheduled by the Division of Medicaid to be held on September 12, 2000, at the Department of Education (old Central High School) auditorium in Jackson. The workshop will begin promptly at 9 am and continue until approximately 3 pm, with a break for lunch included. This workshop will introduce new Medicaid policy, reimbursement methods, and enrollment forms and answer any questions for hospice providers. More information and a registration form will be mailed to enrolled hospice providers.

Provider Name/Number Mismatch

Providers who file paper claims continue to have claims deny for the provider name/number mismatch edit, EOB 222. This applies to all paper claims - HCFA-1500, UB-92, and crossovers. The main causes of this error are:

The individual provider's name is being submitted in first, middle, last name order rather than last, first, middle name order.

The D/B/A name is being used rather than the name used for tax reporting.

The name of the organization is being used rather than the name of the individual provider.

For paper claims to process without getting the provider name/number mismatch error, it is necessary that the provider name and number submitted on claims be entered correctly to match the information in Provider Master File. Failure to bill in this manner will result in the denial of claims.

If you file claims as an individual Medicaid provider of any type or specialty, you must enter your last name first on your paper claim in order to match the information on the Provider Master File.

Example: Dr. John A. Smith must bill as Smith, John A. MD to match the information on the Provider Master File.

If you file claims as a group, facility or any entity other than an individual Medicaid provider, you must enter the provider name exactly as it is listed in the upper right hand corner of your remittance advice (RA) to match the information on the Provider Master File.

Example A: The DOM Medical Center is listed on the RA as The DOM Medical Center. The information entered on the claim must be The DOM Medical Center to match the information on the Provider Master File.

Example B: The DOM Medical Center is listed on the RA as DOM Medical Center. The information entered on the claim must be DOM Medical Center to match the information on the Provider Master File.

Example C: Mississippi DOM Medical Center is listed on the RA as MS DOM Medical Center. The information entered on the claim must be MS DOM Medical Center to match the information on the Provider Master File.

The provider name must be entered as it is on the Provider Master File in field 33 on the HCFA1500 and in form locator 1 on the UB-92.

If you are unsure of how your provider name is listed on the Medicaid Provider Master File, please contact the EDS Correspondence Unit at 1-800-884-3222.

If you want to avoid getting the provider name/number mismatch error, consider filing your claims electronically. If you are interested in information about electronic claims submissions, please contact the EDI Unit at EDS at 1-800-884-3222.

HealthMACS Policy Changes

Effective September 1, 2000, the following services will be excluded from HealthMACS primary care provider (PCP) authorization:

- **Laboratory services**
- **Radiology services**
- **Hospital emergency room (ER) and ER-related services**

Laboratory providers and all services that are billed using CPT codes in the 80000 range will not require a HealthMACS PCP authorization number. If these services are billed on a UB-92 with other services (excluding services provided in an ER), a HealthMACS authorization number will be required.

Radiology providers and all services that are billed using CPT codes in the 70000 range will not require a HealthMACS PCP authorization number. EKG codes 93000, 93005, 93010, and 93041 will not require a HealthMACS PCP authorization number. If these services are billed on a UB-92 with other services (excluding services provided in an ER), a HealthMACS authorization number will be required.

Hospital ER and ER-related services are excluded from the authorization of the HealthMACS PCP. This includes:

All ER facility billing for outpatient admission services in conjunction with a revenue code in the range of 450 through 459; **these billings must include the admission hour (time of admission).** When additional ER services are provided outside of the revenue code range 450 through 459, at least one occurrence of a revenue code in the range of 450 through 459 must exist or a HealthMACS authorization number will be required.

ER professional services billed for services provided in the ER having CPT codes in the range of 99281 through 99285. When other professional services are provided in the ER and are billed along with CPT codes in the range of 99281 through 99285 for the same date of service, a HealthMACS authorization number is not required.

The hospital must provide medical documentation to the PCP for the HealthMACS patient's unified medical record even though ER services do not require HealthMACS authorization. The HealthMACS PCP will also be provided a report from Medicaid that will identify the patients assigned to the PCP that have utilized the ER. This documentation and the report information are valuable to the PCP as the PCP continues to provide primary health care case management and continuity of care services to the HealthMACS beneficiary population.

Replacement of W4100 Code

Effective September 1, 2000, when billing emergency room (ER) professional services for medical assessments provided to HealthMACS beneficiaries in the ER, the appropriate CPT code in the range of 99281 through 99285 should be used to replace the W4100 code.

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 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 new Mississippi Health Benefits program also known as CHIP. Staff will be available to answer questions and address concerns about HealthMACS.Sessions will begin at 9:30 am and run no later than 12 noon for the following locations:

August 2, 2000
Ramada Inn Southwest
Conference Center
1525 Ellis Avenue
Jackson, Mississippi

August 3, 2000
Holiday Inn Northeast
111 US Hwy 11 at US Hwy 80
Meridian, Mississippi

August 8, 2000
Biloxi Beach Resort
2736 Beach Boulevard
Biloxi, Mississippi

August 9, 2000
Hattiesburg Lake Terrace
Convention Center
One Convention Center Plaza
Hattiesburg, Mississippi

August 15, 2000
Executive Inn
1011 North Gloster Street
Tupelo, Mississippi

August 16, 2000
Ramada Inn
Highway 12 at Montgomery Street
Starkville, Mississippi

August 22, 2000
Radisson Natchez Eola
110 North Pearl Street
Natchez, Mississippi

August 23, 2000
Southwest Mississippi Regional Medical Center
215 Marion Avenue
McComb, Mississippi

August 29, 2000
Southaven Public Library
8889 Northwest Drive
Southaven, Mississippi

August 30, 2000
Holiday Inn
1796 Sunset Drive
Grenada, Mississippi

August 31, 2000
Florewood River Plantation
Highway 82 West
Greenwood, Mississippi

September 13, 2000
Ramada Inn Southwest
Conference Center
1525 Ellis Avenue
Jackson, Mississippi

These meetings are open to all providers. Primary care providers and hospitals are especially encouraged to have representatives at any of these meetings. If you have any questions, please contact the Managed Care Hotline at 1-800-627-8488 or the Division of Medicaid Managed Care Unit at 1-800-421-2408.

Circumcision Policy

Effective for the dates of service on and after August 1, 2000, the following policies are applicable to circumcisions:

Routine Newborn and Other Not Medically Necessary Circumcisions
No benefits will be provided for the routine circumcision of newborn infants or other circumcisions for which the medical necessity is not documented according to the criteria listed below.

Medically Necessary Circumcisions
Medically necessary circumcisions will be covered based on documentation of medical necessity. Medically necessary circumcisions may be performed in the inpatient hospital setting (subject to precertification of all inpatient days), the outpatient hospital setting, the ambulatory surgical center, or a physician's office. Each of the following criteria must be met for coverage:

1) Medical necessity for the procedure is fully documented in the medical records,

AND

2) Documentation in the medical records includes:

- a diagnosis which justifies the medical necessity for circumcision. Examples include, but are not limited to, recurrent balanoposthitis or recurrent urinary tract infections, AND
- failure of the patient to respond to conservative treatment, AND
- the recurrent nature of the medical condition,

AND

3) The sole diagnosis is not phimosis. A diagnosis of phimosis alone will not be sufficient documentation of medical necessity,

AND

4) There is documentation such as physician progress notes and office records to justify the medical necessity. A pathology report alone will not be sufficient as documentation of medical necessity.

The medical documentation may be included either in the surgeon's report or the beneficiary's attending physician records. Documentation of conservative treatment must include, but is not limited to, teaching about appropriate hygiene and listing of appropriate drug therapy used to treat the condition. Documentation must be legible and available for review if requested.

Reimbursement for hospital inpatient procedures will be included in the per diem rate of the facility and may be included in the cost report. Facility charges for procedures performed in the outpatient department of the hospital will be reimbursed according to established Medicaid rates for outpatient hospital services. Facility charges for procedures performed in an ambulatory surgical center are paid according to the Medicaid Ambulatory Surgical Center procedure schedule. Physician fees are reimbursed based on the Medicaid Physician Fee Schedule.

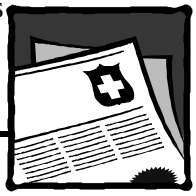
Appropriate anesthesia, which is considered the standard of care, is covered in accordance with the Division of Medicaid's policies for anesthesia services.

Crossover Claim Billing Tips

In compliance with Medicaid policy, the Medicare deductible is not applied toward the 30 inpatient days and service limits.

All paper crossover claims billed for an inpatient hospital deductible must be billed with a bill type 111 (Hospital Inpatient Admit thru Discharge Claim) or 112 (Inpatient Hospital Interim-First Claim). If a claim is billed for an inpatient deductible and the type of bill is not 111 or 112, the claim will be denied with error code 024, **deductible must be billed with type of bill 111 or 112**.

Any questions regarding this important message should be directed to the EDS Correspondence Unit at 1-800-884-3240 unless the Medicare Explanation of Benefits (EOB) shows that the deductible was paid on the second half of the bill.



HIPAA Update

Frequently Asked Questions About *Administrative Simplification*

What does the law require of state Medicaid programs?

Section 1171(5)(E) of the Social Security Act, as enacted by HIPAA, identifies the State Medicaid programs as health plans, which therefore must be capable of receiving, processing, and sending standard transactions electronically. There is no requirement that internal information systems maintain data in accordance with the standards. However, Medicaid programs will need the capacity to process standard claim, encounter, enrollment, eligibility, remittance advice, and other transactions. In addition, as health plans, the State Medicaid programs will be required to comply with other HIPAA standards two years after adoption of the standards.

The standards should benefit Medicaid programs in multiple areas. Here are a few examples:

> A national standard for encounter transactions will provide a much-needed method for collecting encounter data on Medicaid beneficiaries enrolled in managed care. Because of the standards, it will be possible to combine encounter data from managed care with similar claims data from fee-for-service, thus enhancing the ability to monitor utilization, costs, and quality of care in managed care and to compare managed care with fee-for-service.
>
> The standard transactions will include methods for electronic exchange of enrollment information between the Medicaid program and private managed care plans enrolling Medicaid beneficiaries. This will reduce administrative costs of exchanging such information and enhance the reliability of such information.
>
> The conversion to national standards provides an opportunity for Medicaid programs to shift to commercial software or clearinghouses and to stop the expensive maintenance of old, customized transaction systems.

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

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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

AUG

August 2000

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 Effective date of New Circumcision Policy	2 HealthMACS Meeting in Jackson	3 HealthMACS Meeting in Meridian ESC Cut-Off 5 pm	4	5
6	7 Checkwrite	8 HealthMACS Meeting in Biloxi	9 HealthMACS Meeting in Hattiesburg	10 ESC Cut-Off 5 pm	11	12
13	14 Checkwrite	15 HealthMACS Meeting in Tupelo	16 HealthMACS Meeting in Starkville	17 ESC Cut-Off 5 pm	18	19
20	21 Checkwrite	22 HealthMACS Meeting in Natchez	23 HealthMACS Meeting in McComb	24 ESC Cut-Off 5 pm	25	26
27	28 Checkwrite	29 HealthMACS Meeting in Southaven	30 HealthMACS Meeting in Grenada	31 HealthMACS Meeting in Greenwood ESC Cut-Off 5 pm		

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.