Mississippi Medicaid Bulletin

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Diagnosis to Procedure Comparisons

The Division of Medicaid's goal is to pay Medicaid claims as quickly and efficiently as possible. To attain this goal, Medicaid claims are processed by computer. This automated method does not include review by medical personnel or detailed evaluation for appropriate billing procedures. To monitor the appropriateness of procedures in relation to the diagnosis submitted on claims by providers, the Division of Medicaid utilizes the ClaimReview Diagnosis to Procedure editing tool.

In the October 1997 Mississippi Medicaid Bulletin, we advised that the Diagnosis to Procedure Comparison (Edit 446) would be managed on a monitoring rather than denial basis while the activity was being evaluated. In the evaluation process, we identified the need for physician education and chose to send a list of claims to those physicians whose procedures were identified as unexpected for a given diagnosis. The reports for claims processed during the period April 1999 through June 1999 were mailed in October of 1999.

The Division of Medicaid has continued to monitor the activity relating to Diagnosis to Procedure Comparisons and has noted that we continue to process a significant number of claims on which the procedures are not expected with the diagnosis reported on the claim. For further reference, a report of claims processed during July 2000 has been mailed to those providers whose procedures were found unexpected for the diagnosis.

It is essential that we operate in a claims processing environment that will give us the most accurate data for our analysis and statistical purposes. Also, it is essential that we be able to document the medical necessity for procedures based on the corresponding diagnosis. Therefore, effective November 1, 2000, claims on which the procedure is considered unexpected when billed with a given diagnosis will be denied on edit 446. The related error message will be "ClaimReview - Procedure not expected for diagnosis." Expected procedures are those procedures which are predictably associated with the corresponding diagnosis. This edit is applicable to HCFA-1500 claims submitted by physicians, nurse practitioners, clinics, chiropractors, podiatrists, therapists, etc. This edit is not applicable to crossover claims.

We realize that there will be a period of adjustment and that reimbursement will be delayed on claims which require refiling. We are prepared to maintain a process through which we can further educate providers and assist with claims problems relating to this edit. As you prepare for the implementation of this edit, please note the following:

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MISSISSIPPI DIVISION OF MEDICAID

(Diagnosis to Procedure Comparisons continued from page 1)

- Once the edit is activated, it applies to all claims processed on and after November 1, 2000, regardless of the date of service. For example, if you provided a service in July of 2000 and the claim is processed in November of 2000, the edit will apply.

- As stated in the Mississippi Medicaid Bulletin, Special Issue dated November 19, 1996, and the March 2000 Mississippi Medicaid Bulletin, 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 line.

Questions and comments relating to this edit or specific claims may be submitted in writing to the Division of Medicaid, Attn: Policy Division, Robert E. Lee Building, Suite 801, Jackson, MS 39201-1399 or by facsimile to 1-601-359-5252. For review of specific claims, the request should include a copy of the original claim and other supporting documentation that justifies the medical necessity for the procedure. Copies of clinic records relating to the procedure/diagnosis are helpful.

In addition, questions may be directed to Candace Box, Policy Division, or Sandy Puckett, Medical Services Division, at 601-359-6050. Your cooperation is appreciated.

Billing Flu and Pneumonia Immunizations for Adults

The Division of Medicaid (DOM) continues efforts to educate Medicaid providers and beneficiaries on the benefits of receiving flu and pneumonia immunizations prior to the flu season. DOM requests that providers assist in the effort to increase flu and pneumonia protection in the state.

In order to receive maximum reimbursement for providing these services, physicians and nurse practitioners should bill as indicated below:

For beneficiaries who come in only for these vaccinations, physicians and nurse practitioners may bill E & M procedure code 99211, the vaccine code(s), and the G administration code(s). This E & M procedure code **does not count toward the 12 office visit limit** for beneficiaries.

For beneficiaries who are seen by the physician or nurse practitioner for evaluation or treatment and receive these vaccinations, the provider may bill the appropriate E & M procedure code, the vaccine code(s), and the G administration code(s). The E & M procedure code billed in this instance will count toward the 12 office visit limit for beneficiaries.

Rural health clinic (RHC) and federally qualified health center (FQHC) providers will count visits under current procedures. Providers will not count or bill for visits when the only service involved is the administration of influenza or pneumonia vaccine. Payment for influenza and pneumonia vaccines and their administration is made at the time of cost settlement.

All immunizations for children must be handled through the Vaccine Program for Children.

Effective November 1, 2000, procedure code 90724, which reimburses at $3.22, will be closed. Coding and reimbursement for vaccines and administration are as follows:

Influenza			Pneumonia		
Vaccine	90658 (ages 19 and up)	$5.04	Vaccine	90732 (ages 19 and up)	$11.88
Vaccine	90659 (ages 19 and up)	$7.02	Administration	G0009	$ 3.37
Administration	G0008	$3.37			

Implantable Programmable Pump

During the 2000 Legislative Session, House Bill (HB) 1280 was passed. This included an amendment to Section 43-13-117, Mississippi Code of 1972, regarding inpatient hospital services as follows:

> Hospitals will receive an additional payment for the implantable programmable pump implanted in an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per year per recipient. *** * *** This paragraph (c) shall stand repealed on July 1, 2001.
>
> The Division of Medicaid will begin reimbursement for implantable programmable pumps on October 1, 2000. All implantable programmable pumps for Medicaid beneficiaries who are inpatients and who receive such pumps on or after October 1, 2000 will be reimbursed as required by HB 1280.

To receive reimbursement for an implantable programmable pump the hospital will have to:

- Submit a paper UB-92 claim form
- Bill charges on an inpatient claim
- Use revenue code 220
- Attach a written invoice from the provider of the pump for pricing

The Division of Medicaid will not reimburse for implantable programmable pumps for beneficiaries whose inpatient days are not certified by the peer review organization or for beneficiaries over age 21 who have used their 30 inpatient days for the year.

New Mississippi Medicaid Manuals

During the month of October, providers will begin receiving sections of the Medicaid Provider Policy Manual. The policy manual sections will be mailed to providers as they are printed and as labels are ready for mailing. Not all providers will receive the Provider Policy Manual sections at the same time.

The mailing of the provider manual sections implements a change in how information is sent to providers. In the future, information such as manual pages, monthly provider bulletins, and other correspondence, except Remittance Advices (RAs), will be sent to the provider servicing address on file. It is the responsibility of the provider at the servicing address to distribute Medicaid information to others as appropriate, such as a Medicaid billing office, home office, etc. The RA will continue to be mailed to the provider billing address. If additional copies of information mailed to the provider servicing address are needed, please notify the Division of Medicaid, Provider Relations Division, in writing. There will be a subscription fee for the mailing and printing costs. All provider manual information, provider bulletins, and other information are available at **www.dom.state.ms.us.**

When the new sections of the Medicaid Provider Policy Manual are received, notice the format and content of the Medicaid provider manuals have been revised. All existing Medicaid provider manuals are being consolidated into two manuals – (1) a provider **policy** manual and (2) a provider **billing** manual. Because it is not possible to issue all sections of the policy manual at one time and the billing manual is not ready to be issued, please keep your current Medicaid provider manual(s) until advised all content from these manuals has been issued in the revised manual sections.

If you have questions about the sections of the Medicaid provider policy manual, please contact the EDS Correspondence Unit at 1-800-884-3222.

As new sections of the Provider Policy Manual are being mailed to providers, they will also be available at ***www.dom.state.ms.us.*** *Check the website frequently for new policy information.*

Valid Place of Service Codes

The Mississippi Medicaid Management Information System (MMIS) captures a **one - digit** Place of Service (POS) code. However, several providers are submitting claims using a two-digit POS code. As a result, these providers' claims are either being returned for correction or denying. To avoid claim-processing delays, please use one of the POS codes in the box to the right to denote where the service was rendered.

For additional information, please contact the EDS Correspondence Unit at 1-800-884-3222.

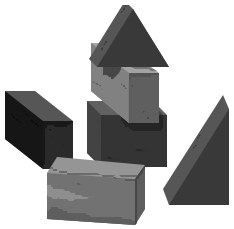
1	Inpatient Hospital
2	Outpatient Hospital
3	Doctor's Office
4	Patient's Home
5	Day Care Facility
6	Night Care Facility
7	Nursing Facility
8	Skilled Nursing Facility
9	Ambulance
0	Other Locations
A	Independent Lab
B	Ambulatory Surgical Center
C	Residential Treatment Facility
D	Specialized Treatment Facility
E	Comprehensive Outpatient Rehabilitation Facility
F	Independent Kidney Disease Treatment Center

Revised EPSDT Periodic Examination Schedule

Based on recommendations from the American Academy of Pediatrics, the EPSDT Periodic Examination Schedule has been revised to require annual examinations for children ages 7-21.

Physical assessments will be given at the following ages in a child's life:

W9370	0 – 1 month	$37.63	0 – 45 days
W9371	2 months	$37.63	46 – 90 days
W9372	4 months	$37.63	91 – 150 days
W9373	6 months	$37.63	151 – 240 days
W9368	9 months	$37.63	241 – 330 days
W9374	12 months	$37.63	331 – 400 days
W9369	15 months	$37.63	401 – 500 days
W9375	18 months	$37.63	501 – 660 days
W9376	2 – 6 years	$37.63	Annually
W9377	7 –21 years	$37.63	Annually



The EPSDT Periodic Examination Schedule has changed.

Cox-2 NSAIDS Placed on Prior Approval

Beginning October 10, 2000, all strengths of Celebrex, Vioxx, and Mobic will be added to prior approval status. As with brand name NSAIDS, prior approval must be requested by calling the EDS Correspondence Unit at 1-800-884-3222.

Stadol Nasal Spray Units Change

Beginning October 1, 2000, pharmacy providers must bill for Stadol Nasal Spray in total milliliters dispensed, e.g., one bottle dispensed must be billed for the quantity 2.5, two bottles dispensed must be billed for the quantity 5, etc. Until September 30, 2000, pharmacy providers should continue billing the quantity of total bottles dispensed e.g., one bottle dispensed to be billed as 1.

Co-Payment Billing Tips

Certain Medicaid beneficiaries are not required to pay co-payments for any Medicaid services. Each exception to co-payment is identified by an assigned code. The code(s) must be entered on the provider claim form(s) in the appropriate section(s). If the exception code is not included on the claim, the co-payment amount is entered and noted on the Explanation of Benefits (EOB). Co-payments are counted as provider income.

Infant Exception Code (For Newborn)

K Infant

Co-Payment Exception Codes

C Children Under 18
P Pregnant Women
N Nursing Facility Residents
F Family Planning Services
E Emergency Room Services*

* Certified by the physician as true emergencies and so recorded in the medical record. Co-pay applies if the co-pay exception code E is not indicated on the claims.

If you have questions, please contact the EDS Correspondence Unit at 1-800-884-3222.

Co-Payment Amounts

Hospital Inpatient	$ 5.00 per day
Hospital Outpatient	2.00 per visit
Physician Office, Home, Emergency Room and Ophthalmological Visit	1.00 per visit
Prescription	1.00 per prescription
Ambulance	2.00 per trip
Home Health	2.00 per visit
Dental	2.00 per visit
Eyeglass	2.00 per pair of eyeglasses
Federally Qualified Health Clinic	1.00 per visit
State Department of Health Clinic	1.00 per visit
Rural Health Clinic	2.00 per visit

The Long Term Care Alternatives Program

The Division of Medicaid (DOM) implemented the Long Term Care Alternatives Program in November 1999 to inform and educate Medicaid beneficiaries, applicants, and the general public about alternatives to nursing home care. DOM is working with the Planning and Development Districts/Area Agencies on Aging (PDD/AAA) to provide a program of information, education, and referral about alternatives to nursing facility care.

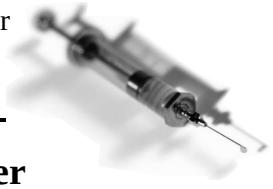
Medicaid applicants and beneficiaries who apply for admission to nursing homes are contacted by a Long Term Care Alternatives Social Worker and told about available home or community-based options to nursing home care. Applicants and beneficiaries can choose home or community-based alternatives or nursing home care. DOM will not deny nursing home placement, even if other alternatives to nursing home care are available.

For additional information about the Long Term Care Alternatives Program, please visit our website at **www.dom.state.ms.us** or contact the Bureau of Long Term Care/Medical Services, Dorothy Idleburg, Ph.D., at 601-359-6050.

DOM is working with the Planning and Development Districts/Area Agencies on Aging (PDD/AAA) to provide a program of information, education and referral about alternatives to nursing facility care.

New Vaccines for Children

New vaccines for children will not be covered as a routine Medicaid benefit until the Centers for Disease Control and Prevention (CDC) has negotiated a price for the vaccine and has added it to the Vaccines for Children program.



Medicare/Medicaid Crossover Claim Limitations Reminder

Providers have six months (180 days) from the Medicare paid date to file a claim with Medicaid. The six-month limitation for Medicare/Medicaid crossover claims is determined by comparing the Medicare payment date against the date of receipt by Medicaid. Timely filing ICNs can not be used on crossover claims. Timely filing ICNs cannot override the six-month limitation. Claims received more than six months after the Medicare payment date are denied unless they meet the following guidelines:

1. Claims over six months old can be processed if the beneficiary's Medicaid eligibility has been approved retroactively. Proof of the retroactive determination must accompany the claim. Dates of service must be within the eligibility period stated on the eligibility approval document. Providers have six months from the date of the retroactive eligibility notification letter to submit claims.

2. The six-month filing limitation for newly enrolled providers begins the date the new provider number is assigned. New providers have six months from the date of the notification letter to submit claims for the eligibility period as stated in the notification letter. A copy of the notification letter must be attached to each claim.

If you have EOMBs (Explanation of Medicare Benefits) stating the claims crossed over to Medicaid and you have no record of payment by Medicaid, or if you have paper or electronic claims that do not appear on your remittance advice after thirty days, please call the EDS Correspondence Unit at 1-800-884-3222 for assistance. If no record of the claim is on file, you may submit a follow-up claim if it is within 6 months of the Medicare EOMB date. To assist the Correspondence Unit, please have your Medicaid number, payment dates, and EOMB available when you call. Follow up on denied claims must be completed within the 180-day limitation.

HIPAA Update

The Final Rule for National Standards for Electronic Transactions was published in the Federal Register on August 17, 2000 (Volume 65, Number 160). The effective date of this rule is October 16, 2000. The compliance date is October 16, 2002 (2003 for small health plans).

What are the major differences between the proposed rule and the final rule?

Applicability

The proposed rule included an exception for person-to-computer transactions (interaction between server to browser, direct data entry, faxback, etc.). This exception has been eliminated in the final rule. Although we recognize that there are no X12N standards for these interactions, there are standard elements and data content. Therefore, those transmissions must use the adopted standard data elements and data content. The "direct data entry" process, using dumb terminals or computer browser screens where the data

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are directly keyed by a provider into a health plan's computer, does not require the format, but the data content must conform. If the data are entered into a system that is outside the health plan's system to be sent later, it must be sent using the full standard.

The final rule includes a statement in the preamble to recognize that the Secretary of Health and Human Services has the authority under HIPAA to adopt standards for all transactions (not just those in electronic form), but she has chosen to exercise her authority for electronic transactions. Most paper forms cannot accommodate all of the data content required on the electronic transactions.

The final rule has eliminated the discussion of internal/external transactions. Instead, the final rule lays out a simpler process to determine when standards must be used for transactions. This process is not defined on the basis of corporate boundaries.

Exceptions for State Law

This issue will be addressed in the final rule for privacy standards.

Definitions

Small Health Plan - the definition was amended to be consistent with the requirements of the Small Business Administration. A small health plan is defined as one with a maximum of $5 million in annual receipts.

Modifications to Adopted Standards - The final rule distinguishes between "maintenance" and "modifications" of the standard transactions. "Maintenance" is defined as those activities necessary to support the use of a standard adopted by the Secretary. These activities include technical corrections to an implementation specification and enhancements or expansion of a data code set. Such changes could be non-substantive, or error corrections. Public comment and notification are required as part of the normal ANSI-accredited standards development process, so a new regulation would not be required. "Modification" is defined as a change to a standard or an implementation specification adopted by the Secretary through regulation.

Designated Standard Maintenance Organizations (DSMOs) - The groups designated as DSMOs were published in a separate Federal Register notice on the same day as the final rule.

Changes to Regulation Text

In parts 160 and 162, the final rule includes the addition of many new definitions to clarify the applicability and scope of the rule. These include definitions for such items as covered entity, business associate, direct data entry, and electronic media. Other definitions were added to aid in the articulation of the process by which standards are adopted and changed; these include definitions for compliance date, modification, Standard Setting Organization (SSO), maintenance, and Designated Standards Maintenance Organization (DSMO).

Language from the proposed rule was revised in the final rule to state that a health plan may not delay the transaction or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the basis that the transaction is a standard transaction.

The final rule names the NCPDP telecommunication standard 5.1 and batch equivalent, instead of X12N standards, for the following transactions with retail pharmacies: eligibility for a health plan, health care payment and remittance advice.

NOTE: This information and a copy of the Standards for Electronic Transactions Final Rule can be obtained from the Health Care Financing Administrations'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

Mississippi Medicaid Bulletins and Manuals are on the Web!
www.dom.state.ms.us

EDS

October 2000

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 • Bill for Stadol Nasal Spray in ml. • Begin billing for implantable programmable pumps	2 Checkwrite	3	4	5 ESC Cut-Off 5 pm	6	7
8	9 Columbus Day Yom Kippur Checkwrite	10 Celebrex, Vioxx and Mobic added to prior approval status	11	12 ESC Cut-Off 5 pm	13	14
15	16 National Boss's Day Checkwrite	17	18	19 ESC Cut-Off 5 pm	20	21
22	23 Checkwrite	24 United Nation's Day	25	26 ESC Cut-Off 5 pm	27	28
29 Daylight Saving Ends	30 Checkwrite	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.