Mississippi Medicaid Bulletin

Volume 7, Issue 6

December 2000

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Due to the Division of Medicaid being closed on December 25 and 26, bank deposits will be delayed until Friday, December 29.

Adult Eyeglass Services

- **Follow-up to notification** of July 1, 2000 for reimbursement of eyeglass services for adults age 21 and older.
- **Effective immediately, the DOM-210 Eyeglass/Hearing Aid Authorization form** for services to be rendered to Medicaid Beneficiaries regarding the one (1) pair of eyeglasses for adults every three (3) years, **is no longer required**.
- **Unprocessed forms were returned to providers with a notification to file claims on a HCFA 1500 without a PA, either electronically or on paper.**

Tips for Billing

- **Be sure to verify Medicaid eligibility for the above services before rendering services to Medicaid or Medicare/Medicaid beneficiaries by calling the Automated Voice Response System (AVRS) at 1-800-884-3222 or by swiping the Medicaid ID card. Always verify whether the Medicaid beneficiary has received prior services under the new adult eyeglass program.**
- **Beneficiaries are allowed one (1) eye exam per fiscal year which counts toward the twelve office visits. Be sure to call the Automated Voice Response System (AVRS) at 1-800-884-3222 or swipe the Medicaid ID card to verify benefit limits.**
- **Progressive, transitional, polycarbonate, hi-index or contact lenses with unspecified codes are not covered for adults. A beneficiary may pay for services not covered by Medicaid.**
- **Medicaid will not reimburse on a more expensive frame with the beneficiary paying the balance. A beneficiary *may* use their present frame if the lens prescription has changed.**

The Division of Medicaid appreciates all services rendered to Medicaid beneficiaries. Thank you for your patience during this transitional phase of a new and very beneficial program for these beneficiaries. If additional assistance is required, please contact Jeanette Williams at (601)359-6050 or 1-800-421-2408, ext. 6138.

MISSISSIPPI DIVISION OF MEDICAID

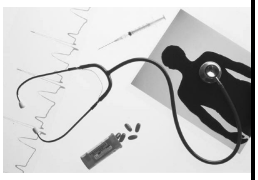
Billing for Dialysis Services

When billing dialysis services rendered for a full month, use the following codes: 90918, 90919, 90920, and 90921. For these codes, one unit is equal to one month. When billing dialysis services rendered for less than a full month, use the following codes: 90922, 90923, 90924, and 90925. For these codes, one unit is equal to one day.

Extended Prescription Benefit

As of November 1, 2000, the prescription benefit increased from five (5) to ten (10) prescriptions per month for all beneficiaries with no prior approval required.

Mississippi Medicaid Disproportionate Share Hospital Program



The Mississippi Medicaid Disproportionate Share Hospital (DSH) program is designed to support those hospitals that provide a significant amount of services to Medicaid beneficiaries with payments above what is reimbursed for Medicaid covered services.

The Mississippi Medicaid Disproportionate Share Hospital (DSH) program is designed to support those hospitals that provide a significant amount of services to Medicaid beneficiaries with payments above what is reimbursed for Medicaid covered services. The amount of funds paid to the DSH hospitals may not exceed the cost to the DSH hospital of providing services to individuals who are eligible for Medicaid, less any payments made for those services by Medicaid, plus the cost of providing services to individuals who are uninsured.

Currently, Mississippi Medicaid designates hospitals as DSH hospitals if they have Medicaid utilization of at least the average of all hospitals located in Mississippi or they have a low income utilization rate of at least twenty-five percent (25%). In addition, the hospital must have at least two (2) obstetricians on staff who have agreed to provide obstetric services to Medicaid beneficiaries unless the hospital's inpatients are predominantly under 18 years of age or the hospital did not provide obstetric services as of December 21, 1987.

The total amount of payments Mississippi Medicaid makes under the DSH program is limited by a federal allotment. The federal DSH allotment has been decreasing due to the Balanced Budget Act of 1997. The allotment in federal fiscal year 1998 was $185,497,470. As a result of this federal limit, the total amount of payments that may be made during federal fiscal year 2001 (October 1, 2000 – September 30, 2001 is limited to $167,925,019.

Long Term Care Alternatives Program

The Long Term Care Alternatives Program continues to educate and inform Medicaid beneficiaries and applicants about possible alternatives to nursing facility placement. Any beneficiary or applicant who applies for nursing facility placement **MUST** have a DOM 260NF faxed to the Long Term Care Alternatives Division of Medicaid at (601) 359-1383. These forms may be obtained by calling EDS at 1-800-884-3222. The point of contact for this program is Kenni Howard, Director of Community Long Term Care.

Hospice

This is to remind all hospice providers that as of October 1, 2000, the new Medicaid payment methodology for hospice went into effect. Also, new Medicaid enrollment forms must be used. Old forms are obsolete and will not be accepted. New forms may be downloaded from DOM's website at **www.dom.state.ms.us.** Click on provider, then manuals, then hospice enrollment form. Information about the new form or payment methodology may be obtained by calling Kenni Howard, Director of Community Long Term Care, at (601) 359-6759 or 1 800-421-2408.

Specific Quantities Must be Billed

Beginning December 1, 2000, all pharmacy providers are required to submit claims to Medicaid for the exact and specific quantity dispensed, accurate to the second decimal place. For example, bottles of Stadol NS Spray or Xalatan Eye Drops must be billed for 2.5 ml. each, Lovenox 30 mg. pre-filled syringes must be billed for 0.3 ml. each, etc. Pharmacy providers should verify with their software vendors that all quantities billed to Medicaid are EXACT, i.e., NOT rounded up from a fraction.

Pharmacy providers have been required since November 1, 1998 to upgrade their software to allow for billing of the exact quantity dispensed. Providers must ensure that this has been done, since an edit will be implemented that will deny claims submitted for "rounded up" quantities.

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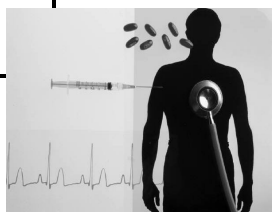

HIPAA UPDATE

The Clock is ticking...Are you ready for HIPAA?

With the signing and publishing of the Final Rule for Health Insurance Reform: Standards for Electronic Transactions on August 17, 2000, the countdown has begun for implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Administrative Simplification (AS) Rules. The compliance date is October 16, 2002 (2003 for small health plans).

Implementation of the standards should benefit Medicaid through improvements in data exchange processes, lower operating costs, consistent data for statewide and national analysis and comparisons, better fraud detection capabilities, a happier provider community, and the opportunity to renovate systems and streamline business processes. Standardized formats and data content should also improve the coordination of benefit process.

The provider community is a big winner with the implementation of HIPAA. Major efficiencies can be achieved after the standards have been implemented. As in the payer community, the providers are also challenged with upgrading their systems and data exchange capabilities, resulting in more efficient and timely inter-provider communications such as coordination of benefits, sending laboratory reports, making referrals, and ordering tests and prescriptions. Standards should also speed up inquiry and response for eligibility verification, service requests or claim status.

Beneficiaries share indirectly in the improvements associated with AS. Standards, combined with on-line data exchange, result in improved coordination of care for the patient. Standards may remove some of the barriers to provider participation which could lead to more choices for the Medicaid beneficiary. As computer and web instruction increases in the classroom and television and web technologies combine, Medicaid clients could have access to health care information such as health care education, rosters of providers, and directions to medical facilities. Also in the future when medical record standards are introduced, there can be more efficient transfer of information as the beneficiary moves from fee-for-service to managed care and vice versa, and from Medicaid eligibility to the State Children's Health Insurance Program.

The hope is that with the implementation of HIPAA, the health care payer, the provider and the beneficiary will find a new and improved landscape at the end of the HIPAA highway. Starting from a location where much of the communication still relies on mail service, telephone calls and fax transmittals and where the parties use a multitude of formats, codes, and conventions, we travel to a new destination where communications are on-line and everyone speaks the same language.

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

December 2000

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				ESC Cut-Off 5 pm	1 *Pharmacy Providers must bill specific quantities.*	2
3	4 Checkwrite	5	6	ESC Cut-Off 5 pm 7	8	9
10	11 Checkwrite	12	13	ESC Cut-Off 5 pm 14	15	16
17	18 Checkwrite	19	20	ESC Cut-Off 5 pm 21	22	23
24 / 31	25 Checkwrite	26	27	ESC Cut-Off 5 pm 28	29 Bank Transfers Occur Today	30

DOM, EDS, and HSM will be closed December 25 and 26.

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.