Mississippi Medicaid Bulletin

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August 2001

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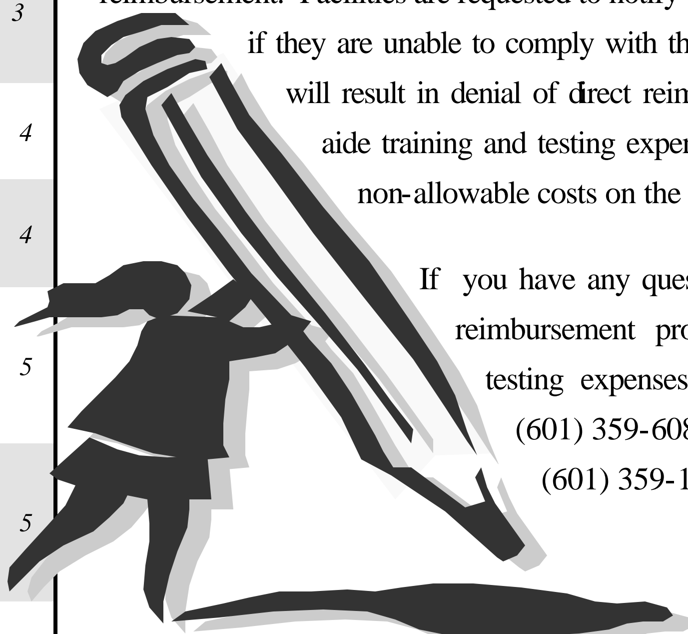
Nursing Facilities that Bill for Nurse Aide Training and Testing Expenses

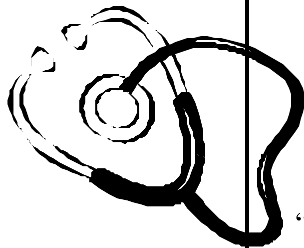
As previously stated in the May 1998 Mississippi Medicaid Bulletin, all nurse aide training and testing expenses must be billed to Medicaid on a monthly basis. Training expenses must be submitted within thirty (30) days of the incurred expense. Testing fees must be billed within thirty (30) days of the test date, and pass/fail results must be included with the billing. Pass/Fail results can include either the results received from ASI or the actual results given to the aide at the time of the tests. This will allow any problems noted in a facility's billing procedures to be corrected and ensure direct payment of all nurse aide training and testing costs.

Facilities must bill nurse aide training and testing expenses monthly in order to receive reimbursement. Facilities are requested to notify the Division of Medicaid in advance if they are unable to comply with this requirement, as failure to comply will result in denial of direct reimbursement of expenses. All nurse aide training and testing expenses, including denied expenses, are non-allowable costs on the Medicaid cost report.

If you have any questions about this requirement or the reimbursement process for nurse aide training and testing expenses, please contact Melinda Blum at (601) 359-6081 or Charissa Wilson at (601) 359-1377.



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, 2001, 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."

HealthMACS and HealthSystems of Mississippi Certification

In August, HealthSystems of Mississippi (HSM) will provide written notification to HealthMACS Primary Care Physicians (PCPs) regarding their HealthMACS enrollees who have been certified by HSM for an inpatient hospital admission. HSM will begin providing this information in preparation for a future HealthMACS program enhancement that will eliminate the PCP's authorization for inpatient admissions that are certified by HSM. When this change in HealthMACS authorization is ready to be implemented, providers will be notified via the monthly Medicaid bulletin.

Effective July 1, 2001, providers submitting DOM260NF forms to the Division of Medicaid should begin using ICD-9 diagnosis codes in Section 19 (Admitting Diagnosis) instead of the written descriptive diagnosis.

ICD-9 Codes for DOM 260NF Forms

Effective July 1, 2001, providers submitting DOM 260NF forms to the Division of Medicaid should begin using ICD-9 diagnosis codes in Section 19 (Admitting Diagnosis) instead of the written descriptive diagnosis.

Policy Start Date

In the June 2001 bulletin, the Division of Medicaid issued new policies for Reduction Mammoplasty and Independent Diagnostic Treatment Facilities and Other Mobile Diagnostic Units. Please be advised that the effective date of each of these policies is June 1, 2001. Copies of these policies for your Mississippi Medicaid Policy Manual will be forwarded in the near future.

Upcoming Changes to the Medicaid Pharmacy Program

We at the Division of Medicaid share your goal in ensuring our patients receive the appropriate medications they need to effectively treat their illness. It is also our goal to be a good steward of the limited state and federal dollars provided to the Medicaid program. It is our belief that both these goals are achievable with effective pharmacy management.

The proposed Pharmacy Benefits Manager (PBM) services contractor, expected to start October 1, 2001, would supplement these drug utilization review (DUR) activities that are required by federal law. We expect the new PBM services contractor to evaluate our program and make recommendations for changes to the program that will slow growth in Medicaid drug expenditures without any restriction or reduction in needed health care for our beneficiaries. There is evidence, based on current DUR activities, that suggests more expensive medications are used when there are less expensive medications that are equally effective.

It is imperative the Division of Medicaid take a more aggressive approach to the effective management of the program due to the following:

For the fiscal year ending June 30, 2001, prescription drug costs were the biggest single expenditure for the Medicaid program consuming 22% of the budget.

Prescription drug costs increased from $339,685,539 in FY2000 to $465,318,052 in FY 2001 representing almost a 40% increase.

Medicaid provided payment for 8,920,159 prescriptions in FY2001. The average annual prescriptions per recipient was 16.34.

The manpower that will be supplied by the PBM services contractor will allow management, both clinical and financial, of Medicaid's pharmacy program that is not presently possible. DOM expects the level of health care delivered to beneficiaries not just to be maintained, but to be improved as a result of these services.

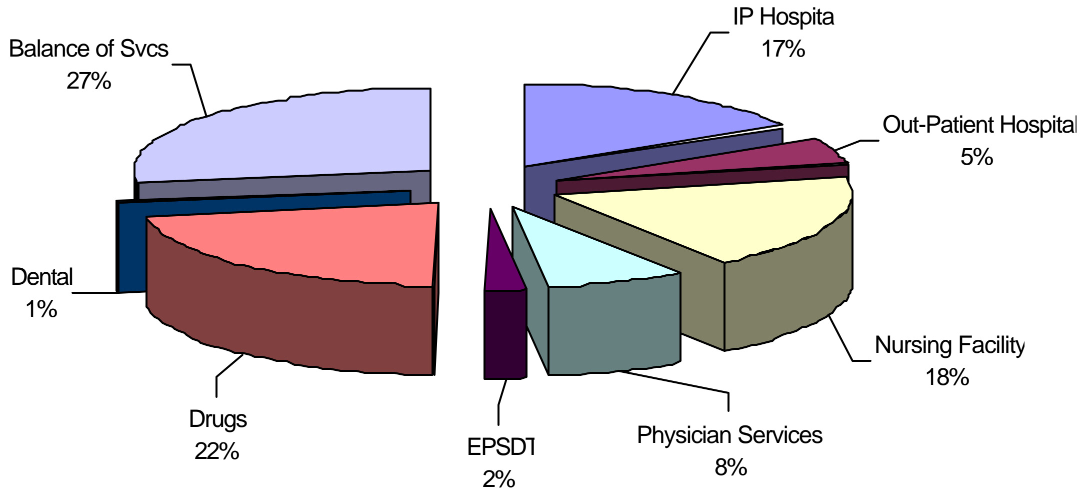
Some positive changes DOM would anticipate include counter-detailing of prescribers to provide education regarding the availability of less costly but equally effective drug therapies, case management to prevent over-medication, detection of "doctor shopper" beneficiaries who inappropriately see multiple physicians, and more required prior approval of drugs to insure the presence of medically justified diagnoses.

It is so important to note that all recommended program changes must be approved by DOM before implementation, all providers and beneficiaries will receive ample notice prior to any changes, and there will be strict over-site of the contractor by a DOM appointed administrator.

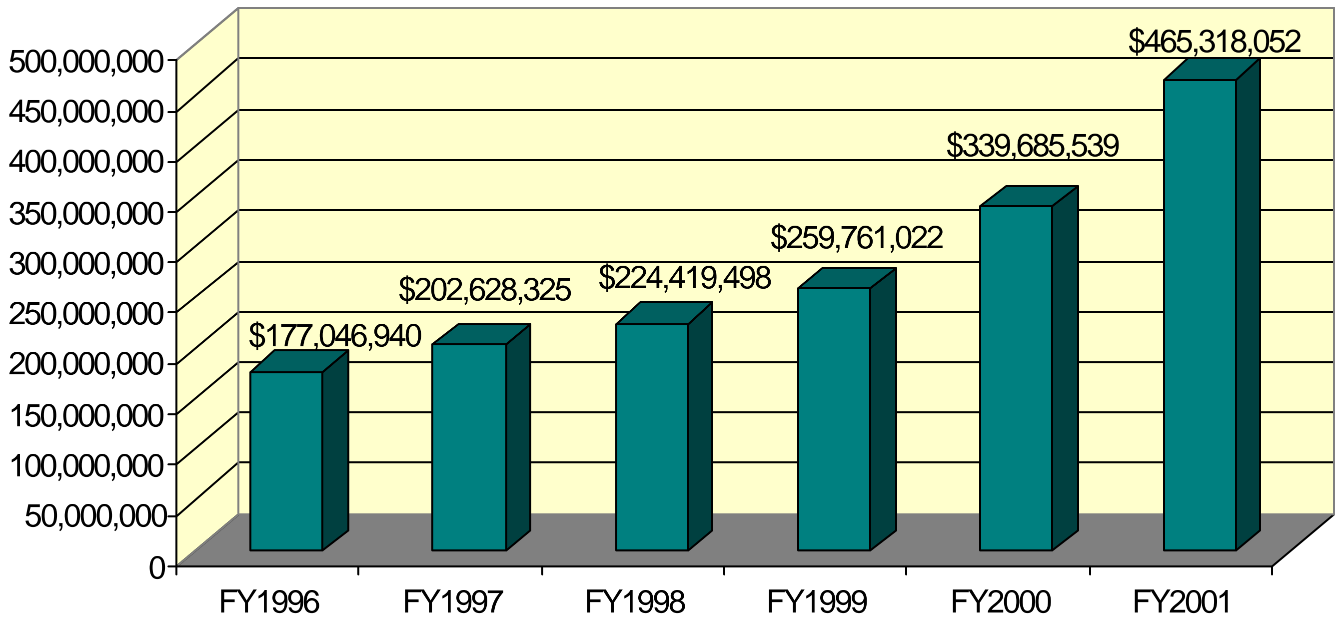
Additionally, the preferred drug list will be developed based on what has been clinically determined as the most cost-effective therapy. The prior authorization process will utilize well-established clinical guidelines. The prescribing practices will be reviewed based on these current guidelines. Please be assured the Division plans to involve a local Pharmacy and Therapeutic Committee comprised of physicians and pharmacists who will be appointed for the purpose of assisting the Division in finalizing the preferred drug list and clinical guidelines for prior approval.

In summary, it is our goal to ensure the maximum cost effectiveness of drug therapy without reduction or restriction of needed and medically justifiable benefits for Medicaid recipients. If you have further questions about our pharmacy program policies and the proposed Pharmacy Benefit Manager services contract, please contact Gay Gipson in our Pharmacy Division, at 601-359-6010. Thank you for your interest in and support of the Medicaid program.

Expenditures for Medical Services - FY 2001



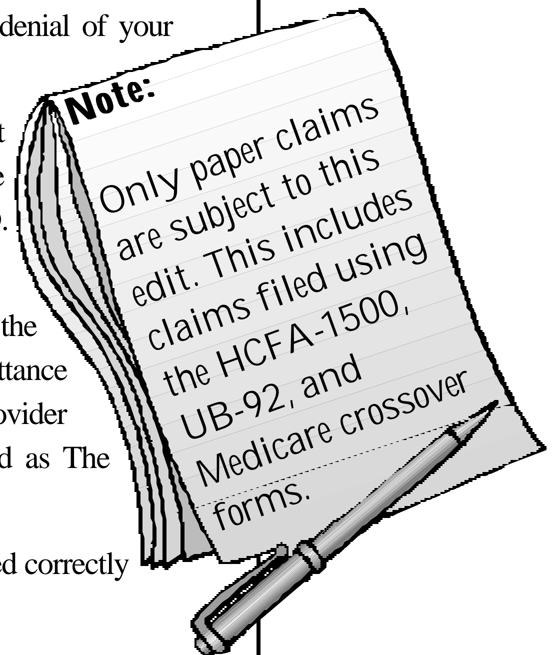
Pharmacy - Total Expenditures



Provider Name/Number Mismatch Edit (Error Code 222)

The purpose of the "Provider Name/Number Mismatch" edit is to reduce the possibility of paying claims to the wrong provider. **Only paper claims are subject to this edit. This includes claims filed using the HCFA-1500, UB-92, and Medicare crossover forms.**

The billing provider name and number are edited against the billing provider name and number on the Medicaid Provider Master File. It is imperative that the provider name and number submitted on your claims be entered correctly and match the information on the Provider Master File. Failure to bill in this manner will result in the denial of your claims.



If you are billing as an individual provider, of any specialty, you must enter your last name first on your paper claim in order to match the information on the Provider Master File. For example, John Smith M.D. must be billed as Smith, John M.D.

Other providers such as groups, facilities, etc. must submit claims with the provider name listed as it is in the upper right hand corner of your Remittance Advice. This is an exact match of your identity in the Medicaid Provider Master File. For example, The DOM Medical Center must be billed as The DOM Medical Center.

The provider name and number submitted on your claims must be entered correctly as follows:

- **On the HCFA-1500 form, this information is placed in Item 33.**
- **On the UB-92 form, this information is placed in Form Locator 1.**
- **On the Medicare Part A form, this information is placed in Item 2.**
- **On the Medicare Part B form, this information is placed in Item 1.**

If you are unsure of your correct billing name or have any further questions, please contact the EDS Correspondence Unit at 1-800-884-3222.

Non-Covered Pharmacy Service

Beginning August 1, 2001, Meridia and Orlistat (Xenical) will not be covered by Medicaid for weight loss.

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

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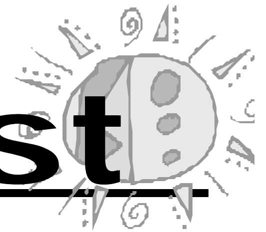

August 2001

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	ESC Cut-Off 5 pm 2	3	4
5	6 Checkwrite	7	8	ESC Cut-Off 5 pm 9	10	11
12	13 Checkwrite	14	15	ESC Cut-Off 5 pm 16	17	18
19	20 Checkwrite	21	22	ESC Cut-Off 5 pm 23	24	25
26	27 Checkwrite	28	29	ESC Cut-Off 5 pm 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.