Mississippi Medicaid Bulletin

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Goodbye and Thank You

Goodbyes are difficult, especially when the relationship has been a positive one. We, the employees of EDS, take this time to thank you for the opportunity to support you. We have grown together as new policies were implemented and have felt pride as we helped ensure quality health care for the Medicaid beneficiaries.

We will miss you; whether we communicated directly or not, we know your name, and we know that you are making a significant contribution to the citizens of Mississippi.

We appreciate the time that we worked together and wish you a happy, prosperous 2002.

FRAUD ALERT

The Department of Health and Human Services has issued a fraud alert regarding individuals or groups who request access to a provider's computers or database information in order to conduct a compliance audit. Recently, in Queens, New York, individuals approached a medical provider and made such a request under the guise of performing a HIPAA audit. When the individuals refused to produce appropriate identification, the provider's billing manager refused their request and notified law enforcement authorities as well as HHS personnel.

If approached with a similar request, providers should deny access to any individual or group who fails to produce identification and proper documentation from the auditing entity. Any such incident should be reported to Medicaid's Program Integrity Bureau at 601-987-3962 or 1-800-880-5920.

MISSISSIPPI DIVISION OF MEDICAID

Requirements for Pre-Admission Screening and Resident Review (PASRR)

Prior to nursing facility placement, all applicants must have a completed Physician's Certification for Nursing Facility and MI/MR Screening (DOM 260 NF). At that time, the decision must be made as to whether a Level II Evaluation is required. The Division of Medicaid is providing clarification as to when a Level II Evaluation for Mental Illness and/or Mental Retardation is required.

Individuals who meet the following criteria must receive a Level II Evaluation for Mental Illness from a Community Mental Health Center:

- Diagnosis of serious and persistent mental illness
- Takes or has a history of taking psychotropic medication on a regular basis for a mental illness

Individuals who meet the following criteria must receive a Level II Evaluation for Mental Retardation (MR) from a Regional Center:

- Diagnosis of mental retardation
- History of both mental illness and mental retardation
- Evidence of deficits in cognitive or behavioral function that indicate the need for a MR evaluation

There are some conditions which supersede or override the "general" criteria for a Level II Evaluation. The following conditions would exempt an individual from the Level II Evaluation:

- A primary diagnosis of Alzheimer's disease, dementia or related disorder regardless of the individual's mental illness/mental retardation history. In this circumstance, the third box at the bottom of the DOM 260 NF should be checked.
- A serious medical condition such as a coma or ventilator dependence or a diagnosis such as Amyotropic Lateral Sclerosis (ALS), Parkinson's disease or Huntington's disease that would significantly impair the person's ability to benefit from specialized services. In this circumstance, the third box at the bottom of the DOM 260 NF should be checked.

The final section of the DOM 260 NF contains three boxes. **Only one box should be checked!**

Incomplete or incorrect DOM 260 NF forms cannot be processed. Evaluations completed on individuals who do not meet the criteria for or are exempt from a Level II Evaluation will not be reimbursed by Medicaid. In addition, the Appropriateness Review Committee (ARC) of the Department of Mental Health will not render a determination. DOM 260 NF Forms that have more than one box checked in the bottom section will not be accepted by Long Term Care Alternatives (LTCA).

Questions concerning the PASRR program should be directed to the Division of Mental Health Services at 601-359-6122.

Pharmacy Program Changes

Within the next few weeks, the Mississippi Division of Medicaid hopes to complete the addition of several generic cough and cold preparations to the list of drugs available for reimbursement by Medicaid. With cold and flu season upon us, these products will give providers a wider range of options when treating cold and flu viruses.

We anticipate that the availability of these lower cost over-the-counter and prescription products will provide an alternative to more expensive medications, as well as more appropriate treatment for symptoms of colds and flu, perhaps even in some cases alleviating the need for antibiotics.

As with all drugs covered by Medicaid, the practitioner will need to provide a written prescription, even for the over-the-counter products, to the pharmacy.

The specific products which will be added are:

- Guaifenesin and Codeine liquid, 100mg/10mg per teaspoonful.
- Guaifenesin and Dextromethorphan liquid, 100mg/10mg per teaspoonful.
- Guaifenesin, Pseudoephedrine, and Codeine liquid, 100mg/30mg/10mg per teaspoonful.
- Guaifenesin 600mg extended/sustained release tablet.
- Pseudoephedrine 30mg tablet.
- Triprolidine and Pseudoephedrine liquid, 30mg/1.25mg per teaspoonful.
- Triprolidine and Pseudoephedrine 60mg/2.5mg per tablet.

We hope that all the products will be available before January 1, 2002. Please call Mississippi Division of Medicaid at 1-800-421-2408 and ask for Pharmacy if you have questions or need additional information.

Requesting a Field Visit

ACS, as your new fiscal agent, in partnership with the Division of Medicaid, provides comprehensive onsite provider support services for all providers. In addition, HealthMACS PCPs have their own support team of managed care provider representatives dedicated to meeting their needs.

All provider field services staff members are available for:

- Training for all newly enrolled and existing Medicaid providers upon request
- Basic enrollment assistance to new providers interested in enrolling in the Mississippi Medicaid program
- Regular regional training seminars
- Claims resolution services
- Electronic Claims Submission and EDI services
- HealthMACS provider support

Our highly trained, experienced staff understands your needs and is ready to serve you. Requesting a visit is as easy as calling our toll free numbers. Please contact Provider and Beneficiary Services at (800) 884-3222 or (601) 206-3000. For HealthMACS providers, we encourage you to contact the HealthMACS Hotline at 1-800-627-8488 or (601) 206-3030 whenever you have a question or would like assistance on Medicaid, claims inquiries, or HealthMACS program or policy issues.

We hope everyone had a safe and happy holiday season, and we want to take this opportunity to express our excitement to serve as the new Mississippi Medicaid fiscal agent. We also would like to reinforce our commitment to providing quality services to all providers and beneficiaries. We look forward to working with you in the months and years to come.

Please take a moment to acquaint yourself with some important facts and changes in procedures listed below:

- If you receive paper checks, please note that ACS will be mailing Remittance Advices separately from your check. This has been done to improve State cash control and security. Both will be sent to the provider's billing address.
- If you need to send an Adjustment or Void to ACS, please do not send a check with your request. We will deduct any amount owed from a future Remittance Advice and payment. This change is also important as it improves State cash control and security.
- If you submit Crossover Claim Forms, we will only be accepting the 1999 Crossover Part-B Claim Form or the 1998 Crossover Part-A Form. By streamlining the Crossover Claim Form, we can increase customer service and efficient claims processing. Please contact ACS Provider and Beneficiary Services to request copies or further assistance. These forms are available on the Division of Medicaid website at **www.dom.state.ms.us**.
- In accordance with program integrity goals, when submitting a crossover claim you must submit the entire Medicare EOMB page as an attachment. Please do not cut a strip of paper off the EOMB. In order to maintain confidentiality when submitting a full page EOMB, you can black out other recipient names and numbers with a black marker. Any claim with a strip cut out of an EOMB will be returned.
- Please remember that your local provider field representative is available to come onsite to your facility to assist you.

We thank you for your patience during this transitional period. All changes that have taken place are intended to improve the service we offer to you. We understand that you may have questions and concerns. Please feel free to contact ACS Provider and Beneficiary Services at (800) 884-3222 or 601-206-3000. We are here to help you!

Please contact ACS Provider and Beneficiary Services to request copies or further assistance. .

Attention! New Timely Filing Procedures

Claims for covered services must be filed within twelve (12) months from the date of the service. **(Exception: Medicare/Medicaid Crossover Claims - See box at the end of this article for details.)** Providers are encouraged to submit their claims as soon as possible after the dates of service.

- ACS can process claims that exceed the timely filing limit in the following situations:

  Claims filed within twelve (12) months of the date of service that were denied can be resubmitted with the internal control number (ICN) from the original date of the denied claim. **The ICN must be placed in the appropriate field on the resubmitted claim in order for payment consideration.** Effective March 1, 2002 any claim that does not have the timely filing ICN placed in the appropriate field will be denied. Please be sure you place the timely filing ICN in the appropriate field. The field for each corresponding claim form is shown below.

Claim Form	Field
HCFA 1500	Field 22
UB 92	Field 37
Mississippi Dental	Field 18
ADA Dental	Field 61
Mississippi Pharmacy	Field 16
Crossover A	NONE
Crossover B	NONE

- Claims over twelve (12) months old can be processed if the Division of Medicaid, Department of Human Services, or the Social Security Administration has approved the beneficiary's eligibility retroactively. Appropriate documentation from the determining agency must accompany the claim and must be filed within twelve (12) months from the date of the retroactive letter.
- The twelve (12) month filing limitation for newly enrolled providers begins with the date of issuance of the provider eligibility letter.

Note: Claims submitted two (2) years from the dates of services will not be paid unless the beneficiary's eligibility is retroactive beyond that limit.

Medicare/Medicaid crossover claims must be filed within six (6) months of the Medicare payment register date. Crossover claims filed after the six (6) month limit will be denied.

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Jackson, MS 39255

If you have any questions related to the topics in this bulletin, please contact the ACS Correspondence Unit at 1-800-884-3222 or 601-206-3000.

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

January

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Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 DOM, ACS & HSM closed	2	3 ESC Cut-Off 5 pm	4	5
6	7 Checkwrite	8	9	10 ESC Cut-Off 5 pm	11	12
13	14 Checkwrite	15	16	17 ESC Cut-Off 5 pm	18	19
20	21 DOM, ACS & HSM closed Checkwrite	22	23	24 ESC Cut-Off 5 pm	25	26
27	28 Checkwrite	29	30	31 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.