Mississippi Medicaid Bulletin

Volume 8. Issue10

April 2002

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Corrections to Special Bulletin

Reduction in Prescription Benefit Limits	Effective Date for 34-Day Supply
Because of the need for physicians and beneficiaries to plan for the reduction in number of medications allowable under Medicaid, the effective date for reduction in allowable prescriptions will be June 1, 2002.	All Prescriptions billed to Medicaid (new and refills) will be limited to a 34-day supply beginning April 1, 2002. This notice resends the previous notice in the Special Bulletin, which had projected May 1, 2002.

Revised Non-Emergency Transportation Policy Manual

Effective April 15, 2002, Section 12.08 of the Non-Emergency Transportation Provider Policy Manual has been revised as follows:

The following may be considered in determining the most suitable transportation services for the beneficiary:

- Access to public transportation
- Time frames (ex: pick-up, drop-off and waiting times)
- Work schedule
- Physical/mental disability (ex: use of a wheelchair, inability to follow simple directions, etc.)
- Physical stamina (ability to stand, sit, wait for extended periods of time, etc.)
- Need to transport equipment and/or an attendant.

Additions, Deletions and Description Changes to the 2002 HCPCS and CPT Codes

The additions, deletions and description changes to the 2002 HCPCS and CPT codes will be loaded into the Medicaid Management Information System (MMIS) in the near future. The 2001 codes should be utilized until the Division of Medicaid (DOM) provides further directions for filing the 2002 codes.

MISSISSIPPI DIVISION OF MEDICAID

Helpful Tips: How to Get Your Claim Right the First Time

In an effort to improve the quality of service it provides, ACS would like to identify the primary reasons why some paper claims are being returned to providers. Before a claim can be entered into the Medicaid Management Information System (MMIS) to be processed for payment, it must first be scanned. After a claim is scanned the electronic image of that claim is transmitted to the Data Entry Department. The Data Entry Department then enters the information from the scanned images into an electronic file. That file is then transmitted to the MMIS for claims payment processing. As a result, it is imperative that all claims be submitted in a condition suitable for scanning. Presently, claims are being returned to providers for the following reasons:

- Illegible handwriting
- Light print due to submitting photocopies instead of original paper claim documents
- Improper claim form and/or missing information

To ensure that your claims will not be returned, please remember the following tips:

1. Do not staple claims together. Providers should place attachments behind the associated claim and place them in an envelope.
2. Sign the claim in ink. Most of the claims are returned because they are not properly signed.
3. Submit requests for Medicaid payment on the appropriate Mississippi crossover claim form. Providers are sending HCFA-1500 and UB-92 claim forms with Medicare Explanation of Benefits (EOB) showing that payment has been received by Medicare.
4. List the third party payment amount in the prior payments field on the UB-92 and in the amount paid field on the HCFA-1500. Continue to submit with the claim the EOB which shows the third party payment.
5. Do not send a stack of claims with only one copy of the attachment if the attachment goes with each claim. Copy the attachment for each claim and place it with the associated claim before submitting the claims for processing.
6. Submit standard 8x11 attachments. Strips, cutouts, etc., are not acceptable.
7. Put the bill date on each claim.
8. Place bill types on UB 92 claim forms and crossover forms for Medicare Part A.
9. Mail or electronically submit your claims. FAX COPIES OF CLAIMS CANNOT BE ACCEPTED.

Attention to these important tips will allow ACS to process your claim accurately. If you have any questions, please call Provider and Beneficiary Services at 1-800-884-3222 or 601-206-3000.

New AVRS Phone Number for the Mississippi Medicaid Voice Information System

Providers can now call the Mississippi Medicaid Voice Information System directly by calling 1-866-597-2675 or 601-206-3090. Using your Medicaid Provider Number you can access beneficiary eligibility, service limits, NSAIDS drug prior authorization, drug coverage, and check amounts. This will allow providers to access the voice response system faster. Providers may also continue to use the current Provider and Beneficiary Services phone number. We encourage providers to take advantage of this new option

Pharmacy Notes

Different NDCs are available for the following products:

- 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, 30 mg/1.25mg per teaspoonful
- Triprolidine and Pseudoephedrine, 60mg/2.5mg per tablet

The Division of Medicaid has tried to provide a wide range of covered NDCs for these generic products. No other cough and cold preparations will be added at this time; however, some may be added at a later date. Prescribers, please remember that for Medicaid to reimburse for covered over-the-counter products, a prescription must be written and presented to the pharmacy. Pharmacies, remember that over-the-counter products should be billed atshelf price.

ACS Announces Spring 2002 Provider Training Workshops

ACS State Healthcare announces the schedule for regional Medicaid provider workshops this spring. The workshops will address Medicaid changes recently passed by the legislature, give tips on claims submission, discuss common billing errors, provide other important information, and answer your billing questions.

These provider workshops are scheduled throughout the State at 11 convenient locations. Two training dates are scheduled in Jackson. There will be four sessions offered on each training date. Providers should attend the session for the claim type they use.

The time and subject of each of the sessions are listed below. Please note the session for providers who bill on the HCFA-1500 is offered in the morning and repeated in the afternoon:

8:30 AM – 10:00 AM	HCFA-1500
10:30 AM – 12:00 PM	UB-92 and Long Term Care
1:30 PM – 3:00 PM	HCFA-1500
3:30 PM – 5:00 PM	Pharmacy and Dental

The dates and locations of the workshops are given below:

April 22 **Meridian** MSU Meridian Campus 1000 Highway 19 North	**April 23** **Columbus** Trotter Convention Center 5th Street North
April 24 **Oxford** Paul B. Johnson Commons University of Mississippi	**April 25** **Robinsonville** Harrah's Convention Center 1100 Casino Strip Blvd.
April 26 **Greenville** Greenville Higher Education Center 2900-A Highway 1 South	**April 30** **Hattiesburg** Lake Terrace Convention Center Plaza One Convention Center
May 1 **McComb** Southwest MS Regional Medical Center 215 Marion Avenue	**May 2** **Natchez** Natchez Community Center 215 Franklin St.
May 6 **Biloxi** Broadwater Resort 2110 Beach Blvd.	**May 8** **Corinth** Shiloh Ridge Golf and Racquet Club 3303 Shiloh Ridge Road
May 9 **Jackson** St. Dominic Hospital Auditorium 969 Lakeland Dr.	**May 10** **Jackson** St. Dominic Hospital Auditorium 969 Lakeland Drive

This is the only announcement of these workshops that you will receive. It is not necessary to reserve space to attend. Please contact ACS Provider and Beneficiary Services at 1-800-884-3222 or (601) 206-3000 or your Provider Field Representative if you have any questions about this upcoming training.

Nursing Facilities Bed Tax Recoupment

Nursing facilities involved in the recoupment process (reduction in Medicaid payment by outstanding bed tax) will be allowed to pick up a check for the balance of their Medicaid payment. Facilities must contact the Medicaid fiscal agent at 1-800-884-3222 to arrange the pickup. Proper identification will be required.

Durable Medical Equipment Orthotic and Prosthetic Co-payments

As authorized by House Bill 1200, the Division of Medicaid will apply co-payments to durable medical equipment (DME), orthotics and prosthetics effective May 1, 2002. DME suppliers must refer to the DME fee schedule to determine the Medicaid allowable fees in order to calculate the correct co-payment amount. The DME fee schedule is on the website for the Division of Medicaid, which is www.dom.state.ms.us.

1. The DME co-payment is applicable to **dates of services on and after May 1, 2002.** Exception codes listed below apply.
2. The DME co-payment will only apply to durable medical equipment (rental and purchase) and orthotics and prosthetics. This is applicable to DME modifiers 1, 2, 3, and 6.
   - Modifier 1 = Monthly Rental
   - Modifier 2 = Daily Rental
   - Modifier 3 = Purchase (New)
   - Modifier 6 = Purchase (Used)

   The co-payment will not apply to repairs, maintenance, or medical supplies (modifiers 4, 5, or 7).
   - Modifier 4 = Repairs
   - Modifier 5 = Maintenance
   - Modifier 7 = Medical Supplies
3. The co-payment for E1399 for modifiers 1, 2, 3, and 6 is $3.00.
4. The co-payment amounts for codes other than E1399 are listed in the chart below (Use the Medicaid DME Fee Schedule as reference in regard to the allowable fees for each HCPCS code and specific modifier).

Modifier	Modifier Description	Co-payment
1	Monthly Rental of Durable Medical Equipment	If the Medicaid allowable fee for specific HCPCS code / modifier is: $10.00 or less, co-payment is $.50 $10.01 - $25.00, co-payment is $1.00 $25.01 - $50.00, co-payment is $2.00 $50.01 or more, co-payment is $3.00
2	Daily Rental of Durable Medical Equipment	If the Medicaid total allowable fee for the partial month for the specific code/modifier is: $10.00 or less, co-payment is $.50. $10.01 - $25.00, co-payment is $1.00 $25.01 - $50.00, co-payment is $2 $50.01 or more, co-payment is $3.00. Example: Daily Rental Allowance of $.60 x 5 units (days) = $3.00 allowance. A co-payment of .50 applies. Example: Daily Rental Allowance of $.60 x 20 units (days) = $12.00 allowance. A co-payment of $1.00 applies. Please note this co-payment is figured again total payment for the partial month..not on a daily basis.
3	Purchase of Durable Medical Equipment (New) Purchase of Orthotics or Prosthetics	If the Medicaid allowable fee for the specific code / modifier is: $10.00 or less, co-payment is $.50 $10.01 - $25.00, co-payment is $1.00 $25.01 - $50.00, co-payment is $2.00 $50.01 or more, co-payment is $3.00
4	Repair	No Co-payment
5	Maintenance	No Co-payment
6	Purchase of Durable Medical Equipment (Used)	If the Medicaid allowable for specific HCPCS code / modifier is: $10.00 or less, co-payment is $.50 $10.01 - $25.00, co-payment is $1.00 $25.01 - $50.00, co-payment is $2.00 $50.01 or more, co-payment is $3.00
7	Medical Supplies	No Co-payment

Attention! 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.

Long-Term Care Facility Cost Report Changes

Effective immediately Schedules 6, 7, 18, and 19 for Dues and Educational Seminars and Training are no longer required. Only amounts over $500 for Miscellaneous, Other Expense and Travel are required to be detailed on Schedules 8, 10, 21, and 22.

If you have questions or need more information, please call the Bureau of Reimbursement at (601) 359-6046.

Policy Manual Reminder

This bulletin is a document for the Mississippi Medicaid Policy Manual and must be placed behind Tab 88 of the manual. All providers are accountable for all policies in the monthly Mississippi Medicaid Bulletins.

ACS
P.O. Box 23078
Jackson, MS 39255

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

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

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April

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SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1 Checkwrite	2	3	4 ESC Cut Off 5:00 p.m.	5	6
7	8 Checkwrite	9	10	11 ESC Cut Off 5:00 p.m.	12	13
14	15 Checkwrite	16	17	18 ESC Cut Off 5:00 p.m.	19	20
21	22 Checkwrite	23	24	25 ESC Cut Off 5:00 p.m.	26	27
28	29 DOM, ACS and HSM CLOSED Checkwrite	30				

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.