Mississippi Medicaid Bulletin

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May 2002

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Diagnosis to Procedure Comparison Edit 446

Based on an assessment of costs relating to the Claim Review software which managed the diagnosis to procedure comparisons (Edit 446), the Division of Medicaid has discontinued the use of the software. Providers will no longer receive edit 446 denials on the remittance advices.

The Division of Medicaid will monitor correct coding and medical necessity through post payment utilization reviews. Providers must continue to provide the correct ICD-9 diagnosis code in Item 24E of the HCFA 1500 claim form which documents the medical necessity for the procedure codes listed in Item 24D.

Providers may not resubmit previously denied claims directly to the Fiscal Agent. If a provider wishes to appeal a denial, he/she must submit a hard copy of the claim with the related clinical records for reconsideration to the Medical Services Division of the Division of Medicaid. The claim will be reviewed for coding accuracy and medical necessity and, if approved, forwarded to the Fiscal Agent for reprocessing.

We are confident that providers are more focused on correct coding practices and, from an evaluation of administrative costs for both the Division of Medicaid and the providers, it has been determined that it is cost effective to turn off Edit 446.

EPSDT Optional Programs

Effective immediately, the Division of Medicaid will not approve any new providers for the EPSDT Case Management and /or Continuing Care optional programs until further notice. These options are being reviewed. The Division continues to recruit Medicaid providers for the EPSDT federally mandated program for eligible children and youth up to age 21. For provider enrollment questions, please contact the EPSDT Division of Medicaid. The phone number is 1-800-421-2408 or 601-359-6150.

Scratch Resistant Coating

Effective June 1, 2002, the Division of Medicaid will no longer provide benefits toward HCPCS Code V2760, Scratch Resistant Coating for eyeglasses. The Division of Medicaid does not consider scratch resistant coating for eyeglasses to be medically necessary for the treatment of a patient's vision. If you require additional assistance, please call 1-800-421-2408 or 601-359-6050.

MISSISSIPPI DIVISION OF MEDICAID

May 2002 Provider Training Workshops

ACS State Healthcare announces the schedule for the remainder of the regional Medicaid provider workshops for May. As mentioned in the previous bulletin, 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.

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:

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

Note: 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.

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 all paper claims filed using the HCFA-1500, UB-92, ADA 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.

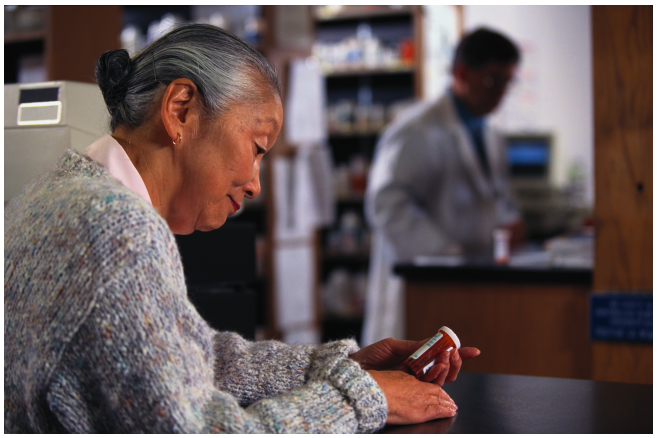
Other providers such as groups, facilities, etc. must submit their claims with the provider name listed as it is in the upper right hand corner of your Remittance Advice. This is an exact match of your identity in the Medicaid Provider Master File. For example, The DOM Medical Center must be billed as 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 ADA form, this information is placed in Field 42.
- 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 ACS at 1-800-884-3222.

If you are interested in sending your claims faster with less chance of error, please call the EDI Department of ACS at 1-866-225-2502 or go to the website www.acs-gcro.com. You will be provided with information and specifications for billing electronically.



Authorization of Prescriptions

Beginning June 1, 2002, Health Information Designs will perform prior authorization review of drugs as required by the Division of Medicaid.

Additional information regarding how to obtain authorization will be forthcoming.

Health Information Designs' authorization determinations do not guarantee Medicaid payment for services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

Maximum Prescriptions Limit

Effective June 1, 2002, the maximum prescriptions allowed per beneficiary will be seven per month. However, prescriptions over five per beneficiary will require prior authorization. Children and youth under age 21 and those beneficiaries institutionalized may receive unlimited prescriptions OVER FIVE, when prior authorized. Prescribers and pharmacies will be notified of the process to obtain authorization in a special bulletin.

Psychological Evaluations

Providers of mental health services to children through the Expanded EPSDT Program are advised that psychological evaluations are eligible for reimbursement by Medicaid only when they are medically necessary to fulfill a specific purpose. Some purposes which might justify the need for a psychological evaluation include, but are not limited to, the following: to determine the level of a child's intellectual functioning, to screen for learning disabilities, to rule out/confirm the presence of a thought disorder, to assess the nature and extent of a mood disturbance, or to assess a child for PRTF placement. Mississippi Medicaid does **not** require that a child receive a psychological evaluation prior to (or as a part of) receiving psychotherapy services. Psychological evaluations that are performed as a *routine* requirement of any provider or program are not eligible for reimbursement by Medicaid.

Psychological Evaluations Required for Psychiatric Treatment Facility (PRTF) Admission

Effective May 1, 2002, psychological evaluations required for PRTF admission may be conducted up to 60 days prior to the actual PRTF admission. The previous requirement for a psychological evaluation 30 days prior to admission has been extended in order to reduce the number of updated psychological evaluations that are conducted when a child/adolescent is placed on a waiting list for PRTF admission.

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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May

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