Mississippi Medicaid Bulletin

Volume 8. Issue 16

October 2002

Inside this Issue

Billing HCPCS Code J3490

Providers billing HCPCS Code J3490 for injectable drugs which do not have a specific HCPCS code must submit a paper claim with the name of the drug, strength, dosage **and method of administration** indicated by the code. Only one (1) unit can be billed with J3490. The claims will be reviewed by the Fiscal Agent Medical Review Unit and priced according to dosage administered to the patient.

Home Uterine Monitors

Effective October 1, 2002, home uterine monitors will no longer be covered under the Mississippi Medicaid program.

Urodynamic Procedures (CPT Codes 51725 - 51797)

When billing urodynamic procedures, both modifier -51 (multiple procedures performed in the same session) and modifier -26 (professional component) may apply. However, the Medicaid claims processing system currently accepts only one modifier per procedure code. Therefore, the Division of Medicaid is authorizing providers to bill only modifier -51 in these situations. When the system is modified to accommodate more than one modifier, this authorization will no longer be valid.

Update to State Plan

For updates to the Medicaid State Plan, please refer to the DOM website (www.dom.state.ms.us). Proposed amendments, retracted/withdrawn amendments, and approved amendments will be posted under the topic "State Plan."

MISSISSIPPI DIVISION OF MEDICAID

Notice to Nursing Facilities: Utilization of the Minimum Data Set (MDS) MPAF Assessment Form

Effective Immediately: The Division of Medicaid will accept the new MDS Medicare PPS Assessment Form (MPAF) as the quarterly assessment with exceptions as follows:

Full Assessment Required: The Omnibus Budget Reconciliation Act (OBRA) of 1987 assessment requirements supercede the use of the abbreviated form. A full assessment must be submitted for initial assessments, significant change in status assessments, significant correction assessments and annual assessments.

Full Assessment Required: Nursing Facilities with a designated Alzheimer=s Unit must submit a full assessment for the quarterly assessment in order to receive consideration for reimbursement.

Additional Requirement: A Mississippi Specific Section S must accompany **ALL** assessments.

Use of the MPAF form is ***optional.*** Facilities may continue to complete and submit the MDS full assessment form for all assessment types.

If you have any questions, please call the Case Mix Helpline at 601-359-5191 or 601-359-6750.

Provider Policy Manual Revisions

The following Division of Medicaid Provider Policy Manual sections have been revised with effective dates as noted. These policies are posted on the DOM website in the Policy Manual at **www.dom.state.ms.us.**

Section 10.81	Home Uterine Monitor - effective 10/1/02
Section 21	Community Based Mental Health Services - effective 10/1/02

ADA Update: Quadrant Codes

To ensure your dental claims are processed correctly, enter the quadrant abbreviation in the tooth number field, Field 59, if a quadrant applies to a dental procedure. The quadrant codes are as follows:

RU - Right Upper	RL – Right Lower
LU - Left Upper	LL – Left Lower

Treatment Authorization/Prior Authorization Numbers for K-Babies Effective Date Change

The procedure for issuing treatment authorization numbers (TAN)/prior authorization (PA) numbers for K-babies is being changed in an effort to reduce some of the problems that have occurred when claims have been filed for these babies.

Effective December 1, 2002, when the provider contacts HSM for a TAN/PA for a K-baby, HSM will determine medical necessity and give the provider the TAN/PA number. At this time, the provider will be advised that the TAN/PA will not be released to the fiscal agent, ACS, until the provider notifies HSM of the baby's Medicaid ID number. The TAN/PA will no longer be transmitted to ACS using the mother's Medicaid ID+K. However, the mother must be Medicaid eligible for HSM to complete the review. When HSM is notified of the baby's Medicaid ID number by the provider, the TAN/PA will be released to ACS and the provider can submit the claim to ACS.

On at least a bi-weekly basis, HSM will send a list to providers to inform the provider that a review has occurred or has been certified and that the baby's Medicaid ID number is needed so that TAN/PA information can be transmitted to ACS.

This change in procedure will be for any TAN/PA requested for a K-baby on and after December 1, 2002. The process will not change for any TAN/PA issued with the mother's Medicaid ID+K prior to December 1, 2002.

Resubmitting Claims

The Division of Medicaid and the fiscal agent, ACS State Healthcare, have identified many problems resulting from providers resubmitting claims repeatedly, sometimes daily, as a means of following up on claims on which processing has not been completed. The Division of Medicaid is directing that claims not be resubmitted as a means of following up on claims. If providers need to check on the status of claims which are in process, they must contact the Fiscal Agent for a status report. If, upon completion of processing, the claim is rejected for a reason which justifies resubmission, then and only then, should providers resubmit claims.

Provider Policy Manuals On the Website

Effective July 1, 2002, the Division of Medicaid is no longer mailing hard copies of the Provider Manuals unless requested by the provider. All provider policies and manual sections will be posted on the DOM website at www.dom.state.ms.us. This process will enable us to update the policy manuals on a timely basis, and providers will be assured that they have access to the most current information. As new or revised policies are released, the Division of Medicaid will notify providers by bulletins.

If you want a hard copy of a policy, please call ACS Provider and Beneficiary Services at 1-800-884-3222 or 601-206-3000. If more than one hard copy is requested per provider number, the provider will be asked to pay for each additional copy.

Providers are responsible for obtaining copies of the policies by printing them from the website or requesting hard copies and placing them in the appropriate sections of the Provider Policy Manual. Providers must maintain a file of all policies in this manual rather than just those applicable to their specific practices.

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.

PHARMACY NOTES:

Effective November 1, 2002, the following changes will be made to Division of Medicaid Prior Authorization (PA) requirements:

PA is no longer required for benzodiazepines. Appropriate prescribing and usage will be monitored via the drug utilization review process.

PA is no longer required for clozapine. Appropriate prescribing and usage will be monitored via the drug utilization review process.

Prior Authorization is required for oral sustained relief (SR) opioid agonists.

Criteria:

- Beneficiaries must have chronic, severe pain that has not responded to alternative pain management choices, such as schedule II opioid agonists, physical therapy, cognitive behavioral techniques and/or medical techniques.
- Additional justification for approval include diagnosis of cancer (ICD-9 codes 141.0-208), arthropathies (ICD-9, codes 715.01-715.9 & 742.2), spinal neurological disorders (ICD-9 codes 720-725), other ICD-9 codes with supporting documentation, additional medical justification for the absence of alternative therapies in debilitated patients.
- Contraindications to oral sustained release opioid agonists include hypersensitivity to opiates, respiratory depression/hypoxia/hypercarbia, severe asthma or COPD, paralytic ileus

Approval will be granted for up to two tablets per day of any single strength. If the request is for more than two tablets per day, additional medical justification will be required for approval based on asymmetric dosing or titration.

For opioid dependent patients, documentation of a titration-weaning schedule must be provided. Approval may be granted for a 34-day supply for up to six months.

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

Presorted
First Class Mail
U.S. Postage Paid
Jackson, MS
Permit No. 53

October

October 2002

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
		1	2	3 EDI Cut Off 5:00 p.m.	4	5
6	7 CHECKWRITE	8	9	10 EDI Cut Off 5:00 p.m.	11	12
13	14 CHECKWRITE	15	16	17 EDI Cut Off 5:00 p.m.	18	19
20	21 CHECKWRITE	22	23	24 EDI Cut Off 5:00 p.m.	25	26
27	28 CHECKWRITE	29	30	31 EDI Cut Off 5:00 p.m.		

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.