Provider Re-enrollment

Provider re-enrollment will begin March 1, 2003. Every Mississippi Medicaid provider is required to re-enroll by completing the newly revised provider application and agreement.

Provider re-enrollment is necessary to meet Health Insurance Portability and Accountability Act (HIPAA) requirements. It will also enable the Division of Medicaid to update provider information for the new provider database that is being developed as part of the renovated Medicaid claims processing system for HIPAA compliance. The renovated system is called *Envision.*

Important things to know about provider re-enrollment:

- Every provider must re-enroll regardless of date previously enrolled.
- Re-enrollment must be done by May 31, 2003. Provider numbers will be closed for providers who do not re-enroll.
- Current provider numbers will have a zero (0) added to the beginning of the provider number.

It will be necessary for you to complete the provider application and agreement to re-enroll. These forms will be mailed to your service address. If you have any questions concerning re-enrollment or completing the form, please call Provider Enrollment at1-800-884-3222 or 601-206-3000.

Beginning March 1st 2003, the provider application and agreement will be available online, so that you can download them for printing and completion or you can complete the application online and submit it electronically. The web site address is http://msmedicaid.acs-inc.com. The site will be available after March 1, 2003.

Provider workshops will be held in March and April. Topics to be covered are HIPAA guidelines, revised software for electronic billing (WINASAP), provider re-enrollment and *Envision.* Refer to the previous page for the spring workshop details.

Spring Clean With Windows-Based Claims Submission Software

Spring is just around the corner and so is the new Windows-based claims submission software. The new Windows-based claims submission software is called WINASAP2000.

Beginning in mid-March and continuing through April, the software will be released to all current NECS submitters.

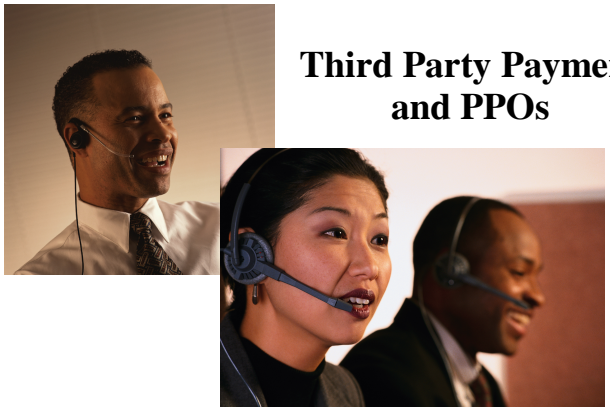
If you do not receive this software packet by **April 30, 2003**, please call the ACS EDI Support Unit at 1-866-225-2502 to request one.

ACS designed the new Windows-based software product called Windows Accelerated Submission and Processing 2000 (WINASAP2000). Just like NECS, this new Windows-based software allows the user to submit claim data electronically from a personal computer to ACS. This software is also free to all active Mississippi Medicaid providers.

To use WINASAP2000, your personal computer must meet the following minimum requirements:

- Windows 95 or higher operating system
- Pentium processor
- CD-ROM drive
- 50 megabytes of free disk space
- 64 megabytes of RAM
- Hayes compatible 9600 baud asynchronous modem
- Telephone connectivity

To learn more about this exciting new product by ACS, look for an article in this edition about upcoming provider training workshops.



Third Party Payment and PPOs

We have received several phone calls concerning the third party payment on claims, when the Medicaid provider is part of a preferred provider organization. The provider must report the contractual agreement (discount) plus the money received as the third party payment.

Currently, Medicaid policy states that when a Medicaid beneficiary is covered by a private insurance policy whose administrator has a preferred provider organization in which the Medicaid provider participates, the following applies:

> Medicaid is to make no payment when billed for the difference between the third party payment and the provider's charges. The provider agreed as a member to accept payment of less than his charges. This agreement and acceptance constitute receipt of a full payment for services. Therefore, the Medicaid beneficiary who is insured has no further responsibility. Medicaid's intent is to make payment only when the beneficiary has a legal obligation to pay.

To comply with this policy, the provider must enter the total of the contractual adjustment and the third party payment as the third party amount in fields 54 of the UB92, 29 of the HCFA 1500, or 19 of the Mississippi Crossover Form. If payment is received, enter zero in the third party field. An explanation of benefits must be attached if the insurance company denies the claim or the amount in the third party field is less than 20% of charges. ACS has been directed to return claims which are not billed in accordance with the policy.

Prior Authorization Needed For Hospice

On July 1, 2002, DOM began requiring prior authorization for hospice services.

Medicaid has been receiving information that is not necessary. **Prior authorization for hospice services is required for Medicaid ONLY individuals.** Individuals who do not have Medicaid, have not applied for Medicaid, or have no intention of obtaining Medicaid, are not required to be approved by Medicaid.

If an individual has been receiving hospice services under some other coverage (i.e., private insurance) but then applies for Medicaid, the appropriate documentation is required at the time the Medicaid application is made.

Hospice providers who are servicing individuals who are **dual** eligibles (Medicare/Medicaid) are required to submit the Medicare hospice enrollment form along with the Medicaid hospice enrollment form to DOM. This is required because, according to federal regulations, Medicare and Medicaid enrollment segments run simultaneously.

For Medicaid ONLY individuals, in accordance with Medicaid policy, required documentation to receive authorization include: (1) The written certification statement signed by the hospice medical director AND the individual's attending physician indicating that the individual's medical prognosis is less than six (6) months if the terminal illness runs its normal course and that hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions; (2) a written plan of care that is developed and signed by all members of the interdisciplinary team, prior to services being provided; (3) any supporting documentation that identifies the beneficiary is terminally ill; and (4) the original DOM 1165 (Mississippi Medicaid Hospice Membership Form).

Documentation should be faxed to (601) 359-9532. The complete Hospice Policy Manual is available on the DOM website.