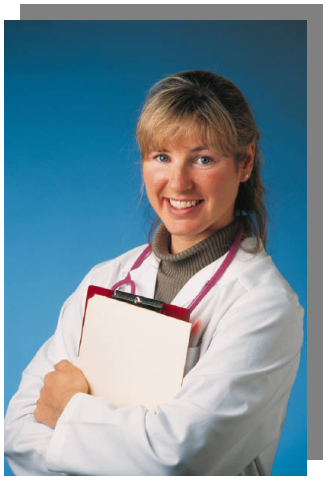
Identification of Prescribers on Pharmacy Claims



The Division of Medicaid is reviewing pharmacy claims for accuracy. An analysis of Medicaid pharmacy claims determined that a substantial number of pharmacy providers submitted claims with either an invalid prescriber number or an unknown prescriber number such as 0019999 or 1999999.

In order to decrease the use of the "generic" prescriber number for pharmacy claims, the Division of Medicaid is implementing the use of the following procedures for indicating the prescriber on prescription claims to assist pharmacists in submitting accurate claims information to DOM:

1. If the prescriber's name and provider number are listed on the Prescribing Providers Lists (Mississippi, Alabama, Arkansas, Louisiana, and Tennessee), this provider number should be filed on the pharmacy claim submitted for payment by Medicaid.

2. If the prescriber's name and provider number are not listed on the Prescribing Providers Lists, the prescriber's office should be contacted by the pharmacy to acquire the provider number. If the issuer of the prescription does not participate in Medicaid as a provider of services, the 0019999 prescriber number should be entered to the pharmacy claim.

3. If the prescriber is a member of a clinic from which the prescription was issued, but the individual physician/nurse practitioner does not have his or her own prescriber number, determine if the clinic's provider number is contained in the listing. If so, use the clinic=s provider number.

4. If the prescription is issued at a hospital or ER for outpatient dispensing and that location has a provider number in the Prescribing Providers Lists, utilize this number or the prescriber's individual provider number.

5. If no prescriber identification number is available following a good faith effort by the pharmacy staff to obtain one, the 0019999 number may be utilized.

The pharmacy is responsible for maintaining accurate and current prescriber identification capability accessible to pharmacy employees. When the utilization of the 0019999 number becomes substantial, the pharmacy provider should again attempt to obtain a Medicaid provider number for prescribers.

In order to receive a current Prescribing Providers List you may contact the fiscal agent. The list is also available at http://www.dom.state.ms.us/Provider/Publications/publications.html.

Accurate prescriber identification of the prescription issuer is required; non-compliance may result in termination of POS privileges.

Change in Prescription Drug Billing for Medicare/Medicaid Beneficiaries

The Division of Medicaid delayed the effective date requiring pharmacies to bill Medicare for those drugs covered by Medicare to allow for billing changes. However, effective April 1, 2003, all drugs covered by Medicare in an outpatient pharmacy setting must be submitted to Medicare as the primary insurer. ACS will deny pharmacy claims for dually-eligible (Medicare and Medicaid) beneficiaries when it is for a Medicare-covered drug.

There are several categories of drugs that are covered by Medicare for outpatients. These include, but may not be limited to:

1. Immunosuppressive agents for transplant recipients covered by Medicare;
2. Total Parenteral Nutrition;
3. Total Enteral Nutrition;
4. Oral Anti-Cancer Agents;
5. Oral Anti-Nausea Agents; and Inhalation Drugs.

Billing Information

Claims submitted to ACS through the pharmacy point-of-sale (POS) system for the drugs or supplies listed above will be denied for dually eligible beneficiaries. A standard NCPDP error message will post advising the pharmacist that the beneficiary is Medicare eligible.

Once the Medicare claim has been approved and processed, Medicare will automatically submit the balance of the claim as a "crossover" to Medicaid (ACS) electronically.

For those claims that do not cross over to Medicaid electronically, the pharmacy provider must complete a Medicare Part B Crossover Form according to the instructions located on our website at http://www.dom.state.ms.us/Provider/crossovr.pdf and submit it to the address noted below.

Medicare crossover claims must be submitted to Medicaid for payment within six months of the Medicare payment date. Claims filed after the six-month timely filing limitation will be denied.

Claims should be sent to the following address:

ACS
P O Box 23076
Jackson, MS 39225

For dually eligible beneficiaries, if Medicare and Medicaid cover the service, Medicaid will pay the full coinsurance and deductible amounts due, based upon the Medicare allowed amount.

For qualified Medicare Beneficiaries (QMB-Medicare Only), if the service is not covered or is denied by Medicare, Medicaid will not reimburse.

Denials from Medicare

Pharmacies may receive denials from Medicare and will need to bill Medicaid for prescriptions. Only Medicare denials for non-covered drugs or lack of Medicare eligibility will be acceptable reasons for Medicaid consideration. Claims denied for incomplete information or improper completion of forms should be resubmitted to Medicare with additions and/or corrections.

If Medicare denies a drug, the drug may be billed to Medicaid on the Mississippi Pharmacy Claim Form with the Explanation of Medicare Benefits (EOMB) from Medicare attached.

Inquiries

For questions concerning any part of this program instruction, please contact the Division of Medicaid's Pharmacy Bureau at 601-359-5253 or ACS, Provider Relations at (800) 884-3222 or 601-206-2900.

Information for Medicare coverage should be addressed to Medicare's Provider Inquiry Unit at 1-866-238-9650.

Provider Policy Manual

The Mississippi Medicaid Provider Policy Manual is available on the website for the Division of Medicaid (DOM) at www.dom.state.ms.us. Providers are notified in the monthly Medicaid provider bulletin of updates to the Provider Policy Manual.

For providers who do not have access to the Internet, a request can be made for a copy of the Provider Policy Manual on CD. A limit of one CD per provider number will be available at no cost. CDs with updated Provider Policy Manual information will be sent as replacement CDs on a regular basis to providers who have previously requested CDs.

If you cannot access the Provider Policy on the Internet and need a CD, please send a written request to ACS at the following address:

ACS
P. O. Box 23076
Jackson, MS 39225

or call Provider and Beneficiary Services at 1-800-884-3222.

Please allow 5 business days to process the request for a CD of the Provider Policy Manual.

If you have trouble with either of these methods for accessing the Medicaid Provider Policy Manual, please call Provider and Beneficiary Services at 1-800-884-3222.

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 status reports. If, upon completion of processing, the claim is rejected for a reason that justifies resubmission, then and only then should providers resubmit claims.

ACS Customer Service

For quicker, more efficient service, please have all pertinent information ready when phoning your ACS Provider and Beneficiary Service representative at 1-800-884-3222.

You will need your:

- Provider ID Number
- Beneficiary ID Number
- Dates of Service

2003 New Bed Values for Nursing Facilities, ICF-MRs and PRTFs

The new bed values for 2003 for nursing facilities, intermediate care facilities for the mentally retarded (ICF-MRs) and psychiatric residential treatment facilities (PRTFs) have been determined by using the R.S. Means Construction Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

Facility Class	2003 New Bed Value
Nursing Facility	$32,210
ICF-MR	$38,652
PRTF	$38,652

Adjustment/Void Request & Payment Refund Procedures

When submitting the Adjustment/Void Form, Sections One through Six should be completed. Requests for reprocessing due to billing errors must be accompanied by a corrected claim form. Credit balances created by adjustments and voids can be recouped from future payments. However, if payment is submitted with the Adjustment/Void form, the check should be made payable to the Division of Medicaid.

Any checks received after January 1, 2003, made payable to entities other than the Division of Medicaid will be returned to the provider along with any supporting documentation submitted.

ACS
P.O. Box 23078
Jackson, MS 39225

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

April 2003

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 **DOM and ACS CLOSED** CHECKWRITE	29	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.