Mississippi Medicaid Bulletin

Volume 9, Issue 5

May 2003

Inside this Issue

Mississippi Division of Medicaid
Provider Re-enrollment Reminder

Provider Re-enrollment deadline is May 31, 2003. If a provider does not enroll by this date, their provider number will be closed.

Anesthesia Manual

The Anesthesia Manual, Section 51.0, has been revised with an effective date of 02/01/03. The policy is posted on the DOM website in the Provider Manuals at www.dom.state.ms.us. Please review this policy. If you have any questions, please call your ACS representative or the Division of Medicaid Bureau of Provider and Beneficiary Relations at 601-359-6133.

The only change to the current policy is the deletion of language which requires that the anesthesiologist must have a signed letter from the hospital or other facility administration on file in his/her office that verifies that the facility is not filing charges to cover costs of the resident/intern/student nurse anesthetist through ancillary charges, cost reports, etc.

Downloading Fee Schedule

Due to the size of the Procedure Code Fee Schedule PDF file on DOM's internet website, some providers have experienced problems downloading it.

To make this information more accessible, html pages have been created which may be accessed from links in the procedure code fee schedule index on the site's Fee Schedule page located at:

http://www.dom.state.ms.us/Provider/Provider_Manuals/Fee_Schedules/fee_schedules.html.

Visitors click links in the index to view the fee schedule for each range of procedure codes. From each procedure code range page, visitors may click a "next" link to display codes in consecutive ranges or click the link to return to the index. The key to fee schedule codes may also be accessed from each page through a link.

The PDF document as well as the zip file containing the fee schedule as an Excel spread sheet and as a text file are still available.

Important News About Local Codes

Over the years, Mississippi Medicaid has developed local billing codes for medical supplies and some other medical services. Effective October 2003, HIPAA regulations will require all states to use standard national HCPCS and CPT codes for billing. We will not accept any local code after September 30, 2003. In addition, we will not accept any obsolete HCPCS or CPT code after that date. Codes that begin with the letter W or Z are local codes. In addition, local code 99999222222 that is used to bill hyperalimentation will have to be replaced with standard codes. Obsolete codes are those HCPCS and CPT codes not listed in the 2003 HCPCS or CPT manuals.

The Division of Medicaid is working on crosswalks of all local codes to ensure that covered services continue to be reimbursed. We are currently working on a complete update of the HCPCS codes for the DME and medical supply program. HealthSystems of Mississippi (HSM) is not authorized to issue Treatment Authorization Numbers (TANs) for DME and medical supplies currently listed under a local or obsolete HCPCS code for dates beyond September 30, 2003. We will keep you informed about replacements for the local and obsolete codes as those crosswalks are completed.

<u>It is important to note that claims billed electronically using local or obsolete codes will be denied beginning October 1, 2003. Please submit any claims with local codes before that date.</u>

We strongly recommend that all providers attend the Mississippi Medicaid Provider Workshops that are tentatively scheduled for July and August. At the workshops, important information will be provided about billing requirements under HIPAA and the updated MMIS claims processing system. This information will assist you in making the transition to the new HIPAA-compliant system.

Frequently Asked Questions

Automated Voice Response System (AVRS)

What is AVRS?
AVRS stands for Automated Voice Response System. This is also known as the Mississippi Medicaid Voice Information System.

How do I access AVRS?
Dial 1-800-884-3222 to access the AVRS system.

When can I access AVRS?
AVRS is available 24 hours a day, 7 days a week.

What equipment do I need to access AVRS?
A touchtone phone.

What can I use AVRS for?
AVRS can be used to verify recipient eligibility, service limits, managed care enrollment status, current check amount, drug NDC coverage, claim status and drug prior authorization.

How many inquiries can I make during one call?
Ten inquiries can be made each time you call AVRS.

Is AVRS easy to use?
AVRS is very easy to use. Voice prompts assist the inquirer throughout the call.

Innovative State Use of the Civil Money Penalty Funds – Incentives for High Quality Care

The Division of Medicaid (DOM) has approved the use of collected sanctioned Civil Money Penalty funds to be awarded to nursing facilities that provide the highest quality of care to residents via recognition as an Enhancement Grant Award and to provide a means for those non-compliant facilities to be awarded educational program funds to attain compliance status and stay in compliance. Nursing facilities are encouraged to make applications for the eligible grant awards for the betterment of residents' quality of life, as funds are available.

Enhancement Grant Award: The goal is to provide enhancements to nursing facilities that have maintained compliance with the federal requirements for long term care. The purpose of the Enhancement Grant Award is to provide a nursing facility with current and past compliance history of the federal requirements the opportunity to receive funding for innovative programs/projects that will directly and/or indirectly benefit the residents by providing an enhanced quality of life. The grant award should be self-sustaining once implemented. For FY 04, **$250,000** has been set aside to award grants in the range of $5000 - $50,000. The grant proposal application may be obtained on the Division of Medicaid website at www.dom.state.ms.us or by telephone request at 601-359-6750. Deadline for completion and receipt of application to DOM is ***June 30, 2003***. The grants shall be awarded on or before ***September 1, 2003.***

Educational Program Award: The goal of this Educational Program Award is to assist nursing facilities that have not been in substantial compliance with federal requirements for long term care facilities to obtain and maintain compliance. The purpose of the Educational Program Award is to provide a nursing facility with current and past non-compliance history of the federal requirements the opportunity to receive funding for educational programs/projects that will directly and/or indirectly benefit the residents as well as assist the facility in providing an enhanced quality of life for the residents. This grant award is a one-time expenditure that will benefit the residents. For FY 04, **$100,000** has been set aside to award grants in the range of $5000 - $20,000. The grant proposal application may be obtained on the Division of Medicaid website at www.dom.state.ms.us or by telephone request at 601-359-6750. Deadline for completion and receipt of application to DOM is ***June 30, 2003***. The grants shall be awarded on or before ***September 1, 2003.***

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 held accountable for all policies in the monthly Mississippi Medicaid Bulletins.

PHARMACY NOTES

Attention: All Providers and Pharmacists

Prior Authorization for Prescription Drugs

The Mississippi Medicaid program has a prior authorization (PA) process for certain prescription drugs. Health Information Designs has been contracted to provide this service for the Division of Medicaid. Please note that generics, in most cases, do not require a prior authorization.

Prior authorization for certain drugs/drug classes enables us to determine that certain prescriptions are medically necessary and part of a specific treatment plan. Prior to implementation of any PA requirement, the PA criteria is reviewed and recommended by a Pharmacy and Therapeutics (P&T) Committee comprised of prescribers and pharmacists.

HID staff is available at 1-800-355-0486 (from 8 a.m. to 6 p.m., Monday-Friday, from 10 a.m. to 4 p.m., weekends and holidays) to verify the status of the PA request and answer any questions. PA forms may be submitted to HID via facsimile at 1-800-459-2135 for consideration. All forms are available on the HID web site at www.hidmsmedicaid.com.

If the PA request is approved, HID updates the POS system immediately and notifies the pharmacy of the PA number. If a PA request is denied a notice is sent via facsimile to the prescriber. All requests will be answered within 24 hours.
The following drugs currently require prior authorization approval:

Oral SR Opioid Agonists (brand only) Actiq Avinza Kadian MS Contin Oxycontin Oramorph SR	**Proton Pump Inhibitors (brand and generic)** Aciphex Nexium Prevacid Prolosec Protonix Prevpac
Non-Steroidal Anti-Inflammatory Drugs (brand only) Arthrotec Lodine XL Mobic Ponstel	**Antihistamines (brand only) and Non-Sedating Antihistamines** Allegra Astelin NS Clarinex Claritin Zyrtex
Cox-2 Inhibitors Bextra Celebrex Vioxx	**Immunosuppressants** Neoral Sandimmune Gengraf
Enbrel **Synagis** **Viagra** **Xenical** **Brand-name multi-source drugs*** **Extension of Benefits (5 per month)**	**Nutritionals** Boost Ensure Glucerna Isocal Jevity Kindercal Pediasure Polycose Twocal HN Ultracal

Please note:

✓ **Extension of Benefits PA**

- This PA number is **not** for drugs that require a prior authorization. This authorization number extends beneficiary's maximum drug coverage from 5 prescriptions monthly to 6 or 7 prescriptions monthly only.
- Any other drug requiring a prior authorization number must be submitted for 1st through the 5th prescription per month and not for the 6th or 7th prescription submitted for payment.
- Audits will be ongoing and restitution will be recommended if this PA number is used incorrectly.
- This PA has a 6-month time span. New PA submission is required with any change in therapy.

✓ **Brand-Name Multi-Source Drugs PA**

The Division of Medicaid does not reimburse for a brand name drug if there is an equally effective generic equivalent available and the generic equivalent is the least expensive.

The only exceptions to this policy are:

- Observed allergy to a component of the generic drug; or
- An attributable adverse event; or
- Drugs generally accepted as narrow therapeutic index (NTI) drugs.
  The following medications are identified as NTI drugs:

  - **Dilantin®**
  - **Lanoxin®**
  - **Tegretol®**
  - **Coumadin®**
  - **Synthroid®**

PA for a brand-name multi-source drug must include:

- The drug requested, the dosage form, strength and directions for use; and
- Previous trials of generic medications including the length of therapy and the **observed** allergic reaction or adverse event, described in detail; and
- A copy of the MEDWATCH report filed with the FDA by the provider ***and/or documentation of observed allergic reaction or adverse event.*** A MEDWATCH Form is available at http://www.fda.gov/medwatch/safety/3500.pdf.
- Duration of this PA may be granted for up to one year.

Due to our legislative mandate, Medicaid does not reimburse for a brand name drug if there is an equally effective generic equivalent available and the generic equivalent is the least expensive. For this reason, requests for brand-name multi-source drugs will be reviewed using the Brand-name Multi-source drug PA criteria regardless of any other PA criteria. For example, a request is received for Anaprox (brand-name NSAID); however, this drug has a generic equivalent. The PA criteria for the brand-name multi-source approval must be met.

Return of Unused Medications Policy

As an update to the February 2003 Medicaid Provider Bulletin, the Division of Medicaid offers the following clarification to the documentation requirements for the return of unused medications.

The LTC facility must maintain a log that properly documents the return of medication not dispensed to the resident for whom they were prescribed. The log must be available to DOM upon request. Documentation should include, at a minimum:

- Name of the resident;
- Drug name;
- Prescription number;
- Strength of medication;
- Date returned;
- Quantity returned; and
- Reason for return.

The dispensing pharmacy receiving the returned medication must adjust the original Medicaid claim from which the prescription was billed and reimbursement received, prorated to the quantity of the prescription returned. Documentation of the returned medications must be maintained by the dispensing pharmacy and made available to DOM upon request. Documentation must include:

- Name of the resident;
- Drug name;
- Prescription number;
- Strength of medication;
- Date returned;
- Quantity returned;
- Reason for return;
- Record of adjustment.

The record of adjustment may be a copy of the void/adjustment form or a documented note in the pharmacy's billing computer as to the date of adjustment.

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

Take the Right Route!

To ensure proper documentation and claim submittal, the following information will serve as your guide to routing your paperwork to the appropriate address. By using the assigned addresses below, you will lessen the chance for errors and shorten the time required to complete your transactions. If you have any questions or comments, please contact Provider and Beneficiary Services at 1-800-884-3222 or 601-206-3000.

Below is a list of each type of form or document with its corresponding address or fax number:

Form #	Title	Send this Form to :
DOM 210	**Eyeglass/Hearing Aid Authorization Form**	Division of Medicaid Bureau of Medical Services 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
DOM 260 NF	**Certification for Nursing Facilities**	Fax to 601-359-1383
DOM 260 DC	**Certification for Disabled Child**	Division of Medicaid Maternal and Child Health 239 North Lamar St, Suite 801 Jackson, MS 39201-1399
DOM 260HCBS	**Certification for HCBS**	Division of Medicaid Bureau of Long Term Care 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
DOM 260 MR	**Certification for ICF/MR**	ACS, P.O. Box 23076, Jackson MS 39225
DOM 301 HCBS	**HM Comm-Based SVS/PH**	ACS, P.O. Box 23076, Jackson MS 39225
Pharmacy	**Pharmacy Authorization Request**	Division of Medicaid Pharmacy Prior Approval Health Information Designs P. O. Box 32056 Flowood, MS 39212
DOM 413	**Level II PASARR Billing Roster**	Division of Medicaid Mental Health Services 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
HCBS 105	**Home and Community Based Services**	ACS P.O. Box 23076, Jackson MS 39225 Attention: Medical Review
MA 1001	**Sterilization Consent Form**	ACS, P.O. Box 23076, Jackson MS 39225
MA 1002	**Hysterectomy Acknowledgement Statement**	ACS, P.O. Box 23076, Jackson MS 39225
MA 1097	**Dental Services for Orthodontics Authorization Request**	Division of Medicaid Bureau of Medical Services 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
MA 1098	**Dental Services Authorization Request**	Division of Medicaid Bureau of Medical Services 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
MA-1148A	**Addendum to Plan of Care**	Division of Medicaid 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
MS/ADJ	**Adjustment Void Form**	ACS, P.O. Box 23077, Jackson MS 39225
MA 1165	**Hospice Membership Form** **Effective July 1, 2002**	Division of Medicaid Long Term Care, Hospice Services 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
MS/INQ	**Claim Inquiry Form**	ACS, P.O. Box 23078, Jackson MS, 39225
MS/XOVE	**Medicare/Medicaid Crossover Form - Part A**	ACS, P.O. Box 23076, Jackson MS, 39225
MS/XOVE	**Medicare/Medicaid Crossover Form - Part B**	ACS, P.O. Box 23076, Jackson MS, 39225
Title XIX	**Pharmacy Claim Form**	ACS, P.O. Box 23076, Jackson MS, 39225
ADA	**American Dental Association Claim Form**	ACS, P.O. Box 23076, Jackson MS, 39225
HCFA 1500	**HCFA 1500**	ACS, P.O. Box 23076, Jackson, MS 39225
UB-92	**UB-92**	ACS, P.O. Box 23076, Jackson, MS 39225

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

PRSRT STD
U.S. Postage Paid
Jackson, MS
Permit No. 53

MAY

May 2003

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