Mississippi Medicaid Bulletin

Volume 9, Issue 6

June 2003

Inside this Issue

DOM to Recover Payments for Post-Death Services

The Office of the Inspector General (OIG) recently completed an audit of Medicaid claims paid for beneficiaries after the date of death. As a result of the audit, OIG recommended that the Division of Medicaid (DOM) implement a process to identify and recover payments for post-death services claimed after the Medicaid claims payment system has been updated to reflect the beneficiary's date of death.

Beginning June 1, 2003, DOM will identify claims paid with dates of service after a beneficiary's death. This will begin with claims for date of service January 1, 1999, and continue as an ongoing process. Any claims identified will be voided and recovery from the provider will be pursued.

New Billing Procedures for Nursing Facilities And Intermediate Care Facilities for the Mentally Retarded

The Division of Medicaid's (DOM) billing procedures for Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded will be changed from the current roster billing to the UB 92 paper form and the 837 Institutional electronic form. These new billing procedures will be effective October 1, 2003, in compliance with the Health Insurance Portability Accountability Act of 1996 (HIPAA).

Billing manuals will be available on DOM's website at www.dom.state.ms.us. Providers will be notified in the coming months in the Bulletin and through DOM's website when the billing manuals are on the website and with additional information regarding this change. If you have any questions, please contact Evelyn H. Silas, Division Director, Bureau of Long Term Care, at 601-359-6750.

Notice to Prescribers and Pharmacies

In an effort to contain cost while maintaining quality health care for our Medicaid beneficiaries, DOM has developed a Preferred Drug List (PDL). Prescribers are strongly encouraged to prescribe these agents when possible to meet the clinical needs of patients. These agents were selected based on their clinical efficacy and cost effectiveness.

Please watch your mail for this list and some frequently asked questions and responses. This information will also be available on DOM's web site at www.dom.state.ms.us.

PASRR Reimbursement

Community Mental Health Centers and/or Regional Centers (CMHC/RCs) conducting Level II Evaluations should follow these guidelines in order to be eligible for reimbursement under the Pre-Admission Screening Resident and Review (PASRR) Program.

1. The CMHC/RC must submit a monthly billing roster, along with page 1 of the Pre-Admission Screening/Resident Review Summary for each Level II evaluation completed. Only one billing roster should be completed for each month and mailed to the following address:

   Division of Medicaid
   ATT: Mental Health Services-ORP
   239 North Lamar Street, Suite 801
   Jackson, MS 39201-1399

2. Page 1 must include all required information listed below for processing:

   Applicant's: Name; Address; Date of Birth; Social Security Number; Sex; and Medicaid Number. It must also include Medicare Number, if applicable, and the Resident Status (NF resident, yes or no)
   Diagnoses: indicated on the Pre-Admission Screening/Resident Review Summary
   Type of Evaluation: Initial or Subsequent, each
   Provider's: Name; Medicaid Provider Number; Name and credentials of the person completing each portion of the Level I and Level II

3. The following procedure codes should be used when completing billing rosters and preparing for reimbursement. The date(s) of services should be included on the billing roster under the number of screening units used.

Procedure Code Service
W3000 - Psychiatric History and Evaluation completed by a Psychiatrist or Licensed Psychologist
W3005 - Psychosocial Assessment completed by DMH certified staff
W3021 -Report Completion/Travel—(case management, including records management, as well as off-site travel to conduct the Level II)

A unit is the actual time spent face-to-face with the NF applicant or the time involved with report completion and/or travel.

For Psychosocial Assessment/Psychiatric History, it is the total beneficiary time spent, not staff time. Two staff members may not spend a total of one beneficiary hour and bill for two hours of staff time.

Requirements for Reimbursement
1. Only one Billing Roster should be submitted for each month.
2. The Billing Roster must be received within 12 months of the date of service or within 30 days from the close of the fiscal year (June 30), whichever is earlier.
3. The Billing Roster must be submitted for the month in which the Level II was completed. If the Level II is begun in one month, but completed in the next month, the billing roster should only be submitted when all required portions of the Level II are completed.
4. Only completed Level II Evaluations, including Psychiatric History and Evaluation, are eligible for reimbursement.
5. All assessments, which are part of the Level II Evaluation, must be signed by the person who completed that assessment.

Provider Re-enrollment News

Thank you for participating in the Mississippi Medicaid Provider Re-enrollment. Your participation allows the providers, the Division of Medicaid, and ACS to take one more step closer to the HIPAA compliant Envision system, which will be coming online in October. The following are several points to remember:

- ACS is currently processing over 15,000 re-enrollment applications.
- Please do not resubmit your application if you have had no response within 30 days.
- You will receive a welcome letter when your re-enrollment has been completed.
- DO NOT use your 8-digit provider number until October 1, 2003**.**

*****Provider Re-enrollment Deadline has been extended to July 15, 2003*****

Points to remember:

Web enrollment

- You can re-enroll via the Web at http://msmedicaid.acs-inc.com. You can download the documents for printing and completion, or you can complete the application online and submit it electronically. Please remember to send all the required documentation to ACS. You will not need to send a paper copy of your application.
- Please be sure to write your Application Tracking Number on all your required attachments.

Signatures

- Section 11, page 13 of 13 must be signed.
- ORIGINAL SIGNATURES ARE REQUIRED ON ALL DOCUMENTATION
- Send signed copies of the Provider Agreement (Check the Credentialing Requirements List to verify two or three).

Civil Rights Compliance for In-State Physicians, Dentists, Nursing Facilities, ICF/MRs, PRTFs and Hospitals

- Return pages 3, 4, and 12 signed, along with the attachments covering your policy on: Nondiscrimination Policy (Example on page 7 of 13; section c-3); Limited English Proficiency Policy (LEP), (Example on page 10 of 13; section c-3); Sensory Impairment Policy (Example on page 9 of 13; section c-3); Program - Facility Policy (Example on page 11 of 13; section c-3).
- The example letters must be changed to reflect the letter you will post in your office, clinic, facility, etc. Remove references to examples and complete the information requested in parentheses by typing over. Example, (**name of provider**) should be changed to be actual name without parentheses.
- If Medicare has conducted a Civil Rights Compliance Review of your facility, a letter should have been mailed to you. If you have received the Medicare certification approval letter, you can send a copy of that letter in lieu of completing the DOM Medicaid Civil Rights packet. (Do not send the original. Make sure the seal can be read.) To inquire if you have completed the Medicare Civil Rights Review, you can contact the Atlanta Regional Office of Civil Rights. The contact number is 404-562-7884. This letter can be dated back as far as the late 1980s.
- If you have previously completed the Civil Rights compliance information with Mississippi Medicaid, you may submit a copy of the Civil Rights Compliance letter.
- If you have no LEP/Sensory/Program-Facility procedure in place, you must send what your process will be on your letterhead. Advise, on letterhead, which procedures you do not have in place.

Continued on the Next Page

Provider Re-enrollment News Continued

Credentialing Requirements List

- Please verify the documentation required for your provider type and mail to ACS Provider Enrollment. Incomplete applications are being returned.

EDI Provider Agreement

- Faxed EDI agreements are no longer accepted. ACS is required to have original signatures on all documentation.
- If you bill electronically, you will not receive a paper Remittance Advice after October 1, 2003.
- Each provider number does not need a separate submitter ID. Each separate billing entity needs a submitter number.
  Ex. 1: Dr. Smith, Dr. Jones, and Dr. Williams all work for the Get Well Clinic. Only the Clinic needs a submitter ID. The doctors would need a submitter ID only if they also billed for their own practice separate from the clinic.
  Ex. 2: Nursing Home Group manages and bills for Extended Stay Home and Like Home Community. Only Nursing Home Group needs to have a submitter ID. They can bill for both facilities under one submitter ID.

Medicare/Medicaid Crossover Claims

This is a reminder that the 180-day timely filing limitation for Medicare/Medicaid crossover claims is determined using the Medicare payment register date as the date of receipt. Claims not filed or not filed correctly by 180 days from the Medicare payment date will be denied.

Most claims cross over to Medicaid from Medicare electronically. However, if after three to four weeks of the provider receiving payment by Medicare a claim has not appeared on the Medicaid remittance advice (RA), the provider should submit a paper claim to Medicaid using the Medicaid crossover claim form and attaching a copy of the Medicare payment register. (The Medicaid crossover claim forms are available on the Division of Medicaid website at www.dom.state.ms.us.) The provider should continue to submit the claim every three to four weeks until it appears on the Medicaid RA.

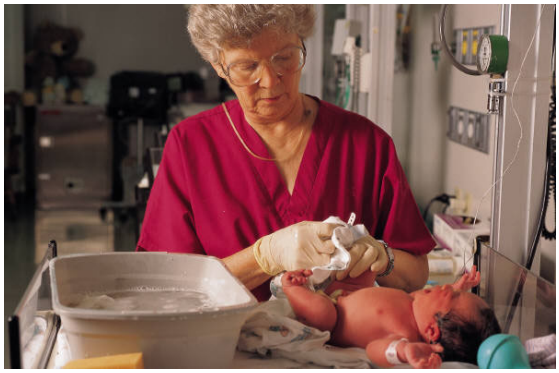
The 180-day timely filing applies to crossover claims that are processed and denied. The provider should resubmit any claims that need to be corrected within the 180-day timely filing limit.

Questions regarding crossover claims should be directed to ACS Customer Service at 1-800-884-3222.

Upcoming Provider Workshops

Provider workshops will be held in July and August to address new features of Envision, the Renovated Medicaid Management Information System (MMIS). Billing and other program changes will also be covered in these workshops. Please watch for dates, locations, and additional information in upcoming provider bulletins.

Medicaid ID Numbers for Newborns



A newborn whose mother is a Medicaid beneficiary is eligible for Medicaid for the first year of life. The exception to this is if the baby is released for adoption. In order to get a Medicaid ID number assigned for the baby as quickly as possible, the birthing hospital must complete the Request for Newborn Health Information form and fax it to the county Department of Human Services (DHS) office in the mother's county of residence. The form should be faxed to the DHS office as soon as possible, but no later than the mother's discharge from the hospital. The policy and form regarding this are found in the inpatient hospital section of the Provider Policy Manual, Section 25.08, pages 1 and 2.

To assist with getting claims filed, it is necessary that the birthing hospital have a procedure for getting the baby's number to its billing staff. It is also important that, upon receipt of the number, the birthing hospital makes any hospital to which the baby may have been transferred aware of the number.

The birthing hospital should not delay in completing the form. The baby needs to get a Medicaid ID number as quickly as possible to expedite claims being filed and payment to providers processed.

If you have questions about the process for getting a Medicaid ID for a newborn, contact ACS Customer Service at 1-800-884-3222.

The Childhood Lead Poisoning Prevention Guidance is Available

EPSDT providers now have access to a reference in blood lead testing.

The Childhood Lead Poisoning Prevention Guidance was developed to support the efforts of the United States Public Health Service (Healthy 2010) in eliminating childhood lead poisoning in Mississippi. The document is available to health departments, community health centers, physicians, pediatricians, housing authorities, and other agencies, programs, and citizens that seek guidance about what constitutes harmful levels of blood lead.

The guide is available on the Mississippi State Department of Health website (www.msdh.state.ms.us). From the homepage, click Health Services to the left of the screen, then Child Health and then Lead Prevention and Screening.

If you do not have Internet access, contact the MSDH Childhood Lead Poisoning Prevention Program at 601-576-7447.

Envision Update:
More New Systems Go Online

In past bulletins and provider workshops, it has been announced that the *Envision* system is being implemented by the Division of Medicaid (DOM) to enhance its existing Mississippi Medicaid Management Information System (MMIS) as well as to address the many requirements of HIPAA. The first major component implemented in the Envision project was the Drug Rebate Analysis/Management System (DRAMS) in February 2003. This system allows for the timely invoicing of pharmaceutical suppliers of rebate monies DOM is entitled to collect. A recent audit by the Office of Inspector General with the Department of Health and Human Services praised DOM and its new DRAMS system for its timely processing of these invoices and said the Mississippi system should be a model to other states in its efficiency and reporting.

The Provider subsystem and a portion of the Web Portal (intranet access to DOM) are two additional Envision components that went live on March 31, 2003. These two systems have been significant in helping Mississippi DOM providers re-enroll online via the intranet with Medicaid as part of its HIPAA initiated requirements (refer to related article on pages 3-4 concerning re-enrollment deadline being extended to July 15, 2003).

Another component going live this month is the OmniTrack Call Reporting and Correspondence system. This system will be used by DOM and ACS to track and monitor telephone calls by both Medicaid providers and beneficiaries. On October 1, 2003, the system will be further enhanced with the addition of the Web Portal Interface to OmniTrack that will allow providers to initiate inquiries directly with DOM or ACS via the intranet in a secure encrypted session.

Below is a list of the general categories, which will be available to Providers by October 1, 2003.

- **Banking Inquiry**
- **Billing Questions**
- **Claims Inquiry**
- **Eligibility Inquiry**
- **Enrollment Information Request**
- **Field Visit Request**
- **General Information Request**
- **Policy Inquiry**
- **Pharmacy Point Of Sale (POS) Inquiry**

Watch for more details on these and other future Web Portal features available to Medicaid providers to be presented in the summer provider workshops.

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 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 nursing facility must have current and past compliance history with federal requirements. 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 the 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 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. The nursing facility must have current and past non-compliance history with federal requirements. 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.

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

June

June 2003

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

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.