Mississippi Medicaid Bulletin

Volume 9, Issue 7

July 2003

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EPSDT Program Changes

Effective July 1, 2003, the Division of Medicaid will implement the following EPSDT programmatic changes. The changes were reviewed and approved by the EPSDT Committee with the endorsement of Centers for Medicare and Medicaid Services (CMS), formerly HCFA, on the first two changes.

1. Closure of the Interperiodic Medical Screen (W9358), Interperiodic Vision Screen (W9360), Interperiodic Hearing Screen (W9364), and EPSDT Dental Screen (W9367) procedure codes.
2. The deletion of the EPSDT Case Management and/or Continuing Care Optional Provider Segments, which require closure of the EPSDT Case Management Annually (W9378), Enrollment (W9387) and Withdrawal (W9388) procedure codes.
3. The EPSDT newborn physical assessment birth to one month (W9370) should only be billed in the hospital if the newborn stay is seven days or greater.
4. Pediarix has been added to the VFC provider vaccine administration reimbursement list. VFC providers can be reimbursed for the new combination vaccine by using the local code W6119 until the appropriate CPT code 90723 can be activated in the new Envision Medicaid Management Information System in October 2003.
5. The EPSDT guidelines for initial anemia assessment for eligible Medicaid beneficiaries have been changed to allow for the assessment up to nine (9) months of age in accordance with the most current recommendation of the American Academy of Pediatrics. Remember, the Hgb or Hct is included in the reimbursement of the EPSDT screening and is not separately reimbursable.

Interperiodic Screens (medical, vision, and hearing) are visits for other medically necessary health care, screens, diagnostic, treatment and/or other measures to correct or ameliorate defects, physical and mental illnesses and conditions. Such services are covered whether or not they are included elsewhere in the State Plan, provided they are described in Section 1905 (a) of the Social Security Act. These services will be reimbursed using the Current Procedural Terminology (CPT) codes as defined by the American Medical Association for Evaluation and Management and applying the state law of 90% of the Medicare fee. Dental screening services are

furnished by a direct referral to a dentist. Between periodic screens, coverage is provided for other medically necessary services.

Continued on the next page

EPSDT Program Changes Continued…

Payment for comprehensive oral evaluation and interperiodic problem focused evaluations will be reimbursed using the Healthcare Common Procedure Coding System (HCPCS) codes as provided by CMS based on a statewide fixed fee schedule authorized by the Mississippi Legislature for dentists only. Case management is included in the well child visit and should not be billed separately.

If there are questions concerning the Division of Medicaid EPSDT programs, please call 1-800-421-2408 or 601-359-6150.

Addendum Required for Evaluative Services

Effective July 1, 2003, psychologists who provide evaluative services to children through the Expanded EPSDT Program (as outlined in Section 21 of the Policy Manual effective 10/01/02) are advised that an Addendum to Plan of Care (POC) form (MA-1148A) must be completed and submitted to DOM for all requests to extend the authorization dates beyond the original request. The servicing provider must sign the Addendum POC form and lines 2D and 4 must be completed. Services should not be provided until after you have obtained authorization from DOM. Please contact ACS at 1-800-884-3222 or 601-206-3000 if you do not have these forms.

Psychiatric Nurse Practitioner

The Division of Medicaid is currently in the process of adding a psychiatric specialty type to the nurse practitioner provider type which will allow nurse practitioners to bill for psychiatric therapeutic procedure codes (90801-90899). For those nurse practitioners that have the certification to be psychiatric mental health nurse practitioners, please submit a copy of your certification to the Division of Medicaid to the attention of Mental Health Services-ORP by July 31, 2003 so that the psychiatric specialty can be added to your provider type.

Psychiatric Service

Effective July 1, 2003, psychiatric therapeutic procedures are limited to 12 visits per fiscal year per beneficiary. These 12 psychiatric visits are separate from the beneficiary's regular physician office visits.

Hospice

The Division of Medicaid is experiencing a significant backlog of hospice applications due to the unexpected volume received. We are working to get these applicants locked in as quickly as possible. Incomplete forms create a large part of the backlog. When you submit Hospice enrollment forms, be sure all forms are complete and all required supporting documentation is included. Please refer to the Medicaid Hospice Policy, Section 14.03 that explains what is required.

There are also **new Hospice enrollment and disenrollment forms** (DOM 1165 and 1166) effective 7/1/03. These may be downloaded after July 1 from the DOM website at http://www.dom.state.ms.us/Provider/Provider_Manuals/Section_14_Hospice_Manual.pdf

If there are any questions concerning the Hospice program, please call the Bureau of Long Term Care at 1-800-421-2408 or 601-359-6141.

Provider Tax ID Numbers

If you are applying for an individual Medicaid provider number, your Medicaid provider number will be entered into the Medicaid system with your Social Security Number (SSN) assigned to it. If you use this number as a Medicaid provider billing number, income or earnings information will be reported to the IRS for this SSN. All physicians, nurse practitioners, CRNAs, nurse midwives, dentists, psychologists, chiropractors, podiatrists, occupational therapists, physical therapists, speech/language therapists, and social workers must have an individual Medicaid provider number. There may be restrictions on whether or not some of the providers can bill Medicaid as a billing provider, but any services rendered by these types of providers must indicate the providers as servicing providers.

Example: John Doe, MD, has an individual Medicaid provider number, and he wants to use this number as both the servicing provider number and the billing number; the Division of Medicaid will report all Medicaid income/earnings to the IRS on his SSN. The only Medicaid application needed is for John Doe, MD.

If you want the Division of Medicaid to report your income or earnings information to the IRS using an employer tax ID number (EIN), you must apply for a Medicaid provider number for that entity. This may be a sole proprietorship, an incorporated individual, other incorporated entity, partnership, etc. The Medicaid provider number of this entity will be entered into the Medicaid system with the EIN assigned to it. The Division of Medicaid calls this a group number even though there may only be one person in this group. If you use this number as a Medicaid provider billing number, income or earnings information will be reported to the IRS for this EIN.

Example: John Doe, MD owns Doe Medical Center. The EIN is issued to Doe Medical Center. An application must be submitted for a group number for Doe Medical Center. The group application should be completed to indicate that Dr. Doe is affiliated with Doe Medical Center. Dr. Doe must submit an application for an individual Medicaid provider number for himself. He will indicate on his application that he is affiliated with Doe Medical Center. Doe Medical Center will bill claims indicating Dr. Doe as the servicing provider. Billing in this manner allows monies earned for services provided by Dr. Doe to be reported on the EIN of Doe Medical Center. However, if Dr. Doe bills claims using only his individual provider number, these monies will be reported on Dr. Doe's SSN.

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

The Division of Medicaid (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 and Accountability Act of 1996 (HIPAA).

Billing manuals will be available on the DOM website at www.dom.state.ms.us. Providers will be notified in the coming months through the bulletin and the DOM website when the billing manuals are on the website and when additional information regarding this change is available. These changes will be reviewed in concurrent sessions of the August 2003 provider workshops. If you have any questions, please contact Evelyn H. Silas, Division Director, Bureau of Long Term Care, at 601-359-6750.

24-7-52

Did you know that you can submit Mississippi Medicaid claims 24 hours a day, 7 days a week, 52 weeks a year? ACS EDI Gateway, Inc. would like to take this opportunity to let all Mississippi Medicaid providers know that claims can be submitted throughout the week and several times a day if necessary and not just on Thursdays. Thursday at 5 p.m. is the cutoff for electronic claims submission. However, to ensure that claims make the cutoff, all providers are encouraged to submit claims throughout the week instead of billing only on Thursdays. If you have any questions, please contact the EDI Support Unit at 1-866-225-2502.

Transplant Manual

Sections 28.04 and 28.10 of the Provider Policy Manual have been revised with an effective date of July 1, 2003 to reflect the following changes:

- Section 28.04- Neuroblastoma and nephroblastoma have been added to the Specific Diagnostic Inclusion Criteria (Autologous BMT or PSC) list.
- Section 28.10- The Foundation for the Accreditation of Hematopoietic Cell Therapy (FAHCT) has been renamed the Foundation for the Accreditation of Cellular Therapy (FACT).

These updated sections of the Provider Policy Manual may be accessed on the Division of Medicaid website at www.dom.state.ms.us. Transplant providers with questions may call the Bureau of Medical Services at (601) 359-5219.

Attention!
August 2003 Provider Workshops

The Division of Medicaid and ACS State Healthcare would like to announce the upcoming schedule for regional Medicaid provider workshops. The workshops will begin August 12, 2003 and continue until August 21, 2003. Sessions will be held in Jackson, Hattiesburg, Meridian, Tupelo, Southaven and Greenville. A final workshop will be held again in Jackson, September 9, 2003.

Workshops will be hosted from 8 a.m. to 5 p.m. There will be an a.m. and p.m. general session and 2 concurrent sessions. The general session will address HIPAA, EDI, the Envision system enhancements and changes, the new format of the Remittance Advice and WINASAP 2003. The concurrent sessions will address billing changes, code changes and other related topics specific to each claim type. Please see dates and locations listed below:

August 12, 2003 **Jackson, MS** **Clarion Hotel and Convention Center** **400 Greymont Avenue** **Jackson, MS 39201**	**August 13, 2003** **Hattiesburg, MS** **Hattiesburg Lake Terrace Convention Center** **One Convention Center Plaza** **Hattiesburg, MS 39401**
August 15, 2003 **Meridian, MS** **Mississippi State University (Meridian Campus)** **Kahlmus Auditorium/(Multipurpose Room)** **1000 Highway 19 North** **Meridian, MS 39307**	**August 19, 2003** **Tupelo, MS** **Ramada Inn and Convention Center** **854 North Gloster Street** **Tupelo, MS 38804**
August 20, 2003 **Southaven, MS** **Desoto Civic Center** **4560 Venture Drive** **Southhaven, MS 38671**	**August 21, 2003** **Greenville, MS** **Greenville Higher Education Center** **Hafter Multipurpose Room** **2900A Highway 1 South** **Greenville, MS 38701**
September 9, 2003 **Jackson, MS** **Clarion Hotel and Convention Center** **400 Greymont Avenue** **Jackson, MS 39201**	

Please plan now to attend one of the above sessions. Information that will be provided during these workshops will be both beneficial and critical to your future billing needs. An itinerary of specific times for each session will be posted in the upcoming August bulletin. If you have any questions, please contact your Provider Field Representative or ACS Provider and Beneficiary Services at 1-800-884-3222 or 601-206-3000. For updates concerning these upcoming workshops, please review your weekly Remittance Advice banner page.

Free CMS HIPAA Training

The CMS Southern Consortium's Achieving Compliance Together Team has developed a series of HIPAA presentations. They can be accessed via the Internet and there is no cost to you.

To access these presentations, simply follow the link**:** http://www.eventstreams.com/cms/tm_001/

You can choose any of the following presentations:
HIPAA Message to Providers from the Southern Consortium Administrator (coming soon)
HIPAA Basics
Provider Steps to Getting Paid under HIPAA
HIPAA Security (coming soon)

Free Fax Back Service
The CMS Southern Consortium's Achieving Compliance Together Team has developed a HIPAA resource in an effort to reach those without internet/e-mail access. Have your fax number handy and call this number: **1-800-874-5894.**

Select Option 1 for the starter set: HIPAA information, resources, and transactions checklist, and then follow the prompts. It's that easy! Other documents are also available (for example, information on Medicare's free billing software and a HIPAA glossary).

HIPAA FAQ's

What is a 997?
A 997 or Functional Acknowledgment is generated when the ACS State Healthcare Clearinghouse validates the submission of the ANSI X12 transmission. The 997 contains Accept or Reject information if the file that was transmitted contained syntactical errors based on the required elements in the Implementation Guides. The report will have the segment and element listed where the error(s) occurred. If the data in the file passes the syntax validation payer, business edits are performed.

What is an 824?
An 824 or Error Report is generated when business edits defined in the Companion Guides fail during the translation of the ANSI X12 837 transaction. The 824 will detail what error(s) are present and if necessary what action the submitter should take. An 824 will be generated if the transmission is accepted or rejected.

What is an 835?
An 835 or Healthcare Claim Payment Advice is an electronic remittance advice in a dataset, not a print image.

What is an 820?
An 820 or Premium Payment is a transaction that sends premium payment information to an insurance company.

What is a 277?
A 277 or Claim Status Response is a transaction that is sent in response to a 276, which is a Claim Status Inquiry transaction. Simply put, it is the answer to the question, "What is the status of my claim?"

What is a 271?
A 271 or Eligibility Response is a transaction that is sent in response to a 270, which is an eligibility inquiry transaction. Simply put, it is the answer to the question, "Is this recipient eligible?"

What is a 278?
A 278 or Prior Authorization is an inquiry and a response transaction. An inquiry for prior authorization is sent as a 278 and a response to that inquiry is sent back as a 278.

Provider Re-enrollment Update

Re-enrollment for Mississippi Medicaid providers is going well. Over 4000 re-enrollment applications have been received. The following are several points to remember:

- Please do not resubmit your application if you have had no response within 30 days. Applications are being processed first in, first out.
- 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 until July 15, 2003.
Applications must be received by July 15 to ensure that your provider number will not be closed as of October 1, 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. If you enrolled via the Web, you only need to send the two original signature Provider Agreements and the other required documents. You do not need to send the packet to us.
- 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 two or three signed copies of the Provider Agreement (Check the Credentialing Requirements List to verify if two or three Provider Agreements are needed).
- If application is for an individual, the individual provider enrolling must sign the signature line on W9. If the application is for a group, the authorized person must sign W9.
- Individual provider enrolling, even if claims are to be paid to group, must sign Direct Deposit form. This certifies that the individual provider knows where the payment is deposited.

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 (Example on page 7 of 13; section c-3),
  Limited English Proficiency (Example on page 10 of 13; section c-3)
  Sensory Impairment (Example on page 9 of 13; section c-3)
  Program - Facility (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 parenthesis by typing over. Example, (**name of provider**) should be changed to be actual name without parenthesis.
- 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 could go 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.

Continued on the next page

Re-enrollment Update Continued…

Credentialing Requirements List

1. Please verify the documentation required for your provider type and mail to Provider Enrollment. Incomplete applications will be returned.
2. A copy of the State Dept. of Health Verification of Certificate of Waiver letter (copy attached) is acceptable as verification of the CLIA number.

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 submitted 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 practices 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. It can bill for both facilities under one submitter ID.

PHARMACY NOTES

Attention: All Prescribers and Pharmacists

Preferred Drug List (PDL):
In an effort to contain cost while maintaining quality health care for our Medicaid beneficiaries, the Division of Medicaid developed a Preferred Drug List (PDL). This list became effective June 2003. A copy of the PDL and some Frequently Asked Questions were mailed to each prescriber. If you did not receive a copy, please refer to the Division of Medicaid's website at www.dom.state.ms.us. Select P and T link, Preferred Drug List and print a hard copy for your reference. If you do not have access to the website, please call the Pharmacy Bureau at 601-359-5253.

All drugs covered by Medicaid are still available. However, brand name drugs on the PDL have a lower co-pay for the beneficiary.

PDL co-pay amounts are:

- $3 brand name non-preferred
- $2 brand name preferred
- $1 all generics

Please note that usual DOM co-pay exceptions and exemptions remain.

Prescription Drug Billing for Medicare/Medicaid beneficiares
Effective March 2003, pharmacies were required to bill Medicare for those drugs covered by Medicare. In order to receive reimbursement from Medicaid when you receive a valid denial from Medicare, please attach a copy of the Medicare EOMB that indicates the denial code with a copy of the Medicaid Title XIX Pharmacy claim form and mail to DOM's Pharmacy Bureau for review and processing. After the initial Medicare EOMB has been submitted to DOM's Pharmacy Bureau and processed, a copy of the original Medicare EOMB with a current Medicaid Title XIX Pharmacy claim form may be submitted for future reimbursements.

Prior Authorization for Prescription Drugs
There remains confusion among providers regarding the prior authorization procedure for prescription drugs. The Division of Medicaid has contracted with Health Information Designs (HID) to provide this service. *Prior authorizations are handled by HID and not the Division of Medicaid. All prior authorization requests are to be routed to HID.*

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Pharmacy Notes Continued…

HID staff is available at 1-800-355-0486 (from 8 a.m. to 6 p.m., Monday-Friday, and 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.

Please note that generics, in most cases, do not require a prior authorization nor do narrow therapeutic index drugs. 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. *If you have not received a response within the 24 hour time frame, contact HID at 1-800-355-0486 to determine status of request.*

The following drugs currently require prior authorization:

Oral SR Opioid Agonists (brand only) Avinza Kadian MS Contin Oxycontin Oramorph SR	**Proton Pump Inhibitors (brand and generic)** Aciphex Nexium Prevacid Prilosec Protonix Prevpac Omeprazole
Non-Steroidal Anti-Inflammatory Drugs (brand only) Arthrotec Lodine XL Mobic Ponstel	**Antihistamines (brand only) and Non-Sedating Antihistamines*** Allegra Astelin NS Clarinex Claritin Zyrtec * exemption = beneficiaries < 21 years
Cox-2 Inhibitors Bextra Celebrex Vioxx	**Immunosuppressants** Neoral Sandimmune Gengraf
Others Needing Individual PA Forms Actiq 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

Extension of Benefits PA

- This PA number is **not** for drugs that require a prior authorization. This authorization number only extends beneficiary's maximum drug coverage from 5 prescriptions monthly to 6 or 7 prescriptions monthly.
- Any other drug requiring a prior authorization number must be submitted for the 1st through 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 may have up to a 12-month time span**. A new PA submission is required with any change in therapy.

Brand-Name Multi-Source Drugs PA

Due to a 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 as noted below for the brand-name multi-source approval must be met.

Continued on the next page

Pharmacy Notes Continued…

This does not mean that DOM will never reimburse for a brand name drug, but it does mean that specific criteria must be met such as:

- 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 â
  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; 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.

If you have any questions , please contact the Pharmacy Bureau at 601-359-5253. Thank you for your attention and adherence to Division of Medicaid's pharmacy program guidelines. Working together, we can provide optimal health care outcomes at reasonable costs for all beneficiaries.

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

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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

July

July 2003

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
		1	2	**3** **EDI Cut Off 5:00 p.m.**	4 **DOM and ACS CLOSED**	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.