Mississippi Medicaid Bulletin

Volume 9, Issue 8

August 2003

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Family Planning Demonstration Program

Effective 10/01/2003, the Division of Medicaid will implement a Family Planning Service Demonstration Waiver. The waiver extends Medicaid coverage for Family Planning Services to women throughout the state that meet the following eligibility criteria:

- Have family income at or below 185% of the Federal poverty guidelines; and
- Are of childbearing age. The target population is women 13 to 44.

Women certified as eligible for family planning services under this Demonstration Waiver will remain Medicaid eligible for five years with eligibility re-certification every two years. Loss of eligibility will occur only when a woman moves from the state, becomes Medicaid eligible in another Aid category, becomes pregnant, or requests that her case be closed.

These women will be eligible for Medicaid coverage for family planning services only. The Automated Voice Response System eligibility transaction response will identify these women as eligible for family planning services only, in Aid Category 92 (FP-W). These women **will not** be eligible to receive any other Medicaid benefits.

Covered services will include annual visits, follow-up visits, medically necessary supplies related to birth control and oral contraceptives.

Abortion is not covered under family planning services.

For more information about the Family Planning Demonstration Waiver Program, you may call the Bureau of Maternal Child Health at 1-800-421-2408.

See dates for Provider Workshops for additional information about the Family Planning Demonstration Waiver.

August 2003 Provider Workshops

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

Workshops will be held from 8:30 a.m. to 4:30 p.m. with registration beginning at 8 a.m. The morning workshops will include a general session with concurrent sessions by claim type. The sessions will be repeated in the afternoon workshops. 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.

Workshop dates and locations are 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**	

Morning Schedule

8:00 – 8:30	**Registration**		
8:30 – 9:50	**General Session – Part I**	**HCFA-1500 Billers**	**Nursing Facility Billers**
10:10 – 11:30	**General Session – Part II**	**DME Billers**	**UB-92 Billers**

Afternoon Schedule

1:00 – 1:30	**Registration (if did not attend morning sessions)**		
1:30 – 2:50	**General Session – Part I**	**HCFA-1500 Billers**	**Nursing Facility Billers**
3:10 – 4:30	**General Session – Part II**	**DME Billers**	**UB-92 Billers**

******Please note that for each morning and afternoon session, the same information will be discussed. You can choose to attend one general session (morning or afternoon) and one claim type session.*******

Continued on the next page

August Provider Workshops Continued…

Dental providers are encouraged to attend one of the General Sessions. There is not a breakout session for dental providers as there are no major changes for the dental program. There will be a handout for dental providers to pick up which will give information regarding any coding changes.

There will be a workshop for pharmacy providers at a later date. This will be announced in a future monthly provider bulletin. Pharmacy providers may want to attend one of the General Sessions for information regarding **HIPAA, EDI, the Envision system enhancements and changes, and the new format of the Remittance Advice.**

All providers should plan now to attend one of these sessions. Information that will be provided during these workshops will be both beneficial and critical to your future billing needs. 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.

PAM (Payment Accuracy Measurement) Project

PAM is a federal/state project whose purpose is to determine the payment accuracy of identified payment strata (areas) within the Medicaid program. The results obtained from this important project will assist in the prompt and efficient payment of Medicaid claims.

Within the Division of Medicaid, Program Integrity is in the process of collecting field data for this project initiative. During the next few months, representatives from the Division of Medicaid will be contacting selected providers by telephone and mail to obtain copies of medical records. You will be given details of this records request when the Medicaid representative contacts you. Your cooperation in copying and forwarding these records to the Division of Medicaid will be appreciated.

This records request is a permitted disclosure under HIPAA privacy regulations. HIPAA regulations at 45 *CFR* Section 164.512 states that "a covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits…or other activities necessary for appropriate oversight of (1) the health care system; (2) government benefit programs for which health information is relevant to beneficiary eligibility; (3) entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or (4) entities subject to civil rights laws for which health information is necessary for determining compliance."

In addition, Medicaid providers are required to comply with a Medicaid records request by an authorized Medicaid employee. Provider Policy Manual, Section 7.03 states: "the provider must maintain auditable records that will substantiate the claim submitted to Medicaid…DOM staff shall have immediate access to the provider's physical services location, facilities, records, documents, book, prescriptions, invoices, radiographs, and any other records relating to licensure, medical care, and services rendered to beneficiaries, and billings/claims during regular business hours…"

The Division of Medicaid appreciates your cooperation with the PAM project. If you have any questions, please contact Carlis E. Faler or Otis Washington, Jr. at 800-880-5920.

Medicaid Card Abuse

Medicaid card abuse means the misuse or misappropriation of the Medicaid card and/or Medicaid identity. The Bureau of Program Integrity, within the Division of Medicaid, investigates reports of suspected card abuse. The most common form of misuse occurs when eligible beneficiaries "lend" their cards to persons not Medicaid eligible.

According to Section 3.05 of the Provider Policy Manual, "It is the responsibility of the provider to verify that a person presenting a Medicaid card for payment of services is the actual Medicaid beneficiary." If a provider suspects that someone other than the actual cardholder is using a Medicaid card, the provider should request a picture ID or some other form of positive identification. If another form of identification is not available, the provider should compare signatures with a signature on file or contact ACS at 1-800-884-3222 to obtain identifying information. The provider should also verify beneficiary eligibility at every visit prior to providing any service.

Providers should also notify local law enforcement authorities and the Division of Medicaid, Bureau of Program Integrity, if they have reason to believe that a person is misusing a Medicaid card. For example, a provider should suspect that there is misuse of a Medicaid card if the provider is familiar with the beneficiary and realizes that the person presenting the Medicaid card or number is not the actual beneficiary. If the person presenting the card or number does not match the identifying information available through ACS, the provider should also suspect that the card is being misused.

An example of a recent case investigated by the Bureau of Program Integrity involved the use of a false identity at a pharmacy. In this case, an individual had posed as a Medicaid beneficiary over a period of about two years. The imposter had obtained numerous prescriptions on several different occasions. During this time period, the pharmacy failed to obtain positive identification and therefore was required to reimburse the Division of Medicaid for services obtained by the imposter.

Call the Medicaid Fraud Hotline at 1-800-880-5920 to report suspected card abuse. When you call, be ready to provide as much information as possible, including:

- The name on the Medicaid beneficiary card presented
- The Medicaid I.D. number on the card presented
- The name of the doctor, hospital, pharmacy, or other health care provider
- The date of service
- A description of the acts that you suspect involve fraud or abuse

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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. Training for providers has been scheduled during the month of August 2003. Please refer to the schedule in this month's bulletin. Notification will be given after Provider Training as to when the billing manuals will be available. If you

have any questions, please contact the Division of Provider and Beneficiary Relations at 601-359-6133 or Division of Institutional Long Term Care at 601-359-6750.

Pharmacy Notes

Medicare/Medicaid Dually Eligible Beneficiaries

It is federal and state law that when a beneficiary is eligible under both Medicare and Medicaid, Medicare is responsible for primary coverage. There are several categories of drugs covered by Medicare for specific indications for outpatients. These include (but may not be limited to):

- Immunosuppressive agents for transplant recipients covered by Medicare
- Total Parenteral Nutrition
- Total Enteral Nutrition
- Some oral Anti-cancer agents
- Some oral Anti-emetic agents
- Liquid Inhalation Drugs

If Medicare denies a specific drug for a dually eligible beneficiary, follow this procedure:

- Submit a paper claim (Medicaid—Title XIX) to the Division of Medicaid's Pharmacy Bureau; a copy of a paper claim is in this newsletter on page 7.
- Type or legibly print pertinent information on the form; include date(s) of service and NDC numbers. Since these documents are hand processed individually, be sure all pertinent and required information is legible and included. This step is crucial for timely payment.
- Mail the original document to DOM, attention Pharmacy Bureau.
- Include a copy of the Medicare denial for the initial hard copy submission to DOM.
- If a beneficiary is receiving drug(s) for non-Medicare covered indications, include documentation from the prescriber stating the indication.
- If a beneficiary is receiving drug(s) for a non-Medicare covered transplant, include documentation from the prescriber regarding the date of transplant and a copy of the Medicare card.
- All other Medicaid policies remain effective.

Any questions about Medicare and the Durable Medical Equipment Point of Sale supplier requirements should be directed to the National Supplier Clearing House at the toll free number 1-866-238-9652 or by accessing the Palmetto Government Benefits Administrator website at www.palmettogba.com.

Questions regarding Medicare/Medicaid Crossover Claims should be directed to ACS Customer Service at 1-800-884-3222. Refer to the June 2003 bulletin, page 4 for more information on this issue.

Default Prescriber Identification

Accurate prescriber identification of the prescription issuer is required; non-compliance may result in termination of POS privileges. The April 2003 Mississippi Medicaid Bulletin, page 4, addressed this subject. Pharmacy Providers consistently using the default provider identification will be receiving notification letters of noncompliance. To receive a current Prescribing Providers List, you may either contact the fiscal agent or go to DOM's website at http://www.dom.state.ms.us/Provider/Publications/publications.html.

Beneficiary Electronic Signatures

Continued on the next page

Electronic beneficiary signatures are acceptable for Medicaid beneficiaries. If multiple prescriptions are dispensed, there must be a signature for each and every prescription dispensed. Records must be auditable and retrievable.

Pharmacy Notes Continued…

Brand Name/Multi-source Prior Authorization

The multi-source/generic legislative mandate was implemented February 2003. Occasionally some generic drugs may be listed as available, but in reality these agents are unavailable. For situations such as these, please call one of the clinicians at HID 1-800-355-0486 or 601-709-0000. Note that these drugs must be unavailable from multiple wholesalers and not a single wholesaler.

ACS/DOM Pharmacist Workshops

Watch the mail for information regarding pharmacy provider workshops to be conducted. Information will be provided by ACS and DOM.

Beneficiary Eligibility Verification

The Mississippi Division of Medicaid has answered an increasing number of telephone calls regarding eligibility verification and determination. Providers are reminded that eligibility verification will only be provided as outlined in the Provider Policy Manual, Section 3.06. Currently, a Medicaid provider may verify beneficiary eligibility status by one of the following methods:

1. Calling the AVRS, 1-866-597-2675
2. Using the Point of Service eligibility verification system
3. Calling the Fiscal Agent at 1-800-884-3222

Due to HIPAA constraints and the overwhelming number of calls, especially from contractors representing providers, DOM will no longer provide eligibility verification except as outlined in the Provider Policy Manual.

Providers are encouraged to educate their staff on the proper methods to obtain eligibility verification at the time services are rendered to reduce delays.

Requests for eligibility verification logged through the DOM Information Officer will incur a charge for clerical and/or professional time and reasonable administrative costs associated with the disclosure of such information under an authorization, as permitted by state statute and the HIPAA Privacy Rules.

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.

MAIL TO:

Mississippi Medicaid Program
Pharmacy Claim
P.O. Box 23076
Jackson, MS 39225

MEDICAID - TITLE XIX

PHARMACY INVOICE
STATE OF MISSISSIPPI MEDICAID PROGRAM

1. Provider Number

Provider Number, Name & Address

1	2. Recipient's Last Name	3. F. Init.	4. Medicaid ID #							5. Rx #		6. Auth Code		7. Phys. ID		8. Partial	9. Date Dispensed			
	10. National Drug Code	11. Subs	12. MAC	13. Quantity		14. Est. Days		15. DOB		16. Blank			17. Copay	18. TPL	19. TPL Amount			20. U/C Charge		
2	2. Recipient's Last Name	3. F. Init.	4. Medicaid ID #							5. Rx #		6. Auth Code		7. Phys. ID		8. Partial	9. Date Dispensed			
	10. National Drug Code	11. Subs	12. MAC	13. Quantity		14. Est. Days		15. DOB		16. Blank			17. Copay	18. TPL	19. TPL Amount			20. U/C Charge		
3	2. Recipient's Last Name	3. F. Init.	4. Medicaid ID #							5. Rx #		6. Auth Code		7. Phys. ID		8. Partial	9. Date Dispensed			
	10. National Drug Code	11. Subs	12. MAC	13. Quantity		14. Est. Days		15. DOB		16. Blank			17. Copay	18. TPL	19. TPL Amount			20. U/C Charge		
4	2. Recipient's Last Name	3. F. Init.	4. Medicaid ID #							5. Rx #		6. Auth Code		7. Phys. ID		8. Partial	9. Date Dispensed			
	10. National Drug Code	11. Subs	12. MAC	13. Quantity		14. Est. Days		15. DOB		16. Blank			17. Copay	18. TPL	19. TPL Amount			20. U/C Charge		
5	2. Recipient's Last Name	3. F. Init.	4. Medicaid ID #							5. Rx #		6. Auth Code		7. Phys. ID		8. Partial	9. Date Dispensed			
	10. National Drug Code	11. Subs	12. MAC	13. Quantity		14. Est. Days		15. DOB		16. Blank			17. Copay	18. TPL	19. TPL Amount			20. U/C Charge		
6	2. Recipient's Last Name	3. F. Init.	4. Medicaid ID #							5. Rx #		6. Auth Code		7. Phys. ID		8. Partial	9. Date Dispensed			
	10. National Drug Code	11. Subs	12. MAC	13. Quantity		14. Est. Days		15. DOB		16. Blank			17. Copay	18. TPL	19. TPL Amount			20. U/C Charge		
7	2. Recipient's Last Name	3. F. Init.	4. Medicaid ID #							5. Rx #		6. Auth Code		7. Phys. ID		8. Partial	9. Date Dispensed			
	10. National Drug Code	11. Subs	12. MAC	13. Quantity		14. Est. Days		15. DOB		16. Blank			17. Copay	18. TPL	19. TPL Amount			20. U/C Charge		
8	2. Recipient's Last Name	3. F. Init.	4. Medicaid ID #							5. Rx #		6. Auth Code		7. Phys. ID		8. Partial	9. Date Dispensed			
	10. National Drug Code	11. Subs	12. MAC	13. Quantity		14. Est. Days		15. DOB		16. Blank			17. Copay	18. TPL	19. TPL Amount			20. U/C Charge		
9	2. Recipient's Last Name	3. F. Init.	4. Medicaid ID #							5. Rx #		6. Auth Code		7. Phys. ID		8. Partial	9. Date Dispensed			
	10. National Drug Code	11. Subs	12. MAC	13. Quantity		14. Est. Days		15. DOB		16. Blank			17. Copay	18. TPL	19. TPL Amount			20. U/C Charge		
10	2. Recipient's Last Name	3. F. Init.	4. Medicaid ID #							5. Rx #		6. Auth Code		7. Phys. ID		8. Partial	9. Date Dispensed			
	10. National Drug Code	11. Subs	12. MAC	13. Quantity		14. Est. Days		15. DOB		16. Blank			17. Copay	18. TPL	19. TPL Amount			20. U/C Charge		

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under that state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency request. I further agree to accept as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized co-payment.

21. Pharmacist's Signature: _____ 22. Date: _____

MS-PHARM

ORIGINAL TO FISCAL AGENT

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

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

August

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SUNDAY	*MONDAY*	*TUESDAY*	*WEDNESDAY*	*THURSDAY*	*FRIDAY*	*SATURDAY*
					1	2
3	4 CHECKWRITE	5	6	**7** EDI Cut Off 5:00 p.m.	8	9
10	11 CHECKWRITE	12	13	14 EDI Cut Off 5:00 p.m.	15	16
17	18 CHECKWRITE	19	20	**21** EDI Cut Off 5:00 p.m.	22	23
24 **31**	25 CHECKWRITE	26	27	28 EDI Cut Off 5:00 p.m.	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.