Mississippi Medicaid

*Volume 9, Issue 9*

**September 2003** **Bulletin**

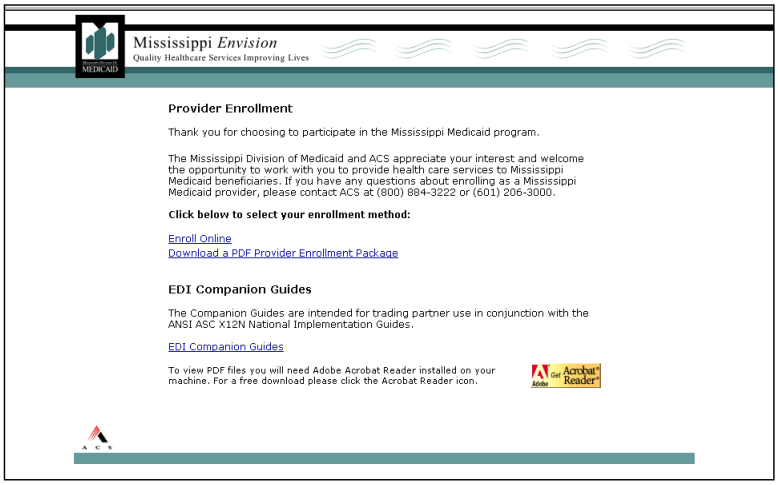
## Important Provider Bulletin

This is an important issue of the Medicaid Provider Bulletin to notify providers of changes in the Medicaid program as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Envision, the revised Medicaid claims processing system. Much of the information in this bulletin discusses changes that are effective October 1, 2003, that may impact claims processing and payment. Please read this bulletin carefully and refer to it when submitting claims on and after October 1, 2003.

Articles in this bulletin include the following:

# Medicaid Information Is At Your Fingertips 24 – 7 – 365

On Monday, October 6, 2003, access to the Mississippi Division of Medicaid's (DOM) system will be further enhanced with the addition of the Web Portal interface to the *Envision* computer system. The Mississippi *Envision* Web Portal provides Medicaid-related content to providers and the interested public. The Web Portal contains two kinds of contents, public and private. The public pages of the Web Portal provide general information such as contact information, frequently asked questions (FAQs), statistics, and other static Web content. No confidential provider or patient-related data is disclosed on the portal's public pages. Private Web pages are accessible only by authorized users and may contain protected provider and patient healthcare information.




Please note that the word "public" in reference to the *Envision* portal's functionality is not synonymous with "non-secure." Rather, public pages of the Web Portal are those that are available to all users, regardless of their registration status: unregistered, pending, or registered. Therefore, some pages that are considered public are also secure and employ 128-bit encryption with SSL v3.0, such as the Web-based provider enrollment application.

At the heart of the *Envision* system is the Medicaid Management Information System (MMIS). The Web Portal interface will allow Mississippi Medicaid providers direct web/internet based access to information contained in the MMIS and other *Envision* subsystems. It is called a Web Portal because the site serves as a "portal" for the exchange of data and other information between the Medicaid providers and the Division of Medicaid. Access to the Mississippi *Envision* Web Portal is available 24 hours a day, 7 days a week, 365 days a year via the Internet at **http://msmedicaid.acs-inc.com**. Don't forget to bookmark the DOM Web Portal in your browser *Favorites* the first time you visit the site so you can quickly return again and again.

In order to use the secure portion of the Web Portal, providers must be registered users.
The first person to register under your provider number will be assigned as the Master Administrator (MA) for all users of your organization. It is important that you keep this fact in mind as you complete the initial user registration so that the appropriate individual becomes the Master Administrator. The MA will be able to add more users in your organization and reset passwords. The MA will also establish what Web Portal access rights each user within your organization has. The MA may assign a user any one, combination of, or all of the following Web Portal rights:

- Beneficiary Eligibility Inquiry
- Payment Status Inquiry
- Ask Provider Relations
- Claims Status Inquiry
- EDI Exchange
- User Administration

Additionally, please note as you plan to register users within your organization that **each registered user is required to have his/her own unique e-mail address**. This is how notification of initial passwords and reset passwords is communicated to members of your organization. If members of your organization do not have their own unique e-mail address, they can obtain a *FREE* e-mail account from any one of the many Internet companies such as Yahoo, Hotmail, Netscape, among others.

Don't delay. Register today, as answers to many of your DOM questions will only be a mouse click away! The address is: **http://msmedicaid.acs-inc.com.**

## HIPAA Contingency

To improve the efficiency and effectiveness of the health care system, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996 which requires covered entities to use national standards for electronic health care transactions. The law is clear that covered entities, including providers and health plans, may not conduct noncompliant transactions after the compliance deadline.

If you are a health care provider who submits electronic healthcare information, it is important that your practice management system supports the use of these transactions. Please communicate with your software vendor or billing agent about their progress towards HIPAA compliance. As the covered health care provider, it is your responsibility to ensure that the transactions you conduct electronically are compliant with the HIPAA regulations. If your practice management systems are unable to support the HIPAA mandated electronic transactions, you will be required to submit your claims on paper unless the Department of Health and Human Services (HHS) extends the period within which you may comply "based on the nature and extent of the failure to comply."

The Mississippi Division of Medicaid (DOM) is currently renovating and testing its Medicaid Management Information System (MMIS) to support adoption of the new standard transactions and will implement all HIPAA mandated electronic health care transactions on **October 1, 2003.**

## September 2003 Provider Workshop Reminder

If you were not able to attend the August provider training workshops, The Division of Medicaid and ACS State Healthcare would like to remind you that a final provider workshop will be held on Tuesday, September 9, 2003. The workshop 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.

The location and schedule for September 9, 2003 is listed below.

**September 9, 2003 - Jackson, MS**
**Clarion Hotel and Convention Center**
**400 Greymont Avenue**
**Jackson, MS 39201**

**Morning Schedule**

| | |
|---|---|
| **8:00 – 8:30** | **Registration** |
| **8:30-11:30** | **General Session ( EDI, Envision, HIPAA, RA and WINASAP 2003)** |
| **8:30 – 9:50** | **HCFA-1500 Billers** |
| **8:30 – 9:50** | **Nursing Facility Billers** |
| **10:10 – 11:30** | **DME Billers** |
| **10:10 – 11:30** | **UB-92 Billers** |

**Afternoon Schedule**

| | |
|---|---|
| **1:00 – 1:30** | **Registration for participants (not attending morning sessions)** |
| **1:30 – 2:50** | **General Session ( EDI, Envision, HIPAA, RA and WINASAP 2003)** |
| **1:30 – 2:50** | **HCFA 1500 Billers** |
| **1:30 – 2:50** | **Nursing Facility Billers** |
| **3:10 – 4:30** | **DME Billers** |
| **3:10 – 4:30** | **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.*******

## Attention All Mississippi Medicaid Providers

October is quickly approaching and so is the switch to the ACS EDI Gateway, Inc. claims clearinghouse. The claims clearinghouse will support the HIPAA mandated electronic transactions, such as the 837 Professional, Dental and Institutional. The clearinghouse will be in effect on October 1, 2003, as of 5:01 PM CDT. Providers billing in the current formats (NECS, WINASAP2000, NSF or UB92) will need to submit those claims for payment no later than **5:00 PM CDT on October 1, 2003**. *(Please Note: All Nursing Homes using the old formats must submit claims for the month of September by 5:00 PM CDT on October 1, 2003*). Any claims received in the NECS, WINASAP2000, NSF or UB92 formats after 5:00 PM CST will not be processed for payment.

## Attention All NECS and WINASAP2000 Users

As of October 1, 2003 at 5:01 PM CDT you will no longer be able to submit claims to Mississippi Medicaid using NECS or WINASAP2000. WINASAP2003 is replacing both NECS and WINASAP2000. This software supports the HIPAA-mandated electronic transactions, such as 837 Professional, Dental and Institutional.

If you have not already received notification to download the software, please do so at http://msmedicaid.acs-inc.com or contact the EDI Support Unit at 1-866-225-2502 to request a copy on CD-ROM.

If you are currently using WINASAP2000, you will be able to convert your patient, provider and reference tables into the new version. Claims will not be converted to the new version. If you are using WINASAP2000 version 7.0, when you convert to WINASAP2003 you will need to correct the provider number from the old 7-digit number to the new 8-digit number (If you are using WINASAP2000 version 8.0, you do not need to correct the provider number). Follow the steps below or contact the EDI Support Unit for assistance at 1-866-225-2502.

Steps to correct Provider Number:

1. Once you have converted the data, open WINASAP2003.
2. Open the Provider Reference table.
3. Select the provider record you need to correct.
4. Click copy located at the bottom of the window.
5. Add a zero to the beginning of the number.
6. Click save.
7. Delete the old record with the 7-digit ID.

As of 5:01 PM CDT on October 1, 2003, you will no longer be able to submit using NECS or WINASAP2000. You will also need to make sure you submit claims with your new 8-digit provider ID. If you need assistance, please contact the EDI Support Unit at 1-866-225-2502.

## UB-92 and CMS-1500 Paper Claim Submission

Effective October 1, 2003, paper submissions of the UB-92 and CMS-1500 claim forms will be processed using Optical Character Recognition (OCR). OCR technology is widely accepted by commercial and governmental healthcare financing organizations. Mississippi Medicaid is implementing the technology in an effort to increase efficiency, accuracy, and more timely processing of Provider claims. OCR processing requires that claims be typewritten on “red drop-out” forms. UB-92 and CMS-1500 claim forms can be purchased from a variety of vendors including forms distributors, print vendors, and office supply companies.

Providers are encouraged to use typewritten “red drop-out” forms for all UB-92 and CMS-1500 paper claims submissions. Handwritten, photocopied, and other black and white formats will cause a delay in claim processing and payment.

## Re-enrollment Update

Review and processing of all provider re-enrollment applications received by August 8, 2003, will be completed by September 30, 2003. Any re-enrollment applications received on or after August 8, 2003, **may not** be completed by the September 30, 2003, deadline. Claims with dates of service beginning October 1, 2003, will deny for any provider whose re-enrollment is not completed by September 30, 2003.

## 8-digit Provider Number

The 8-digit provider number must be used for any claims filed on and after October 2, 2003. Any claims filed with a provider number using fewer than 8 digits will deny for provider number not on file. The 8-digit provider number will also be required to access the AVRS.

## Standard Place of Service Codes for Professional Claims

Listed below are place of service codes that will be used on claims filed on and after October 1, 2003. These codes should be used on professional claims to specify the entity where services were rendered. The Division of Medicaid (DOM) is required to accept all of these place of service codes but is not required to pay for services in places not covered by DOM in accordance with DOM policy and procedures.

| Place of Service Code | Place of Service Name | Place of Service Description |
|---|---|---|
| 01-02 | Unassigned | N/A |
| 03 | School | A facility whose primary purpose is education. |
| 04 | Homeless Shelter | A facility whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). |
| 05 | Indian Health Service Freestanding Facility | A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. |
| 06 | Indian Health Service Provider-Based Facility | A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. |
| 07 | Tribal 638 Freestanding Facility | A facility or location, owned and operated by an American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization. |
| 08 | Tribal 638 Provider-Based Facility | A facility or location, owned and operated by an American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. |
| 09-10 | Unassigned | N/A |
| 11 | Office | Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. |

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*Standard Place of Service Codes Continued…*

| Place of Service Code | Place of Service Name | Place of Service Description |
|---|---|---|
| 12 | Home | Location, other than a hospital or other facility, where the patient receives care in a private residence |
| 13 | Assisted Living Facility | Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services, including some health care and other services. |
| 14 | Group Home | Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and education support services and that promotes rehabilitation and re-integration of residents into the community. |
| 15 | Mobile Unit | A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services. |
| 16-19 | Unassigned | N/A |
| 20 | Urgent Care Facility | Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate medical attention. |
| 21 | Inpatient Hospital | A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions. |
| 23 | Emergency Room – Hospital | A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided. |
| 24 | Ambulatory Surgical Center | A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis. |
| 25 | Birthing Center | A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants. |
| 26 | Military Treatment Facility | A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U. S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF). |
| 27-30 | Unassigned | N/A |
| 31 | Skilled Nursing Facility | A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. |
| 32 | Nursing Facility | A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals. |
| 33 | Custodial Care Facility | A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component. |
| 34 | Hospice | A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided. |
| 35-40 | Unassigned | N/A |
| 41 | Ambulance-Land | A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured. |
| 42 | Ambulance-Air or Water | An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured. |
| 43-48 | Unassigned | N/A |
| 49 | Independent Clinic | A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. |

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***Standard Place of Service Codes Continued…***

| Place of Service Code | Place of Service Name | Place of Service Description |
|---|---|---|
| 50 | Federally Qualified Health Center | A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician. |
| 51 | Inpatient Psychiatric Facility | A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician. |
| 52 | Psychiatric Facility-Partial Hospitalization | A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalizations, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility. |
| 53 | Community Mental Health Center | A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services. |
| 54 | Intermediate Care Facility/Mentally Retarded | A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF. |
| 55 | Residential Substance Abuse Treatment Facility | A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board. |
| 56 | Psychiatric Residential Treatment Center | A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment. |
| 57 | Non-residential Substance Abuse Treatment Facility | A location that provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. |
| 58-59 | Unassigned | N/A |
| 60 | Mass Immunization Center | A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these claims as electronic medical claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall but may include a physician office setting. |
| 61 | Comprehensive Inpatient Rehabilitation Facility | A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services. |
| 62 | Comprehensive Outpatient Rehabilitation Facility | A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology. |
| 63-64 | Unassigned | N/A |
| 65 | End-Stage Renal Disease Treatment Facility | A facility other than a hospital which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis. |

***Continued on the next page***

*Standard Place of Service Codes Continued…*

| Place of Service Code | Place of Service Name | Place of Service Description |
|---|---|---|
| 66-70 | Unassigned | N/A |
| 71 | Public Health Clinic | A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician. |
| 72 | Rural Health Clinic | A certified facility that is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician. |
| 73-80 | Unassigned | N/A |
| 81 | Independent Laboratory | A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office. |
| 82-98 | Unassigned | N/A |
| 99 | Other Place of Service | Other place of service not identified above. |

## Local Code Conversion Table

### Effective For Dates Of Services On And After October 1, 2003

| TYPE SERVICE | LOCAL CODE | HCPCS CODE | MODIFIER |
|---|---|---|---|
| Ambulance | W2000 | A0428 | Origin/Destination Modifiers: D, E, G, H, I, J, N, P, R, S, X |
| Ambulance | W2007 | A0436 | Origin/Destination Modifiers: D, E, G, H, I, J, N, P, R, S, X |
| Ambulance | W2008 | A0435 | Origin/Destination Modifiers: D, E, G, H, I, J, N, P, R, S, X |
| Ambulance | W2010 | A0380 | Origin/Destination Modifiers: D, E, G, H, I, J, N, P, R, S, X |
| NET: Non Emergency Transportation | W2200 | T2001 | None |
| NET: Non Emergency Transportation | W2201 | Code Closed | None |
| NET: Non Emergency Transportation | W2202 | Code Closed | None |
| Ambulance | W2205 | A0428 | Origin/Destination Modifiers: D, E, G, H, I, J, N, P, R, S, X |
| NET: Non Emergency Transportation | W2211 | A0210 | None |
| NET: Non Emergency Transportation | W2212 | A0210 | None |
| NET: Non Emergency Transportation | W2280 | S0215 for NET Individual Providers & T2003 for NET Group Providers | None |

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***Local Code Conversion Table Continued…***

| TYPE SERVICE | LOCAL CODE | HCPCS CODE | MODIFIER |
|---|---|---|---|
| NET: Non Emergency Transportation | W2291 | A0190 | None |
| NET: Non Emergency Transportation | W2292 | A0190 | None |
| Mental Health and CMHC | W3000 | 90862 | HW |
| Mental Health andCMHC | W3005 | 90804, 90806, or 90808 | HW |
| Mental Health and CMHC | W3006 | H0031 | HW |
| Mental Health and CMHC | W3007 | H0032 | HW and HT |
| Mental Health and CMHC | W3008 | H0039 | HW |
| Mental Health and CMHC | W3009 | 90846<br>90847 | HW |
| Mental Health and CMHC | W3010 | 90853<br>90857 | HW |
| Mental Health and CMHC | W3015 | H2030 | HW and HB |
| Mental Health and CMHC | W3016 | H2012 | HW |
| Mental Health and CMHC | W3020 | T1502 | HW |
| Mental Health and CMHC | W3021 | T1017 | HW and HB |
| Mental Health and CMHC | W3022 | T1017 | HW and HA |
| Mental Health and CMHC | W3023 | T1001 | HW |
| Mental Health and CMHC | W3025 | 90849 | HW |
| Mental Health and CMHC | W3026 | H2015 | HW and HA |
| Mental Health and CMHC | W3027 | H0035 | HW |
| Mental Health and CMHC | W3036 | H2019 | HW |
| Mental Health and CMHC | W3037 | H2017 | HW |
| Mental Health and CMHC | W3038 | H2030 | HW and HC |
| HCBS Elderly / Disabled | W3100 | T1016 | U1 |
| HCBS Elderly / Disabled | W3101 | S5150 | U1 |
| HCBS Elderly / Disabled | W3102 | S5151 | U1 |
| HCBS<br>TBI /SCI | W3102 | S5151 | U5 |
| HCBS Elderly / Disabled | W3103 | S5102 | U1 |
| HCBS<br>TBI / SCI | W3104 | S5165 | U5 |
| HCBS Elderly / Disabled | W3105 | S5130 | U1 |

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*Local Code Conversion Table Continued…*

| TYPE SERVICE | LOCAL CODE | HCPCS CODE | MODIFIER |
|---|---|---|---|
| HCBS MR/DD | W3106 | S5150 | U3 |
| HCBS TBI / SCI | W3106 | S5150 | U5 |
| HCBS MR/DD | W3107 | S5136 | U3 |
| HCBS MR/DD | W3108 | A4521 – A4525 | U3 |
| HCBS MR/DD | W3108 | A4554 | U3 |
| HCBS MR/DD | W3108 | A4338 – A4346 | U3 |
| HCBS TBI / SCI | W3108 | Select appropriate DME code | U5 |
| HCBS MR/DD | W3109 | H2019 | U3 |
| HCBS MR/DD | W3110 | T1016 | U3 |
| HCBS MR/DD | W3112 | T1005 | U3 |
| HCBS TBI / SCI | W3112 | T1005 | U5 |
| HCBS Elderly / Disabled | W3113 | S5170 | U1 |
| HCBS Independent Living | W3114 | S5125 | U2 |
| HCBS TBI / SCI | W3114 | S5125 | U5 |
| HCBS Independent Living | W3115 | T1016 | U2 |
| HCBS TBI / SCI | W3115 | T1016 | U5 |
| HCBS MR/DD | W3117 | S5151 | U3 |
| HCBS MR/DD | W3118 | S5136 | U3 |
| HCBS MR/DD | W3119 | S5125 | U3 |
| HCBS MR/DD | W3120 | S5100 | TT and U3 |

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***Local Code Conversion Table Continued…***

| TYPE SERVICE | LOCAL CODE | HCPCS CODE | MODIFIER |
|---|---|---|---|
| HCBS MR/DD | W3121 | T2015 | U3 |
| HCBS MR/DD | W3122 | H2024 | U3 |
| HCBS MR/DD | W3123 | G0151 | U3 |
| HCBS MR/DD | W3124 | G0152 | U3 |
| HCBS MR/DD | W3125 | G0153 | U3 |
| HCBS MR/DD | W3126 | H0045 | U3 |
| HCBS MR/DD | W3127 | T1005 | U3 |
| HCBS Elderly / Disabled | W3128 | T2001 | U1 |
| Mental Health Expanded EPSDT | W3305 | 90804,90806, 90808, 90810, 90812 or 90814 | HA with AH or AJ |
| SCHOOL | W3005 | 90847 | EP |
| Mental Health Expanded EPSDT | W3310 | 90846 or 90847 or H0031 | HA with AH or AJ |
| SCHOOL | W3310 | 90849 | EP |
| Mental Health Expanded EPSDT | W3315 | 90853 90857 | HA with AH or AJ |
| SCHOOL | W3315 | 90853 | EP |
| Mental Health Expanded EPSDT | W3320 | H2012 | HA with AH or AJ |
| Expanded EPSDT | W4001 | 92507 | EP |
| SCHOOL | W4001 | 92507 | EP |
| Expanded EPSDT | W4002 | 92507 | EP |
| SCHOOL | W4002 | 92507 | EP |
| Expanded EPSDT | W4003 | 92507 | EP |
| SCHOOL | W4003 | 92507 | EP |
| Expanded EPSDT | W4010 | 92508 | EP |
| SCHOOL | W4010 | 92508 | EP |
| Expanded EPSDT | W4011 | 92508 | EP |

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***Local Code Conversion Table Continued…***

| TYPE SERVICE | LOCAL CODE | HCPCS CODE | MODIFIER |
|---|---|---|---|
| SCHOOL | W4011 | 92508 | EP |
| Expanded EPSDT | W4012 | 92508 | EP |
| SCHOOL | W4012 | 92508 | EP |
| Family Planning | W5830 | J7300 or S4989 | FP |
| Vaccine For Children (VFC) | W6000, W6001<br>W6005, W6006<br>W6010, W6011<br>W6015, W6020<br>W6025, W6026<br>W6030, W6031<br>W6035, W6036<br>W6040, W6041<br>W6045, W6050<br>W6055, W6060<br>W6065, W6070<br>W6075, W6080<br>W6085, W6086<br>W6090, W6091<br>W6092, W6095<br>W6100, W6101<br>W6102, W6103<br>W6105, W6106<br>W6107, W6108<br>W6116, W6119 | 90471 or<br><br>90471 and 90472 | EP |
| Antepartum Visit 1st Trimester<br><br>Antepartum Visit 2nd Trimester<br><br>Antepartum Visit 3rd Trimester | W6130<br>W6140<br>W6150 | For all three (3) local codes, the following is applicable:<br><br>For Visit #1, 2, or 3: Bill appropriate E & M code per visit<br><br>For Visit #4, 5, or 6: 59425 per visit<br><br>For Visit #7 and above: 59426 per visit | TH on all antepartum maternity visits |
| Expanded EPSDT | W7000 | S9123 | EP |
| Expanded EPSDT | W7001 | S9124 | EP |
| Expanded EPSDT | W7002 | S9524 | EP |
| Not Applicable | W7003 | Code Closed | Not Applicable |

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***Local Code Conversion Table Continued…***

| TYPE SERVICE | LOCAL CODE | HCPCS CODE | MODIFIER |
|---|---|---|---|
| Dental | W7100 | D7999 | None |
| Dental | W8999 | Code Closed | Not Applicable |
| Family Planning | W9009 | 99201 - 99215 | FP |
| EPSDT | W9010 | 99401 | EP |
| Family Planning | W9014 | A4260 | FP |
| HCBS Assisted Living | W9017 | T1016 | U4 |
| HCBS Assisted Living | W9018 | T1020 | U4 |
| Expanded EPSDT | W9021 | 99358 | EP |
| Expanded EPSDT | W9022 | 99358 | EP |
| Expanded EPSDT | W9023 | 99358 and 99359 | EP |
| Expanded EPSDT | W9024 | 99358 and 99359 | EP |
| Expanded EPSDT | W9025 | 99371 | EP |
| Expanded EPSDT | W9026 | 99372 | EP |
| Expanded EPSDT | W9027 | 99372 | EP |
| Expanded EPSDT | W9028 | 99373 | EP |
| Rape | W9127 | Appropriate Evaluation and Management code | None |
| PHRM | W9350 | T1023 | TH |
| PHRM | W9351 | H1002 | TH |
| PHRM | W9352 | T1017 | TH |
| PHRM | W9353 | T1023 | EP |
| PHRM | W9355 | S9470 | TH |
| PHRM | W9356 | H0023 | TH |
| PHRM | W9357 | S9445 | TH |
| EPSDT | W9358 | Code Closed | Not Applicable |
| EPSDT | W9360 | Code Closed | Not Applicable |
| PHRM | W9361 | S9123 | TH |
| PHRM | W9362 | S9470 | TH |

***Continued on the next page***

***Local Code Conversion Table Continued…***

| TYPE SERVICE | LOCAL CODE | HCPCS CODE | MODIFIER |
|---|---|---|---|
| PHRM | W9363 | S9127 | TH |
| EPSDT | W9364 | Code Closed | Not Applicable |
| EPSDT | W9365 | 99173 | EP |
| EPSDT | W9366 | 92551 | EP |
| EPSDT | W9367 | Code Closed | Not Applicable |
| EPSDT | W9368 | 99381 or 99391 | EP |
| EPSDT | W9369 | 99382 or 99392 | EP |
| EPSDT | W9370 | 99381 or 99391 | EP |
| EPSDT | W9371 | 99381 or 99391 | EP |
| EPSDT | W9372 | 99381 or 99391 | EP |
| EPSDT | W9373 | 99381 or 99391 | EP |
| EPSDT | W9374 | 99382 or 99392 | EP |
| EPSDT | W9375 | 99382 or 99392 | EP |
| EPSDT | W9376 | For Age 1 to 4: 99382 or 99392<br>For Age 5 – 11: 99383 or 99393 | EP |
| EPSDT | W9377 | For age 12 – 17: 99384 or 99394<br>For age 18 – 21: 99385 or 99395 | EP |
| EPSDT | W9378 | Code Closed | Not Applicable |
| PHRM | W9379 | T1017 | EP |
| PHRM | W9380 | Code Closed | Not Applicable |
| PHRM | W9381 | S9470 | EP |
| PHRM | W9382 | H0023 | EP |
| PHRM | W9383 | S9445 | EP |
| PHRM | W9384 | S9123 | EP |
| PHRM | W9385 | S9470 | EP |
| PHRM | W9386 | S9127 | EP |
| EPSDT | W9387 | Code Closed | Not Applicable |
| EPSDT | W9388 | Code Closed | Not Applicable |
| EPSDT | W9401 | 99371, 99372, or 99373 | EP |

***Continued on the next page***

***Local Code Conversion Table Continued…***

| TYPE SERVICE | LOCAL CODE | HCPCS CODE | MODIFIER |
|---|---|---|---|
| Mental Health Expanded EPSDT | W9405 | T1017 | HA with AH or AJ |
| Anesthesia | W9500 | 36620 or 36625 | AA, GC, QX or QZ |
| Anesthesia | W9501 | 36488, 36489, 36490, or 36491 | AA, GC, QX, or QZ |
| Anesthesia | W9502 | 93502 | AA, GC, QX, or QZ |
| Maternity Anesthesia | W9510 | 62319 | AA, GC, QX, or QZ |
| Maternity Anesthesia | W9511 | 62311 | AA, GC, QX, or QZ |
| Maternity Anesthesia | W9514, W9515 W9518, W9519 W9520, W9521 W9522 | Select one of following codes: 01960, 01961, 01962, 01963, 01964, 01967, 01968, or 01969 | AA, GC, QX or QZ |
| Newborn Hearing | W9523 | V5008 | None |
| Hearing Aid | Z5250 | V5014 | None |
| Hearing Aid | Z5252 | V5299 | None |
| Hearing Aid | Z5254 | V5299 | None |
| Hearing Aid | Z5255 | V5264 | None |
| Medical Supplies | Z0000 – Z9999 (Excluding Z5250, Z5252, Z5254, and Z5255 as conversion for these codes listed above) | Select appropriate DME code | SC |
| Anesthesia | DP | GC | Not applicable |
| DME | MODIFIER 1 | RR | Not Applicable |
| DME | MODIFIER 2 | KR | Not Applicable |
| DME | MODIFIER 3 | NU | Not Applicable |
| DME | MODIFIER 4 | RP | Not Applicable |
| DME | MODIFIER 5 | MS | Not Applicable |
| DME | MODIFIER 6 | UE | Not Applicable |
| DME | MODIFIER 7 | SC | Not Applicable |

# Codes for Ambulance Services On and After October 1, 2003

**ALS EMERGENCY SERVICES**

| | |
|---|---|
| A0427 | Ambulance service, advanced life support, emergency transport, level 1 (ALS 1-emergency) |
| A0390 | ALS mileage ( per mile) |
| | **Mississippi Medicaid policy does not allow billing for the initial 25 patient loaded miles.** |

**BLS EMERGENCY SERVICE**

| | |
|---|---|
| A0429 | Ambulance service, basic life support, emergency transport, (BLS- emergency) |
| A0380 | BLS Mileage (per mile) |
| | **Mississippi Medicaid policy does not allow billing for the initial 25 patient loaded miles.** |

**NON-EMERGENCY AMBULANCE TRANSPORT (Includes Dialysis Transports)**

| | |
|---|---|
| A0428 | Ambulance Service, basic life support, non-emergency transport (BLS) |
| A0380 | BLS Mileage (per mile) |
| | **Mississippi Medicaid policy does not allow billing for the initial 25 patient loaded miles.** |

**NEONATAL TRANSPORT**

| | |
|---|---|
| A0225 | Ambulance service, neonatal transport, base rate, emergency transport, one way |
| A0390 | ALS mileage (per mile) |
| | **Mississippi Medicaid policy does not allow billing for the initial 25 patient loaded miles.** |

**DRUGS**

| | |
|---|---|
| J0000 – J9999 | Injectable Drugs |
| | **For Mississippi Medicaid, solutions are inclusive in the base rates and cannot be filed separately under the HCPCS "J" Code.** |

**AIR AMBULANCE – HELICOPTER**

| | |
|---|---|
| A0431 | Ambulance service, conventional air services, transport, one way (rotary wing) |
| A0436 | Rotary wing air mileage, per statute mile |

**AIR AMBULANCE – FIXED WING**

| | |
|---|---|
| A0430 | Ambulance service, conventional air services, transport, one way (fixed wing) |
| A0435 | Fixed wing air mileage, per statute mile |

## Non-Emergency Transportation Billing Changes

Effective October 1, 2003, the procedure codes for billing non-emergency transportation services by group providers (provider type J3) will change. Procedure code A0100 is being replaced with procedure code A0110 and procedure code W2280 will be replaced with procedure code T2003. These new codes will be in effect for all transports with a date of service on or after October 1, 2003. Transports prior to that time period should be billed using the old procedure codes. The proper procedure code will be listed at the bottom of the closed transaction summary.

If NET providers have any questions, they may contact the Bureau of Compliance and Financial Review at 1-800-421-2408 or 601-987-4868.

## Type of Service Codes

Claims filed on and after October 1, 2003, will not require the use of type of service codes. This was the code used in field 24C on the CMS-1500 claim form.

## Standard HCPCS and CPT Codes

Effective October 1, 2003, the Division of Medicaid will accept claims that use any of the standard HCPCS and CPT codes. This does not mean that all codes will be paid. The Division of Medicaid will still determine which codes will be paid for Medicaid-covered services and which codes are not for Medicaid-covered services. The Division of Medicaid will continue to price codes and establish pricing methodology based on Medicaid policy and procedures.

## 2003 CPT and HCPCS Codes

The additions, changes and deletions to the 2003 CPT and HCPCS codes are now loaded into the Medicaid Management Information System (MMIS). The new codes are effective for dates of service beginning January 1, 2003. The discontinued CPT and HCPCS codes will not be accepted after September 30, 2003.

## Anesthesia Services Billed by Anesthesiologists and CRNAs

Effective for claims **with dates of services on and after October 1, 2003**, the following changes are applicable to anesthesia services billed by anesthesiologists and CRNAs. These changes are in compliance with HIPAA regulations regarding standard coding and reporting.

1. For anesthesia services performed in conjunction with surgical procedures, anesthesiologists and CRNAs must bill the appropriate code from the CPT Code range 00100 through 01999.

2. Anesthesiologists and CRNAs must report time units in one-minute increments. One minute of anesthesia time will equal one unit. Providers will no longer report time units in 15 minutes (or any part of 15-minute) time increments.

Effective for **dates of services on and after October 1, 2003**, the following changes are applicable to maternity anesthesia services billed by anesthesiologists and CRNAs. These changes are also in compliance with HIPAA regulations regarding standard coding and reporting.

1. Local maternity anesthesia codes W9514, W9515, W9518, W9519, W9520, W9521, and W9522 will be closed. Anesthesiologists and CRNAs must bill the appropriate code from the CPT range 01960 through 01969 for maternity anesthesia.

2. Local codes W9500, W9501, and W9502 will be closed. Providers will report the appropriate CPT codes for the insertion of arterial lines, CVP lines, and flow directed catheters.

For all services (maternity and non-maternity) billed to Medicaid, providers must continue to report one of the following modifiers with each code:

AA Anesthesia performed personally by anesthesiologist
QX CRNA service with medical direction by a physician
QZ CRNA service without medical direction by a physician

Modifier DP is a local modifier which is no longer valid after September 30, 2003. For dates of services on and after October 1, 2003, modifier GC must be utilized when the service has been performed in part by a resident under the direction of a teaching physician.

## Maternity Anesthesia Billed by Delivering Physician

Effective for **dates of services on and after October 1, 2003,** the following coding changes apply to maternity anesthesia services provided by the delivering physician:

1. Local code W9510 will be closed. Providers must report CPT Code 62319.
2. Local code W9511 will be closed. Providers must report CPT Code 62311.

The delivering physician must report modifier TH with 62311 and/or 62319 to identify the service as maternity related.

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## Billing For Maternity Services On and After October 1, 2003

Effective for dates of services on and after October 1, 2003, the Division of Medicaid is making changes to the codes by which delivering physicians are reimbursed for maternity services.

The changes are as follows:

1. Local codes W6130, W6140, and W6150 which are currently used to reimburse antepartum visits will no longer be valid. The closure of these codes is in compliance with HIPAA regulations that prohibit use of local codes.
2. Providers must utilize CPT evaluation and management codes 99201 through 99215, 59425, and 59426 to bill antepartum visits as listed below.
   (A) Providers must bill CPT Codes in the 99201 through 99215 range for antepartum visits 1 or 2 or 3. Bill one code per visit.
   (B) Providers must bill CPT code 59425 for antepartum visits 4, 5, or 6. Bill one code per visit.
   (C) Providers must bill CPT code 59426 for antepartum visits 7 or over. Bill one code per visit.

The number of the antepartum visit is defined as the number of the visit(s) that the beneficiary has been to one physician. For example, if a beneficiary goes to Dr. A for antepartum visit 1, 2, 3, and 4 and then moves and goes to Dr. B, Dr. A will bill the appropriate evaluation and management code for each antepartum visit 1 or 2 or 3 and CPT code 59425 for antepartum visit 4. Dr. B will then bill for his antepartum visits starting with antepartum visit number 1, etc.

3. CPT Codes 59409, 59514, 59612, and 59620 will be closed as of October 1, 2003.
4. CPT Codes 59410, 59515, 59614, and 59622 will be used to reimburse deliveries and postpartum care as of October 1, 2003. The postpartum care is inclusive of both hospital and office visits following vaginal or cesarean section deliveries.
5. CPT code 59430 which is currently used to reimburse the postpartum office visit will be closed and no longer utilized by the Division of Medicaid because both hospital and office postpartum care are inclusive in CPT codes 59410, 59515, 59614, and 59622.
6. Modifier TH identifies "obstetrical treatment/services, prenatal and postpartum" and must be reported with each code for antepartum visits and deliveries and postpartum care. The Division of Medicaid will utilize this modifier to track data and to bypass the physician visit limitation of twelve (12). Antepartum office visits will not be applied to this limitation.

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***Billing for Maternity Services Continued…***

The following chart is being provided as a reference for providers.

| CPT CODE | MODIFIER | DESCRIPTION | BILLING INSTRUCTIONS |
|---|---|---|---|
| 99201 | TH | Office or other outpatient visit for the evaluation and management of a new patient which requires these three components:<br>(1) A problem focused history,<br>(2) A problem focused examination, and<br>(3) Straightforward medical decision making. | Bill for date of services on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit. |
| 99202 | TH | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:<br>(1) An expanded problem focused history,<br>(2) An expanded problem focused examination; and<br>(3) Straightforward medical decision making. | Bill for date of services on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit. |
| 99203 | TH | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:<br>(1) A detailed history,<br>(2) A detailed examination, and<br>(3) Medical decision making of low complexity. | Bill for dates of services on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit. |
| 99204 | TH | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:<br>(1) A comprehensive history,<br>(2) A comprehensive examination, and<br>(3) Medical decision making of moderate complexity. | Bill for dates of services on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit. |
| 99205 | TH | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:<br>(1) A comprehensive history,<br>(2) A comprehensive examination, and<br>(3) Medical decision making of high complexity | Bill for dates of services on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit. |
| 99211 | TH | Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. | Bill for dates of services on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit. |
| 99213 | TH | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:<br>(1) An expanded problem focused history;<br>(2) An expanded problem focused examination,<br>(3) Medical decision making of low complexity. | Bill for dates of services on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit. |
| 99214 | TH | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:<br>(1) A detailed history,<br>(2) A detailed examination,<br>(3) Medical decision making of moderate complexity. | Bill for dates of services on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit. |

***Continued on the next page***

***Billing for Maternity Services Continued…***

| CPT CODE | MODIFIER | DESCRIPTION | BILLING INSTRUCTIONS |
|---|---|---|---|
| 99215 | TH | Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:<br>(1) A comprehensive history,<br>(2) A comprehensive examination,<br>(3) Medical decision making of high complexity. | Bill for dates of services on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit. |
| 59400 | TH | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care | Closed |
| 59409 | TH | Vaginal delivery only (with or without episiotomy and/or forceps) | Closed as of 10/01/03 |
| 59410 | TH | Including postpartum care | Bill for dates of services on and after 10/01/03. |
| 59425 | TH | Antepartum care only: 4 - 6 visits | Bill for dates of services on and after 10/01/03 for each antepartum visit 4 or 5 or 6. |
| 59426 | TH | Antepartum care only: 7 or more visits | Bill for dates of services on and after 10/01/03 for each antepartum visits 7 or over. |
| 59430 | TH | Postpartum care only (separate procedure) | Closed as of 10/01/03. |
| 59510 | TH | Routine obstetric care including antepartum care, cesarean delivery, and postpartum care | Closed. |
| 59514 | TH | Cesarean delivery only | Closed as of 10/01/03 |
| 59515 | TH | Including postpartum care | Bill for dates of services on and after 10/01/03. |
| 59610 | TH | Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery | Closed. |
| 59612 | TH | Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or or forceps) | Closed as of 10/01/03 |
| 59614 | TH | Including postpartum care | Bill for dates of services on and after 10/01/03. |
| 59618 | TH | Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery | Closed. |
| 59620 | TH | Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; | Closed as of 10/01/03. |
| 59622 | TH | Including postpartum care | Bill for dates of services on and after 10/01/03. |

Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), and Mississippi State Department of Health (MSDH) will be reimbursed according to the reimbursement methodology that applies to the clinic, with encounter rate or fee for service, whichever is applicable.

# Procedure Code Changes for EPSDT and PHRM/ISS Services

Effective October 1, 2003, the local W codes for billing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Perinatal High Risk Management/Infant Services Systems (PHRM/ISS) services were converted to Current Procedural Terminology (CPT) and Healthcare Common Procedure Code System (HCPCS) codes as required by the Health Insurance Portability and Accountability Act (HIPAA). EPSDT providers must utilize the Preventive Medicine New Patient CPT codes 99381 through 99385 for initial screenings with an EP modifier, and Preventive Medicine Established Patient CPT codes 99391 through 99395 for periodic screenings with an EP modifier. Any interperiodic visit outside of the EPSDT periodic screenings should be billed using the appropriate CPT Evaluation and Management codes. PHRM/ISS case management agencies must utilize the appropriate HCPCS codes with an EP modifier for PHRM/ISS infants and "TH" modifier for PHRM/ISS Pregnant Women respectively.

Below are three charts listing the procedure code changes for the EPSDT and PHRM/ISS programs.

Chart 1

## EPSDT Periodic Examination Schedule

| Screening Code | | Modifier | Age of Child | Period Limits for Allowable Screening | Unit |
|---|---|---|---|---|---|
| New Patient | Established Patient | | | | |
| 99381 | 99391 | EP | 0 – 1 Months | 0 – 45 days | 1 |
| 99381 | 99391 | EP | 2 Months | 46 – 90 days | 1 |
| 99381 | 99391 | EP | 4 Months | 91 -150 days | 1 |
| 99381 | 99391 | EP | 6 Months | 151 – 240 days | 1 |
| 99381 | 99391 | EP | 9 Months | 241 – 330 days | 1 |
| 99382 | 99392 | EP | 12 Months | 331 – 400 days | 1 |
| 99382 | 99392 | EP | 15 Months | 401 – 500 days | 1 |
| 99382 | 99392 | EP | 18 Months | 501 – 731 days | 1 |
| 99382 | 99392 | EP | 2 – 4 years | Annually* | 1 |
| 99383 | 99393 | EP | 5 - 11 years | Annually* | 1 |
| 99384 | 99394 | EP | 12 – 17 years | Annually* | 1 |
| 99385 | 99395 | EP | 18 - 21 years | Annually* | 1 |

## Vision and Hearing

| Screening Code | Modifier | EPSDT Description | Age of Child | Period Limitations | Unit |
|---|---|---|---|---|---|
| 99173 | EP | Vision Screen | 3 – 21 Years | Annually* | 1 |
| 92551 | EP | Hearing Screen | 3 – 21 Years | Annually* | 1 |

## Adolescent Counseling

| Screening Code | Modifier | EPSDT Description | Age of Child | Period Limitations | Unit |
|---|---|---|---|---|---|
| 99401 | EP | Adolescent Counseling | 9 – 21 Years | Annually* | 1 |

*The annual visit must be performed only once during the state fiscal year. The state fiscal year begins July 1 and ends June 30.

***Continued on the next page***

Chart 2

## Reimbursement for Services to Infants in the High-Risk Case Management Program

**Medicaid will reimburse high-risk case management agencies for case management enhanced services to infants using the procedure codes and limits listed below**:

| NEW PATIENT CODE | ESTABLISHED PATIENT CODE | DESCRIPTION | LIMITS |
|---|---|---|---|
| | **EPSDT EXAMINATION UP TO ONE YEAR OF AGE** | | |
| 99381-EP | 99391-EP | 0-1 Months | 1 Exam |
| 99381-EP | 99391-EP | 2 Months | 1 Exam |
| 99381-EP | 99391-EP | 4 Months | 1 Exam |
| 99381-EP | 99391-EP | 6 Months | 1 Exam |
| 99381-EP | 99391-EP | 9 Months | 1 Exam |
| 99382-EP | 99392-EP | 12Months | 1 Exam |

| CODE | DESCRIPTION | PRICE | Limits |
|---|---|---|---|
| T1017-EP | Infant High Risk Management | $15.10 | Monthly |
| S9470-EP | Nutritional Counseling | $28.97 | 1 of 6 extra screens |
| H0023-EP | Psychological Counseling | $28.97 | 1 of 6 extra screens |
| S9445-EP | Health Education | $28.97 | 1 of 6 extra screens |
| S9123-EP | In-Home Nurse Visits | $28.97 | 1 of 6 extra screens |
| S9470-EP | In-Home Nutritionist (Place of Service) 12 | $28.97 | 1 of 6 extra screens |
| S9127-EP | In-Home Social Worker | $28.97 | 1 of 6 extra screens |
| T1023-EP | Infant Risk Screening | $18.90 | 2 done in the lst year of life |

An encounter payment is generated by these codes for the State Department of Health and Federally Qualified Healthcare Centers. All other codes pay fee-for-Service to individual and group providers.

*Continued on the next page*

Chart 3

## Reimbursement for Services to Pregnant Women in the High - Risk Case Management Program

**Medicaid will reimburse high-risk case management agencies for case management enhanced services to pregnant women using the procedure codes and limits listed below**:

| CODE | DESCRIPTION | UNIT | LIMITS | PROVIDER TYPE | REIMBURSEMENT- |
|---|---|---|---|---|---|
| T1023-TH | Maternal Medical Risk Screen | Encounter | 1 Per Pregnancy per | Physician/ Midwife | $15.12 |
| H1002-TH | Initial Case Mgt. | Encounter (1) | 1 Per Pregnancy | Case Manager | $48.38 |
| T1017-TH | Maternal Case Management | Encounter Monthly | 9 Per Pregnancy | Case Manager | $15.12 |
| S9470-TH | Nutritional Assessment/ Counseling | Personal Encounter | 8 Per Pregnancy in Conjunction with H0023-TH | Case Manager | $16.13 |
| H0023-TH | Psychosocial Assessment/ Counseling | Personal Encounter | NOTE: S9470-TH | Case Manager | $16.13 |
| S9445-TH | Health Education | On-on-One or Group | 10 Per Pregnancy | Case Manager | $ 6.05 |
| S9123-TH | In-Home Registered Nurse Visit | Actual Visit | 5 Per Pregnancy Combined With S9470-TH & S9127-TH | Case Manager | $24.19 |
| S9470-TH | In-Home Nutritionist | Actual Visit Place of Service (12) | 5 Per Pregnancy Combined with S9123-TH & S9127-TH | Case Manager | $24.19 |
| S9127-TH | In-Home Social Worker | Actual Visit | 5 Per Pregnancy Combined with S9470-TH & S9123-TH | Case Manager | $24.19 |

An encounter payment is generated by these codes for the State Department of Health and Federally Qualified Healthcare Centers. All other codes pay fee-for-Service to individual and group providers.

If you have questions concerning the Division of Medicaid, EPSDT Programs please call 1-800-421-2408 or 601-359-6150.

## Family Planning Program

Effective October 1, 2003 the Division of Medicaid will implement a Family Planning Program. This demonstration waiver program extends Medicaid coverage of 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 Family Planning Program will remain Medicaid eligible for five years with eligibility re-certification every two years. Loss of eligibility will occur nly when a woman moves from the state, becomes Medicaid eligible in another aid category, becomes pregnant, reaches the age of 44, or requests that her case be closed.

These women will be eligible for Medicaid coverage of family planning services only. The AVRS eligibility transaction response will identify these women as eligible for family planning services only, in Aid Category 92 (FP-W). They will also be issued a yellow Medicaid card to denote that they are in the Family Planning Program. These women **will not** be eligible to receive any other Medicaid benefits.

Procedure codes that will be used for the Family Planning Program may be found on the DOM website at www.dom.state.ms.us, go to drop down box and select "fee schedule". For more information about the Family Planning Program, you may call the Division of Medicaid at 1-800-421-2408 or (601) 359-6150.

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## DME and Medical Supply Coding Changes Effective October 1, 2003

As a result of the changes required for HIPAA compliance and use of standardized code sets, the Division of Medicaid has made significant changes in the procedure code formulary for durable medical equipment and medical supplies. These changes include the following:

- Closure of obsolete HCPCS procedure codes
- Closure of all local codes, i.e., Z codes for medical supplies
- Replacement of closed codes with appropriate 2003 HCPCS codes

In addition, the fee schedule for DME and medical supplies has been updated. In some cases, this update resulted in increased maximum fees for DME and medical supply items. Also, please be reminded that ostomy supplies and MIC-KEY gastrostomy feeding supplies are being priced at cost plus 15%.

These changes were discussed in detail at the August Provider Workshops. If you were unable to attend, you can access the code crosswalks and updated fee schedule on the DOM web site at www.dom.state.ms.us. If you have any questions, please call the Division of Medicaid at 1-800-421-2408 and ask for Medical Services at Ext. 5683.

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## Dialysis Policy Revised

Effective September 1, 2003, the Division of Medicaid has revised dialysis policy, Section 41.0 of the Provider Policy Manual. Dialysis providers may view these revisions by accessing the DOM website at www.dom.state.ms.us.

# Removal of Certification Requirements for Certain Medical Supplies Related to Diabetes and Asthma

Effective for dates of service on and after July 1, 2003, certification of the following medical supply items through HealthSystems of Mississippi will NOT be required:

| HCPCS Code (prior to 10/1/03) | HCPCS Code (after 10/1/03) | Item Description |
|---|---|---|
| Z7703<br>Z7704<br>Z7705<br>Z7707<br>Z7720<br>Z7880 | A4250 | Diabetic urine test strips or tablets |
| Z7700<br>Z7706 | A4253 | Blood glucose test strips for glucometer |
| Z8250<br>Z8252 | A4259 | Lancets – 100 count |
| Z8360 | A4245 | Alcohol prep pads |
| Z8510 | S8490 | Insulin syringes |
| E0607 | E0607 | Glucometer |
| A4256 | A4256 | Glucometer control solutions – high and low |
| A4254 | A4254 | Replacement batteries for Glucometer |
| A4258 | A4258 | Spring lancet devices |
| A4614 | A4614 | Peak flow meters |
| A4627 | A4627 | Asthma spacers |

Until changes can be made to the MMIS claims processing system later this year, the following temporary procedure must be followed to enable claims for these medical supply items to be reimbursed:

1. The DME provider must obtain a written prescription for the item(s) from the beneficiary's physician. The prescription must be retained in the DME provider file and be available for audit upon request.

2. It is NOT necessary for the provider to submit a Certificate of Medical Necessity (CMN) form to HSM **for these items only**. Providers may use the CMN form as the physician's prescription if they choose. If the CMN form is completed, it must be retained in the DME provider file and be available for audit upon request.

3. The DME provider must complete a Plan of Care form according to the forms and instructions in the Mississippi Medicaid Provider Policy Manual Section 10. The Plan of Care form for items exempted from HSM certification must be completed separately from other items that still require certification.

4. The Plan of Care form(s) must be submitted via mail, or fax to HealthSystems of Mississippi at 1-888-204-0159.

5. HealthSystems of Mississippi will process the Plan of Care form(s) and issue a Treatment Authorization Number (TAN) that will be sent to the provider.

6. The provider must enter the TAN on the CMS-1500 claim form for the item(s) in order for payment to be made.

***Continued on the next page***

***Removal of Certification Requirements Continued…***

7. It is NOT necessary to submit a Medicare Explanation of Benefits (EOB) to HSM for beneficiaries who are dually eligible **for the following supplies only:**

| | | |
|---|---|---|
| Z7703, Z7704<br>Z7705, Z7707<br>Z7720, Z7880 | A4250 | Diabetic urine test strips or tablets |
| Z8360 | A4245 | Alcohol prep pads |
| Z8510 | S8490 | Insulin syringes |
| A4627 | A4627 | Asthma spacers |

These items can be billed directly to Medicaid because they are not covered by Medicare. All other items on the list must be billed to Medicare as the primary payer.

8. All items NOT listed in this document must still be certified by HealthSystems of Mississippi as described in the Mississippi Medicaid Provider Policy Manual Section 10. Items requiring certification must be listed on separate Plan of Care forms from items not requiring certification.

9. This is a temporary process until systems changes can be made later this year. When those changes are completed, this temporary process will become obsolete.

## Pharmacy News

**Pharmacy Paper Claim now available on line.** The pharmacy paper claim is to be utilized for any paper claim needs including Medicare/Medicaid dually eligible beneficiaries whose claims have been denied, rejected, or whose indications are for non-Medicare covered indications. To access the form electronically:

- www.dom.state.ms.us
- Link to Medicaid provider page
- Forms for providers
- Medicaid Pharmacy Invoice

Or directly to:
www.dom.state.ms.us/Provider/Publications/Provider_forms/Title_XIX_pharmacy_invoice.pdf

The claim form may be typed electronically, printed, signed and mailed to the Pharmacy Bureau to facilitate payment. Mailing address is: Division of Medicaid, Pharmacy Bureau, 239 North Lamar St., Suite 801, Jackson, MS 39201.

**Pharmacy Services new website.** Watch for our new link on the Medicaid website. It is being updated for easy navigating and accessibility by users.

## Swing Bed Policy Revised

Effective September 1, 2003, the Division of Medicaid has updated policy, in the Swing Bed Manual, Section 35.0 of the Provider Policy Manual. Swing Bed providers may view these policies by accessing the DOM website at www.dom.state.ms.us.

# Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Claim Submission

Effective October 1, 2003, Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) will be required to bill their claims on the UB92 Claim Form for reimbursement of services provided. The 837 Institutional Electronic form should be utilized for electronic submissions. Turnaround Documents (TADs) will no longer be accepted after October 1, 2003.

In an effort to ensure minimal disruption to September's claims processing, ACS will generate and disseminate TADs for October to providers on September 22, 2003. Any TAD submitted to ACS after October 1, 2003 will need to be submitted on a UB 92 claim form for reimbursement. Processing will proceed as normal for all TADs received before October 1, 2003.

You may obtain a UB-92 claim form by visiting your local office supply store. Please refer to your billing manual for specific instructions on completing the UB 92. A summary of the billing instructions has been provided below as a quick reference guide.

**Summary of Billing Instructions**

1. Blank field – Required, enter the provider's name exactly as it appears in the upper left hand corner of the remittance advice (RA). Enter the provider's mailing address, city, state, zip code and telephone.
2. Blank Field – Not required
3. Patient Control No. – Optional, enter the patient account number. The patient's account control number, when furnished, will be reflected on the RA.
4. Type of Bill – Required, enter the type of bill code. This code indicates the specific type of bill being submitted and is critical to ensure accurate payment.

   Bill types for nursing facilities and ICF/MRs are listed below:

   **891 –** Used when the resulting claim is for a complete stay, admission through discharge (admission through discharge claim).

   **892 –** Used when the resident/client is admitted and is still a resident in the facility through the date noted in Form Locator 6. The resulting claim is the first part of a split bill (interim – first claim).

   **893 –** Used when the stay for the resident/client is for the full month of billing, having been admitted the previous month. The resulting claim is an interim bill (Interim – continuing claim).

   **894 –** Used when the resident/client is discharged in a different month from admission. The resulting claim is the final bill (Interim – last claim).

   **896 –** Adjustment of Prior Claim.

   **897 –** Replacement of Prior Claim.

   **898 –** Void/Cancel of Prior Claim
5. Fed. Tax. No. – Not required
6. Statement Covers Period - Required, enter the inclusive days being reported on the bill in mm dd yy format.
7. Cov D – Required, enter the number of covered days. Date of death and discharge are not counted as covered days.

***Continued on the next page***

***Nursing Facilities and ICF/MR Claim Submission Continued…***

8. N-C D. - Required, enter the number of non-covered days. Date of death and discharge are not counted as covered days.
9. C-I D. - Not required
10. L-R.D. – Not required
11. Blank Field
12. Patient Name – Required, enter beneficiary's name, as it appears on the Medicaid ID card, in last name, first name and middle initial format.
13. Patient's Address - Required, enter the resident/client's mailing address including street number and name or post office box number or RFD, city name, state name, zip code.
14. Birthdate – Required, enter the month, day, and year of birth, mm dd yyyy format.
15. Sex – Required, enter the sex of the patient:
    a. F – female, M – male, U – unknown
16. MS - Not required
17. Admission Date - Required, enter the month, day, and year of the admission of the beneficiary, mm dd yy format.
18. Admission HR – Required, enter time of admission in military time (24 hour clock)
19. Admission Type – Required, enter the admission code. 1 – Emergency; 2 – Urgent; 3 – Elective.
20. Admission SRC – Required, enter the appropriate source of admission code.
21. D HR – Not Required
22. STAT – Required, enter patient status code as of field 6 'through' date.
23. Medical Record Number – Optional

24 – 30. Condition Code – Required if applicable, enter the appropriate condition code taken from the code structure of the Uniform Billing Manual.

31. Blank Field – Not Required

32 – 35. Occurrence Codes and Dates – Required if applicable, enter the appropriate occurrence code and date (dd mm yy format). Refer to the Uniform Billing Manual.

36. Occurrence Span and Dates - Not required
37. Blank Field - Required, if applicable, enter the Transaction Control Number (TCN) for proof of timely filing if this claim is a resubmittal.
38. Blank field – Not required

39-41. Value Codes and Amounts – Required, if applicable, enter the appropriate value code and amount. Refer to the Uniform Billing Manual.

42. Revenue Code – Required, enter the revenue code that identifies a specific service or item.

    Revenue codes for nursing facilities and ICF/MRs are listed below:

    101 – All-inclusive Room and Board

***Continued on the next page***

***Nursing Facilities and ICF/MR Claim Submission: Billing Instructions Continued…***

181 – Hospital Leave (NF residents and ICF/MR clients are limited to 15 inpatient hospital days; the resident or client must be discharged from the NF or ICF/MR on the 16th day.

183 – Therapeutic Leave; Nursing Facility residents are limited to 52 days per fiscal year plus six (6) additional days including the days before and after Thanksgiving and Christmas (Total 58 days). ICF/MR clients are limited to 84 days per fiscal year plus six (6) additional days including the days before and after Thanksgiving and Christmas (Total of 90 days).

43. Description – Required, enter the standard abbreviation of the narrative description for revenue code.
44. HCPCS/Rates – Required, enter the appropriate CPT or HCPCS code for the services.
45. Service Dates – Required, for FDC and Hospital outpatient services only, enter the month, day and year, mm dd yy format.
46. Service Units – Required, for all revenue codes and CPT or HCPCS procedure codes. Enter the number of units for each code.
47. Total Charges - required, enter the total charges pertaining to the related revenue codes for the current billing period as entered in the statement covers period. Charges incurred after the "through" date in field 6 cannot be billed on the UB-92. Enter the grand total charges at the bottom for this field to be associated with revenue code 001.
48. Non-Covered Charges – required, if applicable, enter the charges for any non-covered services such as take-home drugs of services by private duty nurses.
49. Blank Field – Not required
50. Payer – required, enter the name in A, B and C identifying each payer organization from which the provider might expect some payment for the bill. One entry must be Medicaid, if the payer is Mississippi Medicaid. The UB-92 claim form does not have a form field for payer address.
51. Provider Number – required, enter the eight-digit MS Medicaid ID number as it appears in the upper right hand corner of the RA.
52. Rel Info - Not Required
53. Asg Ben - Not Required
54. Prior Payment- Required, if applicable, enter the amount the hospital has received toward payment of this bill prior to the billing date by the indicated payer.
55. Est. Amount Due-Not required.
56. Blank Field-Not required.
57. Due From Patient- Not Required
58. Insured's Name- Required, enter the insured's name in last name, first name order in A, B and C that relates to the payers in Form field 50 A, B and C.
59. P. Rel-Not required.
60. Cert.-SSN-HIC-ID No.-Required, enter the insured's ID number in 50 A, B and C that relates to the insured's name in 58 A, B and C. When entering the Medicaid ID number copy the number exactly as it appears on the Medicaid ID Card. A claim cannot be processed without the proper 9-digit ID number assigned to the individual who is receiving services.

***Continued on the next page***

***Nursing Facilities and ICF/MR Claim Submission: Billing Instructions Continued…***

61. Group Name-Required if applicable, state the name of the group or plan through which the insurance is provided to the insured.
62. Insurance Group No.- Required if applicable, state the number assigned by the insurance company to identify the group under which the individual is covered.
63. Treatment Authorization Code- Not Required
64. ESC – Not Required.
65. Employer Name-Required if applicable, enter the name of the employer that could provide a source of third party insurance payment.
66. Employers Location-Required if applicable, enter the address of the insured's employer.
67. Prin Diag Cd-Required, enter the ICD-9-CM code for the principal diagnosis codes that relate to the billing period.

68-75. Other Diag. Codes-Required, enter the ICD-9CM diagnosis codes that relate to the billing period.

76. Adm. Diag. Cd-Required, enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.
77. E Code-Not required.
78. Blank Field-Not required
79. P.C.-Required, enter code "9" in this field.
80. Principal Procedure Code And Date- - Not Required.
81. A-E Other Procedure Codes and Dates – Not Required
82. Attending Phys. ID-Required, enter the 2-digit state code followed by the physician's license number, name, and Medicaid provider number.
83. Other Physician ID-Required if applicable, enter the 2-digit state code followed by the physician's license number, name, and Medicaid provider number.
84. Remarks - Optional
85. Provider Representative Signature-Required, The form must be signed by a representative of the nursing facility or ICF/MR. The representative is certifying that the payment of eligible Title XIX benefits will be accepted as full payment for covered services and that notice will be given to the fiscal agent of further receipts. The representative is also stating that it is understood that payment and satisfaction of this claim will be from federal and state funds. Anyone filing false claims, statements of documents, or concealing a material fact, may be prosecuted under applicable federal or state laws.
86. Date-Required, enter the date the nursing facility or ICF/MR submits the form to the fiscal agent, dd mm yy format.

If you are unsure of the type of claim form on which you should bill for Medicaid services, please contact ACS State Healthcare at 1-800-884-3222.

## Correcting Multiple Surgery and/or Bilateral Surgery Claims

Multiple surgery and/or bilateral surgery claims with dates of service prior to October 1, 2003, cannot be adjusted in the *Envision* system.

All multiple surgery and bilateral surgery claims with dates of service October 1, 2003, and forward should not be submitted until October 2, 2003, or afterwards to ensure correct processing in the *Envision* system. These claims should be billed in the HIPAA compliant format and in accordance with Division of Medicaid policy.

To correct a claim, for dates of service prior to October 1, 2003, the provider must void the original claim and submit a corrected claim in accordance with policy in effect on October 1, 2003.

## DOM Issues New Surgery Policy

The Division of Medicaid has completed the Surgery Section of the Provider Policy Manual. **The effective date of this new section is October 1, 2003.** Providers may view the new policy by accessing the DOM website at www.dom.state.ms.us and selecting the drop down link "Provider Manuals".

## Mental Health Changes

The Division of Medicaid's Mental Health Services has revised the Community Based Mental Health Services and the Community Mental Health sections of the Provider Policy manual to reflect the following changes effective August 1, 2003. Providers may access these revisions on the Division of Medicaid website at www.dom.state.ms.us.

**Community Mental Health**

Section 15.02: Services--Revised to expand the definition of elderly to correspond with the Department of Mental Health Minimum Standards for community mental health centers.

Section 15.07: Credential Requirements for Day Treatment Staff – Revised to clarify credential requirements for day treatment staff.

Section 15.30: Billing Guidelines – Revised to clarify the appropriate use of the Place of Service Code "7" (nursing facility) and to include the MR/DD diagnosis for Adult Psychosocial Rehab.

**Community Based Mental Health Services**

Section 21.09: Consent to Bill Medicaid--Adds a consent form that consents to treatment and authorizes payment of Medicaid benefits to the authorized provider.

Sections 21.18- 21.20: Defines the process for the Clinical Record Review, the Therapeutic Services Review, and the Psychological Evaluation Record Review and makes each a part of DOM policy.

## 23-HOUR OBSERVATION

Effective for dates of service on and after June 20, 2003, Mississippi Medicaid reimburses for CPT code 99217 "Observation care discharge day management." As described in the 2003 CPT coding manual, this code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." Providers should also refer to the Mississippi Medicaid Provider Policy Manual Section 26.14 for additional policies on coverage of outpatient observation services.

## Timely Filing ICN

Claims processed after October 1, 2003, will be assigned a 17-digit Transaction Control Number (TCN). The TCN is basically the same as the 13-digit Internal Control Number (ICN). Use the **original ICN** originally adjudicated as the Timely Filing ICN when re-submitting claims. The *Envision* system will accept the old 13-digit Timely Filing ICN and the 17-digit TCN.

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## Billing Influenza and Pneumonia Immunizations for Adults

The Division of Medicaid (DOM) is continuing efforts to educate Medicaid providers and beneficiaries on the benefits of receiving influenza and pneumonia immunizations prior to the influenza season. DOM encourages providers to assist in the effort to increase influenza and pneumonia protection in the state.

To receive maximum reimbursement for providing these services, physicians, nurse practitioners and physician assistants should bill for flu and pneumonia vaccines administered to beneficiaries age 19 and over as described below.

- For beneficiaries who come in for these immunizations only, the physician, nurse practitioners, and physician assistants may bill E&M procedure code 99211, the vaccine code(s), and the appropriate CPT administration code. E&M procedure code 99211 will not count toward the 12-office visit limit for beneficiaries.
- For beneficiaries who are seen by the physician, nurse practitioner, or physician assistant for evaluation or treatment and receive these immunizations, the provider may bill the appropriate E&M procedure code, the vaccine code(s), and the CPT administration code(s). The E&M procedure code billed in this instance **will** count toward the 12-office visit limit for beneficiaries.
- Effective October 1, 2003, HCPCS Codes G0008 and G0009 are no longer valid for billing administration fees for flu and pneumonia vaccine to beneficiaries age 19 and over. For dates of service on and after October 1, 2003, providers must bill 90471 if one vaccine is administered and 90472 if a second vaccine is administered. CPT Codes 90471 and 90472 may be billed <u>only</u> with the administration of flu and pneumonia vaccines.
- Rural health clinic (RHC) and federally qualified health center (FQHC) providers will count the visit under current procedures. Providers will not count or bill visits when the only service involved is the administration of influenza or pneumonia vaccine.

Coding reimbursement for vaccines and administration for beneficiaries age 19 and older are as follows:

| Influenza Vaccines | | Pneumonia Vaccine | | Administration Fee | |
|---|---|---|---|---|---|
| CPT Code | Fee | CPT Code | Fee | CPT Code | Fee |
| 90658 | $8.02 | 90732 | $13.10 | 90471 | $6.44 |
| 90659 | $8.02 | | | 90472 | $4.60 |

<u>All immunizations for children up to age 18 must be handled through the Vaccines for Children Program (VFC).</u>

## Vaccines for Children Program New Coding Requirements

Effective October 1, 2003, Vaccines for Children Program (VFC) providers will no longer be able to utilize the codes in the W6000 through W6119 range for billing the administration fees for immunizations. These local codes will be discontinued in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations.

The new billing requirements for dates of services on October 1, 2003, are as follows:
To bill for administration of the immunizations provided in the Vaccines for Children Program, providers must bill CPT Code 90471 with an EP modifier and one unit for the single administration of one vaccine. If more than one is administered, providers must also bill 90472 with an EP modifier and indicate the appropriate number of units based on the number of additional vaccines administered to the beneficiary. Mississippi Medicaid allows $10 for each vaccine administered.

Following the designation of 90471 and 90472 with an EP modifier, the provider must also bill appropriate vaccine code(s) in the CPT 90476 through 90749 range with an EP modifier and show a zero ($00.00) charge. The provider must bill only those codes covered by the VFC Program.

Questions relating to these billing requirements should be directed to the Bureau of Maternal and Child Health at 601-359-6150.

## Medicaid ID Numbers for Newborns

When a baby is born to a mother who is receiving Medicaid at the time of birth, that baby is eligible for Medicaid. The exception to this is if the baby is released for adoption. In order to expedite getting Medicaid ID numbers for these babies, the birthing hospital should complete the Request for Newborn Health Information form and send it to the county Department of Human Services (DHS) for the baby'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.

The hospital should not delay completing the form. The baby needs to get a Medicaid ID as quickly as possible to expedite the claims payment process.

Claims for babies should continue to be billed with the mother's number + K until the baby receives his/her Medicaid ID number. Effective November 1, 2003, the claims will pend for three payment weeks to give DHS time to transmit the baby's Medicaid ID number. If after three payments, the Medicaid ID has not been received, the claim will be processed using a temporary 200 number for the baby. The exception is pharmacy claims which will process with a temporary 200 number due to the pharmacy point of sale process.

Babies will not be sent Medicaid ID cards with 200 numbers. They will be sent a Medicaid ID card once the number is assigned by DHS. This is to prevent babies having multiple Medicaid ID cards and numbers, which causes problems in processing claims. It will also reduce the possibility of misuse of Medicaid services due to one beneficiary having multiple Medicaid ID numbers.

There is no change in the certification process for services that requires HSM to issue a treatment authorization number (TAN). Please refer to the October 2002 provider bulletin for additional information regarding this process.

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

## 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

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# *September*

## *September 2003*

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