Mississippi Medicaid Bulletin

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Update to Medicaid Billing Instructions

The purpose of this article is to highlight important changes in the healthcare industry and the Mississippi Medicaid program as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the revised Medicaid claims processing system, **Envision**.

HIPAA requires covered entities, including providers and health plans, to use national standards for electronic healthcare transactions. If you submit electronic healthcare information, it is imperative that your practice management system supports the use of these transactions. As a covered healthcare provider, it is your responsibility to ensure that the transactions you conduct electronically are compliant with the HIPAA regulations. Please communicate with your software vendor or billing agent about their progress towards HIPAA compliance.

Listed below are some of the changes to the Mississippi Medicaid program effective October 1, 2003:

- The new ACS EDI Gateway, Inc., clearinghouse was implemented October 1, 2003, at 5:01 p.m. CDT for all providers who submit electronically. The clearinghouse will support HIPAA mandated electronic transactions, such as the 837 Professional., Dental, and Institutional claims formats, and the 835 remittance advice.

- WINASAP2003 is replacing NECS and WINASAP2000. WINASAP2003 supports the HIPAA-mandated electronic claims transactions. If you are currently using WINASAP2000 and have not received notification to download the software, please do so at http://msmedicaid.acs-inc.com or contact the EDI Support Unit at 866-225-2502 to request a copy on CD-ROM.

On September 23, 2003, the Centers for Medicare & Medicaid Services (CMS) announced that it will implement a contingency plan to accept non-compliant electronic transactions after the October 16, 2003, compliance deadline. This plan will ensure continued processing of claims from thousands of providers who were not able to meet the compliance deadline and otherwise would have had their claims rejected. Also, CMS will not impose penalties on health plans (like Medicaid) that receive non-compliant transactions, under certain conditions. CMS is clear that this relatively lenient approach will not last indefinitely, and providers who send electronic transactions must continue to work toward being able to conduct these transactions using HIPAA mandated X12N formats.

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Update to Medicaid Billing Instructions Continued…

If your practice management system, software vendor, billing agent or clearinghouse is unable to transmit claims or other transactions in the HIPAA mandated formats, please continue submitting your claims electronically in the existing formats using the new Medicaid policy and guidelines effective October 1, 2003. Please do not submit claims on paper, as this will only delay processing of your claims. Additionally, the 835 electronic remittance advice (RA) will be available for those providers who requested it. All providers will continue receiving a RA in the new paper format for a limited period of time. The print image of the new paper RA will be available for those providers currently receiving the print image via the web.

Provider Quick Contact List
For Assistance With Mississippi Medicaid Claims

There are several resources designed to address your questions concerning Medicaid claims processing, billing, mailing, policy procedures and more. To effectively assist you with these needs, the following information will serve as a guide to contacting the proper resource.

Contact Name	Contact Address/Phone Number/Website (*if applicable)
ACS Medicaid Web Portal	http://msmedicaid.acs-inc.com
ACS Provider and Beneficiary Services	P.O. Box 23078 Jackson, MS 39225 **1-800-884-3222 or 601-206-3000**
• **Claims**	P.O. Box 23078 Jackson, MS 39225
• **Adjustment/Void Requests**	P.O. Box 23077 Jackson, MS 39225
• **Financial Correspondence (Mail with Checks)**	P.O. Box 6014 Ridgeland, MS 39158-6014
Automated Voice Response System (AVRS)	**1-866-597-2675 or 601-206-3090**
ACS Prescription Benefits Services	ACS State Healthcare 365 Northridge Road Northridge Center One, Suite 400 Atlanta, GA 30350 **1-866-759-4108**
Health Information Designs (HID)- To obtain pharmacy prior authorization	**1-800-355-0486** **or** **601-709-0000**
Health Systems Mississippi (HSM) (Peer Review Organization – conducts certification reviews of some Medicaid services.)	**1-888-204-0221** **or** **601-352-6353**
ACS EDI – For assistance with transmission of electronic claims	www.acs-gcro.com **1-866-225-2502**
Division of Medicaid – • Third Party Liability • EPSDT Services	801 Robert E. Lee Bldg. 239 N. Lamar St. Jackson, MS 39201 **601-359-6050** www.dom.state.ms.us
Division of Medicaid – • Provider and Beneficiary Services	801 Robert E. Lee Bldg. 239 N. Lamar St. Jackson, MS 39201 **601-359-6133**

Important Facts for Claims Submitted After October 1, 2003

Please note the following reminders when submitting claims after October 1, 2003. Any claims received after October 1, 2003, that do not adhere to the following requirements will be denied.

- The 8-digit provider number must be used.
- Two-digit standard place of service codes must be used. Place of service codes are driven by the **date of processing**. As a result, you must use the two-digit standard place of service codes on all claims filed after October 1, 2003. Refer to the September 2003 Mississippi Medicaid Bulletin for a complete list of place of service codes.
- Local codes will not be used for dates of service after October 1, 2003. You must use the Current Procedural Terminology (CPT) and Healthcare Common Procedure Code System (HCPCS) codes on claims with dates of service on and after October 1, 2003. Please remember that procedure codes are **date of service** driven.
- National modifiers must be used for all claims filed after October 1, 2003. Local modifiers will not be allowed on any claim regardless of the date of service.
- Any unresolved **nursing home claims** must be billed on the UB-92 claim form after October 1, 2003, regardless of the date of service.
- Please note that all claims received by ACS after October 1, 2003, must have the appropriate codes in order to be processed.

Banner Messages Now Posted on the Web Portal

Remittance advice (RA) banner messages will be posted on the web portal. For providers receiving paper RAs, the banner messages will continue to be printed on the second page of the RA. For providers who only receive electronic RAs, it will be necessary to check the web portal each week for current RA banner messages.

EDI Rejection Reports

EDI Rejection Reports are available on the Internet Data Exchange site (iDex) at http://msmedicaid.acs-inc.com. If you are a current electronic submitter and have indicated on your enrollment form that you want access to iDex, use your Logon Name and Logon ID to access the rejection reports. Rejection Reports are available the day after you submit your claims electronically to EDI. If you have any questions about accessing or reading the rejection reports, contact EDI at 866-225-2502 for assistance. Rejection reports are only available for 30 days.

Important Notice Concerning RA Retrieval - Registered users may also retrieve EDI files using the secure EDI exchange feature of the web portal. Visit http://msmedicaid.acs-inc.com for details.

The Mississippi Envision Web Portal

On October 6, 2003, ACS introduced the Mississippi *Envision* web portal. The web portal provides convenient, "24/7" access to Medicaid information and services. It is your one-stop resource for answers to common Medicaid questions, contact information, provider bulletins, online provider enrollment or enrollment status inquiry, and more. Additionally, secure features include:

- Interactive beneficiary eligibility verification
- Interactive claim status inquiry
- Interactive provider enrollment status inquiry

You are encouraged to visit the web portal and explore all it has to offer. General site content is available to all users at http://msmedicaid.acs-inc.com. To access the secure features described above, you must register to create a web account. Registration is quick and easy at http://msmedicaid.acs-inc.com/general/userreg.jsp.

WINASAP2003

WINASAP2003 is replacing NECS and WINASAP2000. WINASAP2003 supports the HIPAA-mandated electronic claims transactions. If you are currently using NECS or WINASAP2000 and have not received notification to download the software, please do so at http://msmedicaid.acs-inc.com or contact the EDI Support Unit at 866-225-2502 to request a copy on CD-ROM. You can begin using WINASAP2003 to submit Medicaid claims on October 1, 2003 at 5:01 PM CST.

WINASAP2003 is a brand new software product, and you may encounter problems using the software. These problems may have already been reported to EDI and updates may already be available. Please visit the site listed above regularly for possible software updates, or contact the EDI Support Unit for help. After installing the update, if you are still encountering problems, contact the EDI Support Unit to report the problem so that we may make corrections if necessary. Also, call the EDI Support Unit at 866-225-2502 if you need assistance downloading or installing an update.

Provider Re-enrollment

Once your re-enrollment has been completed, ACS will send you a welcome letter with your information. Your provider number will not be closed. It is not necessary to call and inquire about the status of your re-enrollment.
If your application is returned to you in the mail, your provider number will not be closed. Follow the instructions in the letter with your application and resubmit it to ACS Provider Enrollment as quickly as possible at:

ACS Provider Enrollment
PO Box 23078
Jackson, MS 39225

Remember to add a leading zero to your current provider number. This 8-digit provider number should be used on all claims, correspondence, and when using the Automated Voice Response System (AVRS).

Home Health Medical Supply Add-on

Home Health Agency State Plan Amendment 2003-07 was filed with the Secretary of State's office on July 30, 2003, with public notice of this amendment included in selected newspapers on Wednesday, August 6, 2003. State Plan Amendment 2003-07 was filed to allow the Division of Medicaid to change the medical supply payment methodology effective October 1, 2003, to include an add-on to the payment rates set for the Skilled Nursing Care, Physical Therapy, Speech Therapy, and Aide disciplines; to include various technical corrections; and to delete the section of the Plan pertaining to Durable Medical Equipment and transfer it to the section of the Plan for Other Types of Care.

The payment methodology to include the medical supply add-on to each discipline was presented to the Home Health Agency Team on Friday, April 11, 2003. The medical supply add-on will be calculated by using costs from the cost report filed with Medicaid on the Medicare cost report forms. Each provider's medical supply add-on will be calculated by taking the total medical supply cost, dividing it by total medical supply charges, multiplying this ratio times Medicaid medical supply charges per the desk review and dividing this number by total Medicaid visits per the desk review. All provider's medical supply costs per visit will then be trended and arrayed from lowest to highest along with total Medicaid visits per the desk reviews. The cost associated with the median visit will be determined and the ceiling will be calculated at 105% of the median. The final add-on to each provider's four disciplines will be the lower of their trended cost or the ceiling. The medical supply add-on will be applied to each discipline's rate outside the ceiling for that discipline. For example, if the medical supply add-on is $1.50, the total payment rate for a physical therapy visit would be $66.50. ($65.00 + $1.50)

Providers should file all Medicaid medical supply charges on the UB-92 using revenue code 270. Also, to facilitate these changes, all Home Health providers will need to properly file their Medicaid cost reports with the correct amount of Medicaid medical supply charges and Medicaid visits.

If you have any questions concerning these changes, please contact Karen Thomas at (601) 359-5186.

Important ENVISION Conversion Information for DME Providers

The Division of Medicaid has directed HealthSystems of Mississippi to provide the following instructions to DME providers concerning conversion of TAN's in the Medicaid Envision claims processing system. Please consult the DOM web site at www.dom.state.ms.us for additional information and answers to Frequently Asked Questions. All questions related to claims and billing must be directed to your provider representative at the fiscal agent or the Division of Medicaid.

1. Medical Supply Items Exempt from HSM Review:
Effective for claims submitted 10/1/03 and after, Medical Supplies exempt from certification by HSM may be billed directly to the fiscal agent without a TAN. HSM will no longer process and/or certify these items on/after 10/1/03. A Certificate of Medical Necessity and Plan of Care form should NOT be submitted to HSM for these items after 10/1/03. A physician's prescription is required but should be filed in the beneficiary's record by the DME provider.

HCPCS Code (prior to 10/1/03)	HCPCS Code (after 10/1/03)	Item Description
Z7703, Z7704 Z7705, Z7707 Z7720, Z7880	A4250	Diabetic urine test strips or tablets
Z7700, Z7706	A4253	Blood glucose test strips for Glucometer
Z8250, 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

2. New Billing Modifier Values:
In accordance with HIPAA requirements, **DME providers must use valid HCPCS modifiers** on all claims submitted **on or after 10/1/03**. The Medicaid Envision claims processing system will only process claims with valid HCPCS modifiers after 10/1/03.

Modifier Value Conversion Map:

Description	Valid Modifier	Invalid Modifier
DME Monthly Rental	RR	1
DME Daily Rental	KR	2
DME Purchase New	NU	3
Repair	RP	4
Maintenance Ventilator	MS	5
DME Purchase of Used Equipment	UE	6
DME Purchase of Medical Supplies	SC	7

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Important ENVISION Conversion Information for DME Providers Continued…

No additional action is required of the DME provider for TAN's with invalid modifiers issued prior to 10/1/03. The Medicaid Envision claims processing system will electronically convert the invalid DME modifiers (1-7) on active TAN's to valid modifiers (RR, KR, NU, etc.). For claims submitted after 10/1/03 the provider should always use the valid modifiers. **There is an exception to this electronic conversion for E1399 items as described in item #3 below.**

3. Code "E1399" (Miscellaneous) Submission
When submitting certification requests to HSM, **the DME provider must use valid HCPCS codes** from the revised formulary list and avoid the use of a E1399 (miscellaneous) code whenever possible.

If requesting multiple items that require the E1399 code, **each item must be submitted on separate Plan of Care forms** and HSM will issue **separate TANs for each item.** For DME requests submitted on or after 10/1/03, only one "E1399" code can be issued/submitted per TAN. Per HIPAA coding regulations, **the invalid billing modifier values of A, B, C, etc. currently used to differentiate multiple E1399 codes can no longer be used.** Only TANs with multiple E1399 items that extend past 10/1/03 need to be resubmitted to HSM with appropriate POC forms for assignment of a new TAN number for each item.

It will NOT be necessary to obtain a new CMN form if there is a current form dated on or after April 1, 2003. A copy of the current CMN form should be submitted to HSM with a new POC form. If the CMN form was completed prior to April 1, 2003, a new CMN form must be submitted.

4. Retrospective Reviews
When requesting a "Retrospective Review" (due to retroactive beneficiary eligibility only) providers must submit the **procedure code effective at the time of the item delivery**. While the invalid procedure code will be certified and billed, the valid modifier will be required on all claims **submitted** on and after 10/1/03.

5. Codes Ending on 9/30/03:
As you are aware, many local and invalid HCPCS codes are ending on 9/30/03. **Valid HCPCS codes must be used for certification requests on or after 10/03/03.** Please access the DOM, Provider web site **www.dom.state.ms.us** for the updated DME fee schedule to determine which valid HCPCS codes are open.

HSM will automatically extend existing TANs that have a 9/30/03 end date, **for the high volume codes listed below, until 12/31/03.** The new TAN using the valid code will be added to the existing TAN beginning 10/01/03 until 12/31/03. HSM will re-issue the certification letters for each TAN affected. DME providers **do not** need to submit any additional documentation to HSM for TANs meeting these guidelines. Revised certification letters will be faxed by 10/3/03. **Providers will need to submit new CMN and POC forms for these items using appropriate valid HCPCS codes and modifiers no later than 12/31/03.**

Code Before 10/1/03	Item Description	Code On & After 10/1/03	Units/ Month
A5123	SKIN BARRIER, W/FLANGE (SOLID, FLEXIBLE	A4373	92
E0608	APNEA MONITOR	E0618	3
K0168	ADMINISTRATION SET, SMALL VOLUME NONFILTER	A7004	3
K0171	ADMINISTRATION SET, SMALL VOLUME FILTER	A7006	3
K0180	AEROSOL MASK, USED WITH DME NEBULIZER	A7015	3
K0183	NASAL APPLICATION DEVICE	A7034	1
K0185	HEADGEAR	A7035	1
K0187	TUBING FILTER, DISPOSABLE	A7037	3
K0190	CANISTER, DISPOSABLE, USED WITH SUCTION	A7000	3

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Important ENVISION Conversion Information for DME Providers Continued…

Code Before 10/01/03	Item Description	Code On and After 10/01/03	Units/Months
K0192	TUBING, USED WITH SUCTION PUMP	A7002	3
Z7110	BAG-FEEDING, STERILE WITH TUBING	B4035	92
Z7115	BAG-FEEDING, FLEXIFLO PUMP SET	B4035	92
Z7117	BAG-FEEDING, FLEXIFLOW TOP FILL	B4035	92
Z7243	STERILE GAUZE SPONGE 4X4	A6402	300
Z7535	CATHETERS, ALL PURPOSE, URETHRAL	A4351	92
Z7560	CATHETERS BARD, TOUCHLESS, INTERMITTENT	A4351	92
Z7595	CATHETERS, SUCTION, UNSPECIFED	A4624	92
Z7840	DIAPERS, ADULT- DISPOSABLE	A4523	558
Z7841	DIAPERS, JUNIOR-DISPOSABLE	A4533	558
Z7845	DIAPERS, SMALL WAIST	A4521	558
Z7846	DIAPERS, MEDIUM WAIST	A4522	558
Z7847	DIAPERS, LARGE WAIST	A4523	558
Z8132	GLOVES, EXAM, LATEX/VINYL, NON-STERILE	A4927	300
Z8230	K-Y JELLY, TUBE 5OZ. TUBE	A4402	3
Z8300	OXYGEN, E CYLINDER (INCLUDES DELIVERY)	E0443	30
Z8500	SYRINGE, FEEDING	B4034	14
Z8540	SYRINGE, W/NEEDLE, 10CC	A4209	172
Z8555	SYRINGE W/O NEEDLE, TAPER OR LOCK TIP	A4213	52
Z8575	SYRINGE, W/O NEEDLE, 60CC	A4213	14
Z9008	TRAY, TRACH CLEANING	A4629	92
Z9320	WATER, STERILE SOLUTION "FOR IRRIGATION"	A4323	92
Z9560	IV PUMP SETS	A4305	92
Z9569	CENTRAL LINE CARE KIT	A4221	14
Z9992	BATH BENCH, PLASTIC COATED, HIGHBACK	E0245	Purchase Only
Z9996	FEEDING PUMP: WITHOUT ALARM AND	B9000	3

Important Note: The TAN's for these codes are being extended based on average utilization of medical supplies, not individual medical records. Providers should dispense medical supplies based on the physician's orders and bill Medicaid only for supplies utilized by the beneficiary.

For all items with TAN end dates of 9/30/03 **not** listed in the table above, providers must submit a new POC form using appropriate valid procedure codes and modifiers. It will **NOT** be necessary to obtain a new CMN form if there is a current form dated on or after April 1, 2003. A copy of the current CMN form should be submitted to HSM with a new POC form. If the CMN form was completed prior to April 1, 2003, a new CMN form must be submitted.

6. Manual Pricing

In an effort to minimize the number of DME and medical supply items billed with an E1399 procedure code, the Division of Medicaid has opened additional valid HCPCS codes that match many of these items. If a specific valid HCPCS code exists for an item, the specific code must be billed. In some cases, the item must be manually priced by HSM at the time of certification because there is no fee on file. As new Medicare fees become available, these manually priced items will be assigned a fee at 80% of the current Medicare fee as required in the Medicaid State Plan. **For all items listed on the DME Fee Schedule with a PAC 810, the provider must submit a manufacturer's invoice with the cost of the item to the provider with the CMN and POC forms.** HSM will use this information to assign a manual price to the item.

DME and Medical Supply Information on the Web

The 2003 DME Fee Schedule and an updated DME code conversion table are now on the DOM website. Directions for acquiring new TANs for HCPCS codes that have replaced those codes deleted 9/30/2003 are also available on the website. Access the Mississippi Medicaid website at www.dom.state.ms.us and click on "DME/Medical Supply Information" to view DME updates.

Billing Reminders for Procedure Code, Place of Service Codes and Modifiers

- Local codes should not be used for claims with dates of service on and after October 1, 2003. You must use the Current Procedural Terminology (CPT) and Healthcare Common Procedure Code System (HCPCS) codes on claims with dates of service on and after October 1, 2003. Procedure codes are **date of service** driven.
- Two-digit standard place of service codes must be used on all claims filed on and after October 1, 2003, regardless of the date of service. Place of service codes are driven by the **date of receipt**.
- National modifiers must be used for all claims filed on and after October 1, 2003, regardless of date of service. Modifiers are driven by the **date of receipt**.

Updated Adjustment/Void Request and Claim Inquiry Forms

For your convenience, updated Adjustment Void Request forms and Claim Inquiry forms are now available on the ACS web portal address at http://msmedicaid.acs-inc.com. You can print these forms from the website or call ACS Provider and Beneficiary Services at 1-800-884-3222 or 601-206-3000 to request paper copies.

Change in Billing Routine Foot Care for Systemic Conditions

Effective for dates of service on and after October 1, 2003, obsolete HCPCS code M0101 for routine foot care will be closed. It is being replaced with HCPCS code S0390 "Routine foot care; removal and/or trimming of corns, calluses, and/or nails and preventive maintenance in specific medical conditions (e.g., diabetes) per visit". Providers should review the Physician Manual Section 5.09.9 for policy related to payment of routine foot care for systemic conditions only.

Nursing Facility and ICF/MR Providers Patient Status Code Addendum

Please note that during the August and September 2003 provider workshops, status codes 30, and 31-39, were inadvertently omitted from the list of status codes, which were distributed in the UB92 Billing Instructions for Nursing Facilities and ICF/MRs.

Status codes 30 and 31-39 are defined as follows:

30	**Still patient**
31-39	**Still patient to be defined at state level, if necessary**

Status codes are required for form locator (field) 22 on the UB92.

Attention Mississippi Medicaid Providers
Telephone Menu for Provider and Beneficiary Services Call Center

Please note the menu has changed when calling the Provider and Beneficiary Services Call Center. After dialing 1-800-884-3222 or 601-206-3000, the options have changed and are as follows:

If you are a pharmacy, press 1.

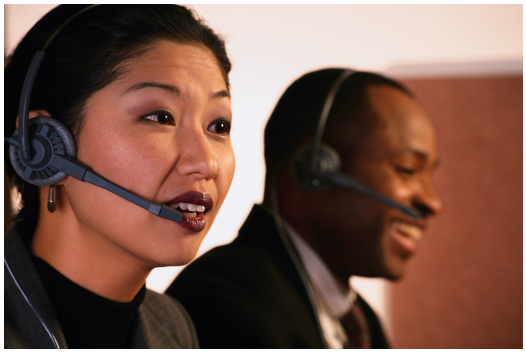
If you are a beneficiary, press 2.

For beneficiary eligibility and check amount inquiries, press 3.

For provider enrollment services, press 4.

For the EDI technical support phone number, press 5.

For all other inquiries, press 6.



In addition, please be aware that you can now access all Medicaid information through the MS Medicaid Web Portal at http://msmedicaid.acs-inc.com. You can enroll online, check claim status, check beneficiary eligibility, and check current policy through the web portal.

Pharmacy POS Help Center

Effective October 6, 2003, pharmacy POS calls should be directed to 866-759-4108. Questions from providers regarding check amounts and beneficiary eligibility should be directed to the Automated Voice Response System at 866-597-2675 or 601-206-3090.

Pharmacy Program Updates for Pharmacies and Prescribers

Over-the-Counter (OTC) Drugs

Medicaid covers some over-the-counter (OTC) drugs pursuant to a written or verbal prescription. Covered OTC products must be manufactured by pharmaceutical companies who are participating in the Federal Drug Rebate Program. OTC drug prescriptions are included in the monthly drug benefit limit.

Effective October 5, 2003, Medicaid will reimburse covered OTC drugs at the lessor of the estimated shelf price plus a $3.91 dispensing fee or the usual and customary amount billed. The usual and customary charges billed to Medicaid must be no more than what is charged to the general public for retail sale. In **no** case will Medicaid reimburse more than the amount billed.

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Pharmacy Program Updates for Pharmacies and Prescribers Continued…

The Division of Medicaid defines estimated shelf price as the lowest of the following:

- Mississippi Estimated Acquisition Cost (MEAC) – State Law defines the MEAC as the Average Wholesale Price (AWP) less 12%. AWP is based on surveys of drug wholesalers and manufacturer-supplied information for a drug product. The AWP price is provided by First DataBank.
- Federal Upper Limit – This is the unit price as published by the Centers for Medicare and Medicaid Services (CMS) in the State Medicaid Manual, Section 6305, Upper Limits for Multiple Source and Other Drugs and revisions.
- BaseLine Price – The BaseLine Price is developed by First DataBank as a statistical model that involves the Blue Book Unit Price, Direct Unit Price, and Net Wholesale Unit Price. This price shows the current market price and reflects changes in the market.
- Wholesale Net Unit Price – This is the published unit price that a manufacturer charges a wholesaler (commonly referred to as the wholesale acquisition cost, or WAC) and is provided by First DataBank.
- State Maximum Allowed Cost (SMAC) – The Division of Medicaid does not currently have a SMAC.

OTC drugs are covered as follows with a prescription:

Acetaminophen- Drops, Liquid, Suppositories
Acetaminophen Tabs- 325 mg, 500 mg
Al & Mg Hydroxide- Tabs & Suspension
Al & Mg Hydroxide/Simeth. –Tabs & Suspension
Ammonium Lactate 12% Cream & Lotion
Aspirin Tabs- 81 & 325mg (Buff/Chew.E.C.)
Benzoyl Peroxide Gel- 5% & 10%
Brompheniramine/Pseudo Liquid
Brompheniramine/Pseudo/DM Liquid
Calcium Carbonate- 500 mg Tabs, Suspension, Powder (Dialysis Pts. Only)
Chlorpheniramine Tabs & Syrup
Clemastine 1.34 mg Tabs
Clotrimazole 1 % Topical- Cream & Soln.
Clotrimazole Vaginal cream 1% & 2%
Dexbrompheniramine/Pseud 6/120mg Tabs
Dextromethorphan Polystirex 30/5ml Suspension
Diphenhydramine Caps-25 & 50 mg & liq.
Ferrous Sulfate - Drops, Liquid, 325 mg Tabs, Slow Release Iron Tabs
Guaifenesin Syrup- AC, DAC, DM, Plain
Hydrocortisone Cream- 0.5% & 1.0 %
Ibuprofen Suspension

Insulin (All)
Lacrilube Ophth. Ointment
Loperamide Liquid & Tabs
Loratadine(Alavert)Tabs,ODT,12hr,Syrup
Mag.Gluc. 500mg, Mag. Cl. Sr. 64 mg Tab
Miconazole 2% Topical Cream
Miconazole Vaginal Cream 2 %
Naphazoline/Pheniramine Ophth. Drops
Niacin Tabs & Caps- 50,100,125,250,400, 500mg
Nicotine- Gum, Lozenges, Patches
Omperazole OTC 20 mg (Prilosec)
Oral Electrolyte Mixtures (compares to Pedialyte)
Permethrin Cream Rinse
Phenazopyridine 95 mg Tab
Prenatal Vitamins
Pseudoephedrine- Liquid & Tabs
Pyrantel Pamoate Susp 144mg/ml
Renal Vitamins (Dialysis Pts. Only)
Tears (Artificial) Ophth. Drops
Tolnaftate Cream And Powder
Triple Antibiotic Ointment
Triprolidine/Pseudo – Liquid & Tabs

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Pharmacy Program Updates for Pharmacies and Prescribers Continued…

DOM ***may not cover all*** available package sizes.

New OTC Items

1. Effective November 1, 2003, the Division of Medicaid will cover the following loratadine OTC products. Please note that prior authorization is not required.

Drug	NDC	PKG
Alavert® 10 mg oral tablets	00573-2645-30	30
Alavert® 10 mg orally disintegrating tablets	00573-2620-48	48
Alavert® Allergy Sinus	00573-2660-24	24
Claritin® Syrup		

2. Effective November 1, 2003, the Division of Medicaid will cover Prilosec® OTC. Please note that prior authorization is not required.

Drug	NDC	PKG
Prilosec® OTC	37000-0455-04	42

Changes as a result of Envision

Due to the implementation of our renovated HIPAA compliant claims processing system, a few changes were implemented

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1. Pharmacists are no longer required to key in prior authorization numbers.
2. Edits that post will provide a more detailed description.
3. A dedicated pharmacy POS call center is available at 1-866-759-4108.

Maximum Dosing

In accordance with State law, the Division of Medicaid's policy states that a pharmacist may not bill for a quantity that exceeds a 34-day supply. In order to allow for more accurate billing of a 34-day supply, an edit has been implemented regarding maximum dosing. The Division of Medicaid will allow a prescription to be billed at 150% times the maximum dose calculation as determined by the Federal Drug Administration and the manufacturer's recommended maximum total daily dose and supplied to First DataBank. If a beneficiary requires more than this amount, the prescriber must request an exception override of this requirement by seeking approval from Health Information Designs (HID). A copy of maximum request override form is in this bulletin on page **13**. It may also be found on the HID web site at www.hidmsmedicaid.com. Please note that supporting documentation must be in beneficiary's medical record to substantiate a request for total maximum daily dose in excess of recommended maximum dose. Approval will not be granted for non-FDA approved indications.

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Pharmacy Program Updates for Pharmacies and Prescribers Continued…

Total Parenteral Nutrition (TPN)
Claims for TPN (hyperalimentation, IDPN, and IPN) solutions must be submitted as follows:

1. Claims are to be billed on a paper Mississippi Medicaid Pharmacy Claim form. Please write "TPN" on the top of each claim for identification purposes only.
2. Claims are to be billed monthly for a 34-day supply.
3. Claims should list the actual NDC number(s) with the corresponding quantities of each ingredient used beginning with the most costly ingredient. Please note that the use of the code 99999222222 is no longer valid. Any claim using this code will be returned to the provider.
4. The provider should bill for the number of liters of TPN that was dispensed to the beneficiary during the billing period.
5. To receive the compounding fee, enter a C on the claim following the NDC for each ingredient.
6. The maximum dispensing fee shall not exceed $30.00 per liter. The quantity for those non-covered NDCs will not be included in the total liter quantity to determine the dispensing fee.
7. For dually eligible beneficiaries having Medicare and Medicaid, Mississippi Medicaid will not cover these TPNs if Medicare denies the therapy based on Medicare's coverage criteria. Such claims should **not** be submitted to DOM.

Vaccines
Influenza and pneumococcal vaccines are covered vaccine services for Medicaid beneficiaries 19 years of age or older. These are the only vaccines available via the pharmacy program. For additional information please refer to Section 34 of the Provider Policy Manual regarding Medicaid's policy for immunizations.

Medicare-covered Drugs
When Medicaid beneficiaries have both Medicare and Medicaid coverage, pharmacy providers are required to bill Medicare first for those drugs covered by that program. Those drugs that DOM recognizes as routinely covered by Medicare will deny if submitted first to Medicaid. Residents of long-term facilities are exempt from this requirement**.**

Due to restrictions imposed by Medicare on some drugs, such as restrictions to a certain diagnosis, an override exception is available whereby Medicaid can be billed for these drugs when not covered by Medicare. In order to obtain this override exception, the drug may be billed to Medicaid on the Mississippi Pharmacy Claim Form and the Explanation of Medicare Benefits (EOMB) from Medicare must be attached regardless of the reason for denial. These claims should be sent to the following address and not to the fiscal agent:

Division of Medicaid
Attn: Pharmacy Bureau
239 N. Lamar Street, Suite 801
Jackson, MS 39201-1399

You may obtain a copy of the Mississippi Pharmacy Claim form at
www.dom.state.ms.us/Provider/Publications/Provider_forms/Title_XIX_pharmacy_invoice.pdf

After the initial paper claim submission, the beneficiary's information will be profiled so that future claims for the same beneficiary and the same drug can be billed electronically through the pharmacy POS system. The usual POS edits and co-payment requirements will apply.

FAX TO: 1-800-459-2135
HEALTH INFORMATION DESIGNS, INC.
P.O. BOX 320506
Flowood, MS 39232
Phone: (800) 355-0486

MAXIMUM UNIT OVERRIDE
REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid #:_____

DOB:_____ City: _____
Month Day 4 Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ Medicaid ID #:_____

City: _____ State:_____ Phone #:_____

Fax #: _____

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

_____
Physician's Signature and date

PHARMACY INFORMATION

Dispensing Pharmacy:_____ Provider ID#_____

Phone #:_____

City: _____ State:_____ Fax #:_____

DRUG/CLINICAL INFORMATION

Drug Name:_____ Quantity/Month:_____

Diagnosis:_____ Maximum Qty Requested:_____

Reason for Request:

List current dose strength: _____ mg **List current dosing frequency: _____**

Length of current therapy: _____ months

List requested dose strength: _____mg **List requested dosing frequency: _____**

Medical Justification:_____

_____

_____

**Supporting documentation must be available in the patient record

FOR HID USE ONLY
Eligibility Verified by _____
Approved _____
Denied/Code:_____
From Date _____ Thru Date_____
Reviewed by_____
HID#_____ PA# _____

Revised PHRM/ISS Risk Screening Form

The PHRM/ISS risk screening assessment form has been revised with an effective date of October 1, 2003. Medicaid providers (physician, nurse practitioner/midwife and physician assistant) can now use a separate risk screening form to identify high-risk pregnant women and high-risk infants one year of age and under for the PHRM/ISS program. Both the maternal (T1023-TH) and infant (T1023-EP) risk screening assessments generate a fee-for-service reimbursement for private providers for both positive and negative screens.

These risk screening assessment forms may be downloaded from the DOM website www.dom.state.ms.us/Provider/Publications/Provider_Forms/provider_forms.html.

For the name of a PHRM/ISS case management agency provider in your area or any questions concerning the PHRM/ISS program, please call the Bureau of Maternal and Child Health at 1-800-421-2408 or 601-359-6150

Verifying K-baby Eligibility

Providers cannot verify the eligibility of a newborn by using the mother's Medicaid ID number with a K at the end. When verifying eligibility for a newborn, the provider must verify eligibility using:
(1) the mother's ID on the baby's date of birth as the baby is eligible if the mom was eligible on the date of birth; or
(2) baby's permanent ID when it has been assigned.

Delivery-Related Procedure Codes

The following delivery-related CPT codes have been reopened in order to allow providers to bill the appropriate CPT code that describes the service performed: 59409 Vaginal delivery only (with or without episiotomy, and/or forceps); 59430 Postpartum care only (separate procedure); 59514 Cesarean delivery only; 59612 Vaginal delivery only, after previous Cesarean delivery (with or without episiotomy, and/or forceps); and 59620 Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery.

Providers are reminded that postpartum care includes hospital and office visits following vaginal or Cesarean delivery. If the provider does not perform the delivery but only performs the postpartum hospital and postpartum office visits, CPT code 59430 should be billed. This is applicable when the provider performing the postpartum care is NOT the same provider or member of the provider group that performed the actual delivery service. If a postpartum office visit is the only service provided, the appropriate CPT Evaluation and Management (E/M) code should be billed for that visit.

Billing for Maternity and Newborn Services

Providers who bill for maternity-related and newborn hospital services have previously been required to use Type of Service (TOS) B on the claim in order to bypass the PRO requirement for certification of inpatient hospital stays. For claims processed on and after October 1, 2003, providers should bill maternity and newborn hospital services with the appropriate CPT code and a -TH modifier to allow these claims to bypass the PRO requirement. Providers should refer to the Physician Manual Sections 5.05.11 and 5.07.1 for policy related to PRO certification of maternity and newborn services.

NOTICE

Innovative State Use of the Civil Money Penalty Funds - Incentives for High Quality Care Enhancement Grant Award and Education Program Award

The deadline for submission of grant applications is January 15, 2004. Application requirements are located on the Division of Medicaid website as follows: www.dom.state.ms.us. At the "select a link", choose Civil Money Penalty (CMP) Funds. A summary of each grant is provided below. If you have any questions, contact Evelyn Silas, Division Director, Institutional Long Term Care, at 601-359-6750.

Enhancement Grant Award: The goal is to provide enhancements to nursing facilities that have maintained compliance with the federal requirements for long term care. The purpose of the Enhancement Grant Award is to provide a nursing facility with current and past compliance history of the federal requirements the opportunity to receive funding for innovative programs/projects that will directly and/or indirectly benefit the residents by providing an enhanced quality of life. The grant award should be self-sustaining once implemented. For FY 05, **$250,000** has been set aside to award grants in the range of $5000 - $50,000. The grant proposal application may be obtained on the Division of Medicaid website at www.dom.state.ms.us or by telephone request at 601-359-6750. Deadline for completion and receipt of application to DOM is ***January 15, 2004.*** The grants will be awarded on or before ***April 1, 2004.***

Educational Program Award: The goal of this Educational Program Award is to assist nursing facilities that have not been in substantial compliance with federal requirements for long term care facilities to obtain and maintain compliance. The purpose of the Educational Program Award is to provide a nursing facility with current and past non-compliance history of the federal requirements the opportunity to receive funding for educational programs/projects that will directly and/or indirectly benefit the residents as well as assist the facility in providing an enhanced quality of life for the residents. These awards are available to facilities with current and past history of non-compliance with federal requirements. This grant award is a one-time expenditure that will benefit the residents. For FY 05, **$100,000** has been set aside to award grants in the range of $5000 - $20,000. The grant proposal application may be obtained on the Division of Medicaid website at www.dom.state.ms.us or by telephone request at 601-359-6750. Deadline for completion and receipt of application to DOM is ***January 15, 2004***. The grants will be awarded on or before ***April 1, 2004.***

Providers Submitting Anesthesia Claims

Providers submitting claims for anesthesia services must use both the appropriate CPT code and anesthesia modifier on each line of the claim. Claims submitted without the anesthesia modifier on each claim line will be denied.

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 39225

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If you have any questions related to the topics in this bulletin, please contact ACS at 1-800 -884 -3222 or 601 -206 -3000

Mississippi Medicaid Bulletins and Manuals are on the Web
www.dom.state.ms.us

November

November 2003

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3 CHECKWRITE	4	5	6 EDI Cut Off 5:00 p.m.	7	8
9	10 CHECKWRITE	11 DOM and ACS CLOSED	12	13 EDI Cut Off 5:00 p.m.	14	15
16	17 CHECKWRITE	18	19	20 EDI Cut Off 5:00 p.m.	21	22
23 30	24 CHECKWRITE	25	26	27 DOM and ACS CLOSED EDI Cut Off 5:00 p.m.	28 DOM and ACS CLOSED	29

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.