Mississippi Medicaid Bulletin

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Denied Individual Claims With Dates of Service Spanning 09/30/2003 –10/01/2003 Must Be Submitted as Two Separate Claims

With the implementation of the Mississippi Division of Medicaid's (DOM) new *Envision* system and its transition to HIPAA mandated national code sets on October 1, 2003, ALL claims that have Dates of Service (DOS) where the service date span is inclusive of the 09/30/2003 and 10/01/2003 time period, must be submitted as two separate claims. This is due to changes in DOM's assignment of new provider types, which took effect on 10/01/03. Any denied individual claims with this inclusive DOS span (9/30/03 – 10/01/03) previously submitted by providers should be resubmitted as two new claims. The first claim should cover any consecutive service date span prior to, and including, 09/30/2003. The second claim should cover the remaining service date span beginning on 10/01/2003 and ending on the last DOS.

This is not a system change. Where services were rendered that spanned this 9/30 to 10/1 date range and were billed as two separate claims, the claims have paid without problems, assuming they were otherwise submitted in compliance with DOM billing policies and guidelines.

ACS and DOM will not be reprocessing any previously denied claims that have an inclusive DOS span of 09/30/2003 and 10/01/2003. It is the provider's responsibility to properly re-bill the services as two separate claims in order to receive reimbursement.

FluMist Vaccine

Effective for dates of service on and after September 1, 2003, Mississippi Medicaid will reimburse physicians $9.95 for the FluMist influenza vaccine when given to beneficiaries ages 5 through 49. There will be no separate administration fee paid for the FluMist vaccine. Rural Health Clinics and Federally Qualified Health Centers will be reimbursed in accordance with the methodology applicable to their provider type.

Where do I put my Medicare number?

Medicare issues provider numbers for every location where a provider works. A Mississippi Medicaid provider can only have one (1) Medicaid provider number that is used for wherever he/she works. The number travels with the provider to all of his/her locations where services are provided. (This does not apply to institutions such as pharmacies, hospitals, nursing homes and other such institutions.)

When a provider is issued a Medicare number, it is the providers' responsibility to notify Medicaid of this number. The Medicare number on which you bill must be linked to the Medicaid provider number to which you want the crossover claims paid. To link the Medicare – Medicaid numbers appropriately, the provider must furnish ACS Provider Enrollment with the Medicare number and the Medicaid provider number to which he/she wants this number linked along with the effective date of this linkage.

Help! My crossovers are paying to the wrong Medicaid number. What do I do?

Most electronic Medicare crossover payment problems relate to incorrect Medicare – Medicaid number linkage. When crossovers are not paying correctly, you first need to determine what Medicare number you are billing with. The next step is to determine which Medicaid number should be receiving the payments. There are two ways to determine if the Medicare – Medicaid number linkage is incorrect:

1. The individual provider is receiving a remittance advice with crossover payments that should be made to the group.
2. Claims that should be crossing over from Medicare to Medicaid electronically are not appearing on any remittance advice, and they must be billed to Medicaid on paper.

If the provider numbers are linked incorrectly, the provider must send in writing to ACS Provider Enrollment the correct Medicare provider number and the Medicaid number to which it should be linked and the effective date of this linkage. The provider should also request that the Medicare number be removed from all other Medicaid provider numbers except the Medicaid provider number to which the provider wishes the Medicaid payments be made.

In addition, the individual provider or a group member that has been given signature authority must sign all requests for provider file maintenance. These requests can be faxed to ACS Provider Enrollment at 601-206-3015 or mailed to:

ACS State Healthcare
PO Box 23078
Jackson, MS 39225

ACS Provider Enrollment will then remove the Medicare number from the incorrect Medicaid number(s) and add the Medicare number to the correct Medicaid number. Once this has been completed, electronic crossovers should begin to pay systematically to the appropriate provider according to the request.

New Forms For Hospice Providers

With the cooperation of the hospice providers, the Bureau of Long Term Care Hospice Program has continued to reduce the backlog of hospice enrollment/disenrollment forms experienced in recent months.

Providers should note the following:

- All portions of the enrollment (DOM-1165) and disenrollment (DOM-1166) forms must be completed.
- Providers must write or type N/A in blanks, if applicable.
- Incomplete forms will be returned unprocessed.
- Disenrollment forms must be completed, signed, and submitted to DOM within 48 hours of the disenrollment or the hospice provider will be responsible for charges incurred by the beneficiary. **There are no exceptions.**

Hospice enrollment/ disenrollment forms have been revised to add spaces for documentation of the county where the services were rendered and the beneficiary's social security number. The new forms may be downloaded from the DOM web site at: http://www.dom.state.ms.us/Provider/Provider_Manuals/Section14_Hospice_Manual.pdf. Providers must begin using these forms immediately.

Hospice Billing Tip

When billing hospice revenue code 659, if the patient has expired or has been discharged from the facility, do not include the date of death or discharge in the calculation of the units billed. If this date is included, you may receive a denial for edit code 0185. For example: if the patient's beginning date of service is 01/01 and the patient was discharged on 01/10, the units billed should be reflected as 9 units. The date of death or discharge will not be paid and should not be included in the calculation of the units billed.

Cost Report Notice
To All Long-Term Care Providers

The Division of Medicaid contract for electronic cost reports with MediMax Technologies ended January 20, 2004. Effective this date, the software is not available, and cost reports should no longer be submitted electronically. Please continue to submit a paper copy of all cost reports. The instructions and an Excel version of the forms and schedules are available on our website at www.dom.state.ms.us under Select a Link, LTC Cost Report & Instructions. They are also listed under the Medicaid Provider Information link.

Please remember that software developed in-house by the cost report preparer must be approved for use by the Division of Medicaid. For approval, submit a printed version of the cost report forms and schedules from your software to the Bureau of Reimbursement. It will be checked for formatting conformity. Formula reliability is solely the responsibility of the preparer and will not be checked by the Bureau of Reimbursement during this approval process.

If you have any questions, please call Margaret King at (601) 359-6155.

Policy Manual Additions/ Revisions

The following policies and policy sections have been revised and/or added to the DOM Provider Policy Manual. Providers of these services may view these changes by accessing the DOM website at www.dom.state.ms.us and selecting the drop down link "Provider Manuals".

Section	Policy	Effective Date	New	Revised	Revised Sections
31.0	Pharmacy	02/01/04	X		
12.0	Non-Emergency Transportation(NET)	03/01/04		X	12.01-12.16

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.

Take the Right Route!

To ensure proper documentation and claim submittal, the following information will serve as your guide to routing your paperwork to the appropriate address. By using the assigned addresses below, you will lessen the chance for errors and shorten the time required to complete your transactions. If you have any questions or comments, please contact Provider and Beneficiary Services at 1-800-884-3222 or 601-206-3000.

Below is a list of each type of form or document with its corresponding address or fax number:

Form #	Title	Send this Form to :
DOM 210	**Eyeglass/Hearing Aid Authorization Form**	Division of Medicaid Bureau of Medical Services 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
DOM 260 NF	**Certification for Nursing Facilities**	Fax to 601-359-1383
DOM 260 DC	**Certification for Disabled Child**	Division of Medicaid Maternal and Child Health 239 North Lamar St, Suite 801 Jackson, MS 39201-1399
DOM 260HCBS	**Certification for HCBS**	Division of Medicaid Bureau of Long Term Care 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
DOM 260 MR	**Certification for ICF/MR**	ACS, P.O. Box 23076, Jackson MS 39225
DOM 301 HCBS	**HM Comm-Based SVS/PH**	ACS, P.O. Box 23076, Jackson MS 39225
Drug PA	**Drug Prior Authorization Request**	Health Information Designs P. O. Box 32056 Flowood, MS 39212 Fax to 800-459-2135
DOM 413	**Level II PASARR Billing Roster**	Division of Medicaid Mental Health Services 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
HCBS 105	**Home and Community Based Services**	ACS P.O. Box 23076, Jackson MS 39225 Attention: Medical Review
MA 1001	**Sterilization Consent Form**	ACS, P.O. Box 23076, Jackson MS 39225
MA 1002	**Hysterectomy Acknowledgement Statement**	ACS, P.O. Box 23076, Jackson MS 39225
MA 1097	**Dental Services for Orthodontics Authorization Request**	Division of Medicaid Bureau of Medical Services 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
MA 1098	**Dental Services Authorization Request**	Division of Medicaid Bureau of Medical Services 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
MA-1148A	**Addendum to Plan of Care**	Division of Medicaid Maternal and Child Health 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
MS/ADJ	**Adjustment Void Form**	ACS, P.O. Box 23077, Jackson MS 39225
MA 1165	**Hospice Membership Form** **Effective July 1, 2002**	Division of Medicaid Long Term Care, Hospice Services 239 North Lamar St., Suite 801 Jackson, MS 39201-1399
MS/INQ	**Claim Inquiry Form**	ACS, P.O. Box 23078, Jackson MS, 39225
MS/XOVE	**Medicare/Medicaid Crossover Form - Part A**	ACS, P.O. Box 23076, Jackson MS, 39225
MS/XOVE	**Medicare/Medicaid Crossover Form - Part B**	ACS, P.O. Box 23076, Jackson MS, 39225
Pharmacy	**Pharmacy Claim Form**	ACS, P.O. Box 23076, Jackson MS, 39225
ADA	**American Dental Association Claim Form**	ACS, P.O. Box 23076, Jackson MS, 39225
HCFA 1500	**HCFA 1500**	ACS, P.O. Box 23076, Jackson, MS 39225
UB-92	**UB-92**	ACS, P.O. Box 23076, Jackson, MS 39225

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 Manuals
are on the Web
www.dom.state.ms.us
And
Medicaid Bulletins are on the Web Portal
http://msmedicaid.acs-inc.com

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

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.