Mississippi Medicaid Bulletin

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March 2004

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UB-92 and CMS-1500 Paper Claim Submission

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.

3-Digit vs. 4-Digit Revenue Codes

Currently, DOM and ACS only accept 3-digit revenue codes. If your software has a revenue code field which accepts a 4-digit revenue code, please work with your software vendor to ensure the software only outputs the true 3-digit revenue code.

Call Record Tracking Numbers

When calling the ACS Call Center, ask for the call record number (CRN) from the Call Center Associate prior to ending your call. Make a record of this number, as it will be useful if there is a need for you to follow up on an inquiry.

Pharmacy Program Updates

Enteral Reimbursement

The Division of Medicaid has received several complaints from providers concerning reimbursement rates for certain enteral or nutritional products. Please fax the Pharmacy Bureau a copy of the pharmacy invoice with your written complaint. These problems will be resolved on a case-by-case basis and will be considered only if accompanied by the invoice. The Pharmacy Bureau fax number is: 601-359-9555.

Drug Benefit for Family Planning Program

Beneficiaries with YELLOW Medicaid cards are enrolled in the Family Planning program. The ONLY drugs covered by DOM through pharmacy providers are:

- Ortho Evra patches
- Lunelle Injection
- Depo-Provera Injection.

All other birth control medications must be obtained from the prescriber.

Questions and Answers regarding the Pharmacy Program

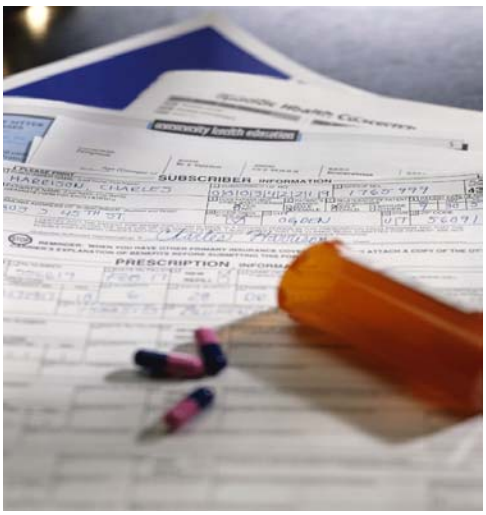
Question: What actions should be taken for the following prescription rejections?

Edit	***Example***
Age Exception	Certain Triptans prescribed to persons over age 60
Pregnancy Exception	Butabarbital prescribed to pregnant women
Sex Exception	Viagra prescribed to a female or Arimidex prescribed to a male
Generic Required	Delestrogen currently unavailable generically

Answer: Call the Division of Medicaid's Pharmacy Bureau staff at 1-800-421-2408 or 601-359-5253. You will be assisted on a case-by-case basis.

Question: Why do some generic drugs require a co-pay of $3.00?

Answer: First Data Bank (FDB) identifies the brand or generic status of drugs based on information provided by the manufacturer. This is called the Generic Therapeutic Indicator (GTI). If the GTI indicates the drug is a brand the co-pay will be $3.00.



Note: A written, faxed or telephoned prescription may be refilled, in compliance with the prescriber order, up to a limit of eleven times.

Ambulatory Surgical Center Updates

The Division of Medicaid has updated the list of procedures approved for Ambulatory Surgical Centers (ASC) according to the Department of Health and Human Services Update of Ambulatory Surgical Center List of Covered Procedures. The indication that the procedure may be performed in an ASC does not constitute Medicaid coverage.

The Division of Medicaid has also updated the group rates paid to Ambulatory Surgical Centers (ASC) according to the Mississippi State Plan based on the Centers for Medicare & Medicaid Services (CMS) revised rates and wage indices. The new rates are listed below and are effective for dates of services on and after February 1, 2004.

Group 1	257.00
Group 2	343.92
Group 3	393.06
Group 4	486.03
Group 5	552.54
Group 6	641.55
Group 7	767.22
Group 8	754.18
Group 9	1032.53

2004 HCPCS Code Update

The Division of Medicaid has begun accepting the 2004 *Health Care Procedure Coding System* (HCPCS) codes with an effective date of January 1, 2004. Providers may begin billing the 2004 HCPCS codes with appropriate modifier(s) for dates of service on or after January 1, 2004.

A transition period will be given to allow time for providers to make necessary changes. Therefore, providers may bill current codes through March 31, 2004. Claims for dates of service on or after April 1, 2004 must be submitted using the new 2004 HCPCS codes and modifiers.

2004 ICD-9-CM Diagnosis Code Update

The Division of Medicaid is now accepting the 2004 ICD-9-CM diagnosis codes for dates of service on or after January 1, 2004. Providers who received claim denials for invalid diagnosis codes should resubmit their claims for payment.

Providers must ensure they are not adding a zero to the end of an ICD-9-CM diagnosis code unless the zero is truly a part of the diagnosis code.

How to File the Beneficiary Number on Your Claims

There is a total of 12 numbers on a beneficiary's Medicaid ID card. The first 9 numbers are the beneficiary's Medicaid ID number. The last 3 numbers are the card control suffix which is used only by the Division of Medicaid. When filing claims, use the first 9 numbers only. Do not include the last 3 numbers on claims. Including the last 3 numbers can potentially cause a processing delay or denial of your claims.

Claims Submission for the Implantable Programmable Baclofen Pump

Hospitals may now submit claims for the Baclofen pump directly to the fiscal agent. Submit charges on a paper UB-92 claim form, separate from all other charges, using revenue code 220 **only**. A copy of the invoice for the pump must be attached to the claim form for pricing purposes. Please refer to Section 25.20 of the Medicaid Provider Policy Manual for additional information on the Implantable Programmable Baclofen Pump.

Mississippi Medicaid Provider Policy Manual Additions/ Revisions

The following policies and policy sections have been added to and/or revised in the Mississippi Medicaid 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
12.0	Non-Emergency Transportation (NET)	03/01/04		X	12.01-12.16
38.0	Maternity	04/01/04	X		

Policy Manual Reminder

This bulletin is a document for the Mississippi Medicaid Provider 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.

Dental Providers

On October 1, 2003, the Division of Medicaid converted to the Envision claims payment system and implemented billing changes to bring the Division in compliance with HIPPA requirements. In order to standardize billing for dental services, significant changes were made to the way dental claims are received and processed. It has been a challenge for the Division of Medicaid to implement the required billing/system changes, and there have been a significant number of claim denials for providers. The Division of Medicaid and ACS have worked and are still working to make system modifications to correct these problems and minimize the impact on providers. During our investigation we found conflicts between the X12 billing format, WINASAP, and the Envision system that involve the national tooth number, surface, and quadrant designations. At this point, all identified problems have been corrected and denied claims are being reprocessed or can be rebilled.

The information provided below is a quick reference list of necessary information for dental codes that require specific tooth number, surface or quadrant information.

Required Fields per Dental Procedure Code			
Code	Surface	Tooth #	Quadrant
D1351		X	
D2140	X	X	
D2150	X	X	
D2160	X	X	
D2161	X	X	
D2330	X	X	
D2331	X	X	
D2332	X	X	
D2390	X	X	
D2391	X	X	
D2392	X	X	
D2393	X	X	
D2394	X	X	
D2930		X	
D2931		X	
D2940		X	
D3220		X	
D3310		X	
D3320		X	
D3330		X	
D4210			X
D4211			X
D4240			X
D4241			X
D4260			X
D4261			X
D4341			X
D4342			X
D7140		X	
D7210		X	

Continued on next page

(Dental Providers continued from page 5)

D7220		X	
D7230		X	
D7240		X	
D7241		X	
D7250		X	
D7280		X	
D7281		X	
D7310			X
D7320			X

The Envision system will accept the following tooth number and surface designations per the X12 billing format:

- Primary teeth are identified with an upper case letter beginning with A and ending with T, or AS through TS for supernumerary primary teeth.
- Permanent teeth are identified by a number from 1 to 32, or 51 to 82 for supernumerary permanent teeth.
- The areas of the oral cavity are identified as:

  00 – Entire Cavity
  01 – Upper Right Perm. Tooth 01 or Maxillary Area
  02 – Upper Right Perm. Tooth 02 or Mandibular Area
  09 – Upper Left Perm. Tooth 09 or Other Area of Oral Cavity
  10 – Upper Left Perm. Tooth 10 or Upper Right Quadrant
  20 – Lower Left Perm. Tooth 20 or Upper Left Quadrant
  30 – Lower Right Perm.Tooth 30 or Lower Right Quadrant
  40 – Lower Left Quadrant
  L – Primary Tooth L or Left Oral Cavity
  R – Primary Tooth R or Right Oral Cavity

DME Providers – Procedure Codes

All DME providers must use valid 2004 HCPCS codes in accordance with the established coding guidelines. Providers should refer to the official CMS 2004 HCPCS update information for assistance with codes, descriptions, and other relevant data. The DME miscellaneous code, E1399, or other miscellaneous codes cannot be used if a valid HCPCS code exists. Existence of a code does not constitute Medicaid coverage. Providers must refer to the appropriate Mississippi Medicaid Provider Policy Manual and/or fee schedule to determine Medicaid covered services. The new 2004 HCPCS codes are effective for dates of service beginning January 1, 2004. The discontinued DME and Medical Supply HCPCS codes are listed below. These codes have a three-month grace period and will be accepted through March 31, 2004.

Continued on the next page

DME Providers – Procedure Codes continued from page 6

Deleted DME Codes

A4214	A6430	E0979	K0033	K0084	K0532	K0556	K0591	K0621
A4319	A6432	E0991	K0035	K0085	K0533	K0557	K0592	K0622
A4323	A6434	E0993	K0036	K0086	K0534	K0558	K0593	K0623
A4621	A6436	E1066	K0048	K0087	K0538	K0559	K0594	K0624
A4622	A6438	E1069	K0049	K0088	K0539	K0560	K0595	K0625
A4631	A6440	K0016	K0054	K0089	K0540	K0581	K0596	K0626
A4644	A7019	K0022	K0055	K0100	K0541	K0582	K0597	L1885
A4645	A7020	K0025	K0057	K0103	K0542	K0583	K0610	L2102
A4646	E0142	K0026	K0058	K0107	K0543	K0584	K0611	L2104
A4712	E0145	K0027	K0062	K0112	K0544	K0585	K0612	L2122
A6421	E0146	K0028	K0063	K0113	K0545	K0586	K0613	L2124
A6422	E0165	K0029	K0079	K0268	K0546	K0587	K0614	S8180
A6424	E0943	K0030	K0080	K0460	K0547	K0588	K0615	S8181
A6426	E0975	K0031	K0082	K0461	K0549	K0589	K0616	S8470
A6428	E0976	K0032	K0083	K0531	K0550	K0590	K0617	

Catheter Insertion – CPT Codes 51701 and 51702

Effective for dates of service on and after 10/1/2003, Medicaid will reimburse physicians for CPT codes 51701 (insertion of non-indwelling bladder catheter) and 51702 (insertion of temporary indwelling bladder catheter; simple). These codes replace CPT code 53670 which was deleted 9/30/2003. CPT codes 51701 and 51702 are considered integral to the office visit and may not be reported in conjunction with the billing of a visit.

Billing Tip

Please remember not to highlight any information on your claims or attachments prior to submitting them to ACS for processing. All claims and attachments are scanned and anything highlighted scans as solid black, which prevents keyers from reading the information. If you need to identify specific information, it should be circled.

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.

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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

March

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Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	1	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.