Mississippi Medicaid Bulletin

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Change of Ownership and/or Change of Tax ID

As of October 1, 2003, providers that have a change of ownership (CHOW) do not receive a new Medicaid provider number. The new provider must submit a CHOW provider application. Once this application is processed and approved, ACS will update the provider file with the new owner information and effective dates for the CHOW. The provider application is the same as a new or re-enrolling provider, except the provider indicates the application is being completed due to a CHOW. The application is available from the following website: http://msmedicaid.acs-inc.com.

As of October 1, 2003, providers who have a change of tax ID unrelated to a CHOW do not receive a new Medicaid provider number. The provider must submit the following to the fiscal agent:

1. a letter requesting the change,
2. a signed original W-9 form, and
3. verification of the tax ID. This must be a preprinted document from the IRS or a notarized statement that includes the tax ID.

Updates to the existing pages in the Medicaid Provider Policy Manual will be forthcoming.

Extension of Hospital Cost Report Filing Due Dates

Due to the unavailability of the Provider Statistical and Reimbursement reports, the Division of Medicaid is extending the hospital cost report filing due date for providers with year-ends of August, September, and October 2003. The extended due date is May 3, 2004.

No other provider types will be affected by this extension. If you have questions, please call the Bureau of Reimbursement at 601-359-6132.

1099s for Tax Year 2003

There are several issues surrounding the tax year 2003 IRS Form 1099 that was mailed to Medicaid providers. Corrected 1099s have been mailed to all providers that should have received a 1099 for tax year 2003. The income listed on the first 1099 was **not** reported to the IRS. Only the income listed on the 1099 marked “Corrected” has been reported to the IRS. The issues and resolutions are as follows:

Issue: Line 2 of the provider name and address was printing with incorrect names or with group affiliations that never existed.
Resolution: The corrected 1099 reflects the provider’s correct name or correct Doing Business As name.
Issue: Providers that did not file claims with Medicaid for tax year 2003 received 1099s.
Resolution: Providers that should not have received a 1099 initially will receive a 1099 with a $0.00 amount.
Issue: Withholding amounts were not printed on the 1099s. Providers who are having monies withheld due to an IRS name-number mismatch did not have those amounts listed on the initial 1099s.
Resolution: These amounts were printed on the corrected 1099s.

Recipient’s Identification Number. This number is formatted as an IRS Employer Identification Number. If income is reported to the IRS on a Social Security Number (SSN), the format will not look correct. The number listed is the number under which the income was reported to the IRS. For example, a SSN will be formatted as follows: 12-3456789 instead of 123-45-6789.

Other concerns that providers have about 1099s:

1. Providers are reporting that the Payer’s Federal Identification Number is not their Tax ID number. This is correct; this identification number is the Tax ID number that belongs to the Division of Medicaid.
2. The 1099s have an amount in block 7 – Nonemployee Compensation. This is correct. Payments from the Division of Medicaid are reported as Nonemployee Compensation.

1099s that are generated by the Division of Medicaid are reflective of the claims that have processed during that tax year. If a claim was filed using an individual provider number as a billing provider ID, then the income will be reported to the individual’s Social Security Number. Also, if crossover payments are being made to the individual instead of the group, a 1099 will be generated with income reported to the individual’s SSN.

If individual providers are receiving a Remittance Advice with their Medicaid provider number and their SSN on the cover page, then claims are being paid and monies reported to their SSN. If the claims are Medicaid primary, then the billing provider number on the claims should be changed to the appropriate group provider number. If the claims are Medicare crossover claims, then the Medicare provider number should be removed from the individual’s Medicaid provider number and placed on the Medicaid group provider number that should receive the payments. See February 2004 Bulletin article titled “Where do I put my Medicare number?” for more information regarding incorrect Medicare Crossover payments.

Important Reminders for Claims Submitted On Or After October 1, 2003

Please remember the following when submitting claims on or 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, the two-digit standard place of service codes must be used 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. The Current Procedural Terminology (CPT) and Healthcare Common Procedure Code System (HCPCS) codes must be used 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.

Revised Guidelines for Adjusting/Voiding Claims On Or After October 1, 2003

The guidelines on how to adjust/void claims on or after October 1, 2003, which were included in the December 2003 bulletin were incomplete. ACS State Healthcare is preparing revised guidelines for providers' use. Visit the Mississippi Medicaid Web Portal at http://msmedicaid.acs-inc.com for the revised guidelines.

Paper Claim Submission

Effective 2/16/2004, Optical Character Recognition (OCR) was implemented to facilitate more efficient processing of paper claims. OCR technology is widely accepted by commercial and governmental healthcare financing organizations and allows for more timely and accurate processing of provider claims.

OCR processing requires that claims be typewritten on "red drop-out" forms. UB92 and CMS1500 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 UB92 and CMS1500 paper claim submissions. Handwritten, photocopied, and other black and white formats will cause a delay in claim processing and payment.

You Spoke, We Listened!!!

The Division of Medicaid and ACS State Healthcare received tremendous feedback from the Medicaid provider community on the new format of the remittance advice (RA). While it was not possible to implement all recommended changes, the following changes have been incorporated:

- The paper RA will be broken down by claim types. Medicaid primary claims will be listed first, followed by Medicare Crossover Claims. The claims will then be sorted internally by paid and denied and finally by recipient last name.
- The Claim Type will be listed on each page in the RA header.
- The entire recipient name will be listed for Medicare Crossover claims.
- Dental claims will have the tooth number or quadrant listed on the line.
- Dates of Service are being added to each line.
- The Servicing Provider is being added to each line.
- The Claim Adjustment Segment descriptions will be changed from 'LI ADJUST' to 'LINE ADJUSTMENT'
- Line Level Claim Adjustment Segments will not be listed on denied claims. Only the header Claim Adjustment Segment will be listed.
- The allowed amount is being added to the paper RA
- The total outstanding credit balance will be added to the summary page.

The revised instructions for the new remittance advice have been included with remittance advices during the month of March. However, should you need additional assistance, you may contact the ACS Provider and Beneficiary Services Call Center at 1-800-884-3222 or 601-206-3000.

Third Party Liability

The Division of Medicaid and ACS State Healthcare have received many inquiries from the provider community regarding correct procedures for filing claims to Medicaid when third-party liability is involved. The complete policy information on third-party liability can be found in Section 6 of the Division of Medicaid Provider Policy Manual. If you do not have a current copy of the policy, it can be accessed at the Division of Medicaid's website at http://www.dom.state.ms.us. Once you have accessed the home page, click on the link on the left-hand side entitled "Provider Manuals". Once this page is displayed, click on the link entitled "Section 6 – Third Party Recovery."

Spring 2004 Provider Workshops

The Division of Medicaid and ACS State Healthcare are planning the Spring 2004 provider workshops. The workshops will be conducted by provider type and will be designed to address issues and topics which are of most importance to the Medicaid provider community.

More specific information, including dates and locations, will be posted on the Mississippi Medicaid Web Portal at http://msmedicaid.acs-inc.com when it becomes available.

Provider Tax ID and Social Security Numbers on Provider File

A Medicaid provider **cannot** have both a Social Security Number (SSN) and a Tax Identification Number (TIN or EIN) associated with one Medicaid provider number.

All physicians, nurse practitioners, physician assistants, CRNAs, nurse midwives, dentists, psychologists, chiropractors, podiatrists, occupational therapists, physical therapists, speech/language therapists and social workers must have an individual Medicaid provider number. All individual provider files must be entered into the Medicaid system with the SSN of the individual.

If you are a physician, nurse practitioner, physician assistant, CRNA, nurse midwife, dentist, psychologist, chiropractor, podiatrist, occupational therapist, physical therapist, speech/language therapist, social worker, or any other individual provider with a provider number and you wish to have your Medicaid income reported to a TIN or EIN, you **must** obtain a group provider number and link your individual Medicaid provider number to the billing group. The billing group will bill Medicaid claims indicating the individual provider as the servicing provider. When Medicaid claims are paid, the "Pay To" provider will be that of the billing group provider with the TIN or EIN.

If you wish to verify that your Medicaid provider number has the correct SSN or TIN, you may do one of the following:

- Consult the Medicaid RA that has the provider number and the SSN or TIN to which the income is being reported.
- Consult the welcome letter that was mailed to you when the re-enrollment process was completed.
- Contact the ACS Provider and Beneficiary Call Center at 1-800-884-3222 or 601-206-3000.

Attention Hearing Aid Providers

Effective for dates of service on or after October 1, 2003, hearing aid providers must obtain prior approval before billing for HCPCS codes V5014 "Repair/Modification of Hearing Aid" and V5299 "Hearing Aid not Otherwise Classified". Providers receiving denials for claims submitted with dates of service on or after October 1, 2003 must submit an Eyeglass/Hearing Aid Request Authorization Form and applicable documentation for approval. After receiving an authorization number, the claim can be resubmitted for payment.

Billing Tip

****When completing your claim, do not forget to enter the number of units being billed.****

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.

Where do I put my Medicare number?

Medicare issues provider numbers for every location where a provider works. A Mississippi Medicaid provider can have only 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 pharmacies, hospitals, nursing homes and other such institutions.)

When a provider is issued a Medicare number, it is the provider's 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 and 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 must 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.

Common Nursing Home Provider Billing Issues

Nursing Home providers began submitting their claims on UB92s in October 2003. The Division of Medicaid and ACS State Healthcare have noticed several provider billing issues that nursing home providers are experiencing. Following are the issues and guidelines on how to correct these issues when filing your claims with Medicaid.

Patient Status Codes

- Bill with the appropriate patient status codes from the Uniform Billing Manual.
- The field for patient status codes on the UB-92 claim form is Form Locator 22.
- Use the bill type (Form Locator 4 on the UB-92), which corresponds to the patient status code.
  - If the bill type is an interim claim, patient status 30 – still a patient must be billed.
- On the UB-92 claim form, the bill type should be entered in Form Locator 4.
- In WINASAP2003, the bill type should be entered on the Claims Data tab.

Revenue Codes

- The appropriate revenue codes for nursing facilities are:
  - 101 All-inclusive Room and Board
  - 181 Hospital Leave
  - 183 Therapeutic Leave
- Bill revenue codes in ascending order when billing claims.
- There should only be one occurrence of revenue code 101.
- There may be multiple occurrences of revenue codes 181 and 183.

Reject Reports

- When using WINASAP2003, please be sure to check your reject reports after submitting claims electronically.
- Review the Claims List to verify that the status of your claims has gone from BILLED to ACCEPTED.
- Providers can check two hours after the initial transmission by simply clicking [Tools], [Receive Response] which connects to the EDI host and then reviewing the Claims List.
- If the status is REJECTED, the claims were NOT sent to the Envision claims processing system for processing.

Covered Days

- When using WINASAP2003, covered days MUST be entered in two places. They are as follows:
  1. Claim Data Tab – Claim Data section – field entitled "COV D"
  2. Claim Line Tab – Be sure to include the correct number of units for each revenue code

Conversion to X12…Just Around the Corner

If you are one of the approximately 30% of users still sending claims in the old format, your time is running out. Currently 70% of the electronic submitters for Mississippi Medicaid are sending claims in the ANSI X12N format. As this percentage increases, the Division of Medicaid will soon be issuing a cutoff date for the old format. Look for more information to come in future bulletins regarding the date.

In the meantime what can you do?

- Contact your software vendor, billing agent or clearinghouse and ask their status.
- Find out if they have been in contact with EDI to begin testing the new format.
- Provide your vendor with the following telephone number for questions about testing: 850-558-1630, option 6
- Make sure you have completed your enrollment form with EDI
- Investigate the possibility of using WINASAP2003 (for small volume providers only)

Don't sit idly by watching the percentage of X12 users increase and get caught at the last minute scrambling for a vendor…..do something now.

Medicare Crossovers B

In response to provider concerns, the Division of Medicaid has authorized a Medicare Crossover Pilot program. The pilot program allows the submission of crossover claims on standard billing forms (CMS1500 and UB92) rather than the state-specific crossover form currently used. Providers may begin submitting Medicare B crossover services using the new guidelines. Providers are encouraged to watch the Bulletin for articles related to pilot implementation of Medicare A crossover services.

The Medicare EOMB will continue to be required when submitting crossover claims for processing. In addition, providers are required to circle the applicable recipient information on the EOMB. Medicare covered and non-covered services will continue to be billed separately.

Attached are guidelines to follow when submitting crossover claims for processing. Claims submitted as part of the Crossover Pilot Program should be addressed to:

ACS State Healthcare
Attn. Crossover Pilot Program
PO Box 23076
Jackson, MS 39225

If you have questions regarding the Crossover Pilot Program, please contact ACS Customer Service at 1-800-884-3222. Providers not participating in the pilot should continue to submit using the crossover claim forms.

Filing Paper Crossover Claims To Mississippi Medicaid

Filing Medicare Part B Crossover Claims on the CMS1500

- Submit a legible copy of the CMS 1500 claim form that was submitted to Medicare. If there is no copy of the Medicare claim or Medicare was billed electronically, prepare a CMS 1500 claim form according to Medicare guidelines.
- In field 1, enter Xs in the boxes labeled "Medicare" and "Medicaid."
- Ensure that the beneficiary's nine-digit Medicaid number is in field 1a.
- Enter the eight-digit Medicaid provider number in field 33. If field 33 contains a group provider number, enter the eight-digit Medicaid treating provider number in field 24k.
- Circle the corresponding claim information on the Explanation of Medicare Benefits (EOMB). Attach the EOMB to the back of the claim.

Filing Medicare Crossover Claims on the UB92

- Submit a legible copy of the UB92 claim form that was submitted to Medicare. If there is no copy of the Medicare claim or Medicare is billed electronically, prepare a UB92 claim form according to Medicare guidelines.
- Enter the word "CROSSOVER" in field 2.
- Enter the eight-digit Medicaid provider number in field 51B.
- Ensure that the beneficiary's nine-digit Medicaid number is in field 60B; field 60A must contain the patient's Medicare number.
- Circle the corresponding claim information on the Explanation of Medicare Benefits (EOMB). Attach the EOMB to the back of the claim.

Altered EOMBs

The Medicare Explanation of Medicare Benefits (EOMB) must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider may line out patient data not applicable to the claim submitted.
- The provider may line out any claim line that has been previously paid by Medicaid, that the provider chooses not to bill Medicaid, or that has been paid in full by Medicare.
- If the claim lines on the EOMB have been lined out, the "claim totals" line on the EOMB must be changed to reflect the deleted line(s).
- The claim lines or "recipient section" on the EOMB that are being submitted for reimbursement must be circled.

Checking Eligibility

Eligibility may be checked via the AVRS at 1-800-884-3222 and via the Envision web portal at http://msmedicaid.acs-inc.com. Please note that you must complete the web account registration process before accessing beneficiary eligibility information.

What happened to my electronic claims?

If you are a WINASAP2003 (the free software provided by the ACS EDI Gateway to submit X12 claims to Mississippi Medicaid) user, please read the following:

As a WINASAP2003 user, after you submit your claims to ACS, you will need to retrieve a report that lets you know the status of your file. This report is generally available two hours after you submitted the file and is called a 997, Functional Acknowledgement. The 997 will tell you whether the file was accepted or rejected and will change the status of your claims from billed to accepted or rejected. If the status of your claims changes to rejected, please call the EDI Help Desk at 866-225-2502 and log a research ticket. Once the research is logged, a business analyst will get back in touch with you to explain the error. Usually, you will be contacted within two or three business days. It can take longer depending on the complexity of the error. Keep in mind that an entire file rejects, so even though you may have submitted 50 claims in that file and only one had a problem, the entire file rejects and none of the claims in that file will be sent to Mississippi Medicaid for processing. You will need to correct the one claim and resubmit all of the rejected ones.

To receive a 997 in the WINASAP2003 program, click Tools, then Receive Response File, then click Receive. You will not actually see the report as it is received and the status of your claims is changed. If, after following the above steps you do not see the status of your claims change from billed, please wait another hour or two. It can take longer than two hours to deliver the reports. If you still have not received a report after 24 hours, call the EDI Help Desk at 866-225-2502.

Finally, please keep in mind that an "accepted" status simply means that the file you submitted met HIPAA compliancy rules. There is another set of edits the claims have to clear before being passed on Mississippi Medicaid for processing. At this step, however, not all of the claims will be rejected if there is a problem with only one claim. Only that one claim will be rejected. These errors are reported on the 824 report. At this time, WINASAP2003 is not receiving the 824 report. If some of your claims made it to Mississippi Medicaid but not others, then you may have an 824 report explaining why. Contact the EDI Help Desk at 866-225-2502 to log a research ticket.

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.

Web Portal Registration

On October 6, 2003, the Mississippi Medicaid Web Portal was launched. The web portal provides another alternative to using the ACS Provider and Beneficiary Call Center or the Automated Voice Response System (AVRS). The website for the web portal is http://msmedicaid.acs-inc.com.

The web portal has two areas that can be accessed from the initial home page. One area is non-secure and allows access to the general public without registration. The second area is a secure website that requires registration and provides additional functionality that is associated with the Call Center and the AVRS.

The non-secure area allows the general public (provider and beneficiary) to access general Medicaid information, which includes Medicaid policy, provider publications, and RA banner messages. This area also allows a provider to access the late breaking news section, which identifies claims processing issues, Medicaid policy changes and system reprocessing information. Other commonly accessed features of the non-secure area are the Frequently Asked Questions (FAQs), Billing Tips and Ask Provider Relations sections.

Important Registration Information

- To register, the provider must provide the 8-digit Medicaid provider number, the corresponding Social Security number or tax identification number, and the last 5-digits of the bank account that is currently active on the provider's file.
- At registration, each provider must choose a unique user ID that the provider determines and a valid e-mail address. The password for the account that is registered is e-mailed to the address that is supplied at registration.
- A separate registration is required for each provider number. This is a security feature. Only the registered provider's information will be given when conducting provider inquiries for claims and payment.
- Group providers cannot add individual providers to their profile. The individual provider must register separately and then invite the group provider members to join their account by using the 'Add Existing User' feature.

WINASAP2003 v 4.05 Corrections and Enhancements

The latest version of WINASAP2003 (the free software provided by the ACS EDI Gateway to submit X12 claims to Mississippi Medicaid) was made available on February 6, 2004, to all WINASAP users. To upgrade to the latest version, visit http://msmedicaid.acs-inc.com and click on Publications, then WINASAP2003 Software, then Updates. Below is a list of the corrections and enhancements in this latest version:

- The date buttons on Institutional and Nursing Facility Home Health Pages and Professional Spinal Manipulation Window were fixed.
- The tab order on the Spinal Manipulation, Service Facility Info, and Other Subscriber Info for professional claims was fixed.
- The installation instructions that allowed users to specify a destination for the application were removed. The software now automatically downloads files to destination C:\Program Files\ACS\WINASAP2003.
- The registry entries are verified when initially installing the software. If the registry entries are not correct, the software corrects them.
- The Backup and Restore functionalities now validate backup files. The software searches for the existence of certain files in the zip file and tells the software that it backed up the correct directory. There is now a message that pops up if the backup is invalid to "Contact the EDI Support Unit".

If you have any questions or problems with the software, contact EDI at 866-225-2502.

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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

April

April 2004

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

Checkwrites and Remittance Advices are dated every Monday. However, funds are not transferred until the following Thursday, and Remittance Advices usually arrive the following Friday.