Mississippi Medicaid Bulletin

Volume 10, Issue 5

May 2004

Points of Interest:

Filing Limitations for Medicare/Medicaid Crossover Claims

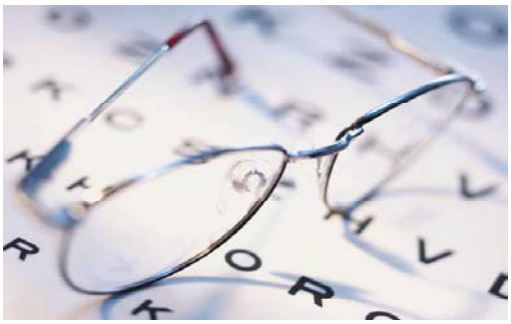
Federal regulations require that all crossover claims be paid within six (6) months of the Medicare disposition of the claim. Medicaid cannot pay for any crossover claims that are not filed or followed up on in a timely manner. It is important that providers do immediate follow-up for any crossover claims that are not paid or are denied by Medicaid. The six-month filing limitation for Medicare/Medicaid crossover claims is determined using the date on the Medicare explanation of Medicare benefits (EOMB). Claims filed after the 6-month timely filing limitation will be denied.

If the Medicare EOMB indicates the claim was crossed over electronically to Medicaid and it does not appear on your Medicaid remittance advice (RA) within 30-45 days, the claim should be filed on a Medicaid crossover form with the Medicare EOMB attached. The Medicaid crossover form is available from the following website: www.dom.state.ms.us. Using the bar on the left of the page, scroll to Medicaid Provider Information and then select either the Crossover Form Part A or the Crossover Form Part B.

See the article below regarding important information on Medicare Crossovers.

Important Information on Medicare Crossovers

- Paper Medicare crossover claims which were voided in error in November 2003 will be reprocessed by ACS. The provider should not resubmit these claims.
- Duplicate Medicare crossover claims which were paid by Medicaid between 10/1/03 and 2/23/04 will be recovered on future remittance advices. Unless otherwise advised, the provider should not take any action on these duplicate claims.
- Duplicate Medicare crossover claims paid prior to 10/1/03 must be voided by the provider. An exception is lab claims from April 2003 through September 2003 which were crossed over from Cahaba.
- Refer to the above article regarding Filing Limitations for Medicare/Medicaid Crossover Claims.



MISBILLING BY EYE CARE PROFESSIONALS

Recent audits of eye care professionals (ophthalmologists, optometrists) have shown that some providers have misbilled both E/M and eye care codes. For Mississippi Medicaid billing purposes, optometrists and ophthalmologists are categorized as eye care professionals and are subject to the policy requirements contained in the Mississippi Medicaid Provider Physicians Manual. In many instances, providers have billed initial office visit and initial visit eye care codes when the appropriate code should have been an established office visit. Since established office visit codes are typically paid at lower rates than the initial visits, misbilling in the described manner has resulted in overpayments to many eye care providers.

As stated in the manual, Section 5.05.11, "each Medicaid recipient is limited to one (1) initial service visit as a new patient, per physician, every three (3) years. This procedure can only be used one (1) time per patient by the same physician or physicians' group, if the same medical chart is used."

CPT 92002 and 92004 are also for billing services provided to new patients. The CPT Manual 2004 states that "a new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years."

It is recommended that eye care providers review their current billing practices to ensure that their billing conforms to Medicaid policy.

Providers should review their claims. If overpayments are detected, please contact Otis Washington, Division of Medicaid, Program Integrity at (601) 987-3962.

Cost Report Notice To All Long-Term Care Providers

Effective January 20, 2004, the MediMax technologies software is no longer available, and cost reports should not 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 DOM's 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.

AMBULATORY SURGICAL CENTER SCHEDULE

The Ambulatory Surgical Center (ASC) Group Designation and Rate Schedule is now available on The Division of Medicaid website www.dom.state.ms.us under the heading of Medicaid Fee Schedules.

Customer Service Tip

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.

Mississippi Physician License Expiration

On June 30, 2004, all physician licenses issued by the Mississippi State Board of Medical Licensure will expire. When providers renew and receive their updated license, please fax a copy to ACS Provider Enrollment at 601-206-3015. The Mississippi Medicaid provider number should be included on the fax so the appropriate provider file can be updated to reflect the new eligibility end date. Failure to provide an updated license could result in claim denials, inability to access the web portal, and payment delays.

Family Planning Program

Effective October 1, 2003, the Division of Medicaid implemented a Family Planning Program. This demonstration waiver program extends Medicaid coverage of family planning services to women throughout the state that meet the following eligibility criteria:

- Have family income at or below 185% of the Federal poverty guidelines; and
- Are of childbearing age. The target population is women 13 to 44.

Women certified as eligible for family planning services under this Family Planning Program will remain Medicaid eligible for five years with eligibility re-certification every two years. Loss of eligibility will occur only when a woman moves from the state, becomes Medicaid eligible in another aid category, becomes pregnant, reaches the age of 44, or requests that her case be closed.

These women are eligible for Medicaid coverage of family planning services only. The AVRS eligibility transaction response identifies these women as eligible for family planning services only, in Aid Category 29 (FP-W). They are issued a yellow Medicaid card to denote that they are in the Family Planning Program. These women **are not** eligible to receive any other Medicaid benefits.

For more information about the Family Planning Program, you may call the Division of Medicaid at 1-800-421-2408 or (601) 359-6150.

Usage of Modifiers 50 and 51

When billing Mississippi Medicaid, modifiers 50 and 51 are designated for use on CPT codes that range from 10000 to 69999. Using modifiers 50 and 51 on codes that fall outside the range of 10000 to 69999 may cause inaccurate reimbursement for services rendered to Mississippi Medicaid beneficiaries.

Please remember to always bill the appropriate number of units on all codes that are billed to Mississippi Medicaid.

ACS Customer Service

For quicker, more efficient service, please have all pertinent information ready when contacting Provider and Beneficiary Services at 1-800-884-3222.

You will need your:

- Provider ID Number
- Beneficiary ID Number
- Dates of Services
- Billed Amount

For follow-up calls, remember your call record number (CRN).

ANESTHESIA REIMBURSEMENT METHODOLOGY EFFECTIVE FOR DATES OF SERVICE ON AND AFTER 10/01/03

Maternity CPT Codes 01961, 01967, 01968, and 01969

The Division of Medicaid has authorized modifications to the methodology for reimbursing maternity anesthesia on certain codes. Effective retroactively for dates of service on and after October 1, 2003, the reimbursement for CPT Code 01961, 01967, 01968, and 01969 will be fee for service (flat fee). Providers must note that CPT Codes 01968 and 01969 are add-on codes and must be billed with CPT 01967.

CPT Code 01961 …….. $372.29
CPT Code 01967……$402.82
CPT Code 01968……$124.60 (Add-on code which must be billed with CPT 01967)
CPT Code 01969……$207.67 (Add-on code which must be billed with CPT 01967)

All claims previously submitted with CPT Codes 01961, 01967, 01968, and 01969 with dates of service on and after October 1, 2003, will be voided by the fiscal agent, ACS. After the provider receives a remittance advice showing the voided claim, the provider may then resubmit the claim to be reimbursed fee for service. When billing for these codes, the provider must always report one (1) unit in field 24G of the CMS 1500 claim form.

The 5% reduction authorized by House Bill 1200 in the 2002 legislative session will be applied to the fee.

Coding Guidelines for Bilateral Tubal Ligation or Urgent Hysterectomy Following Delivery

CASE SCENARIO	REIMBURSEMENT
A bilateral tubal ligation (BTL) is performed at a distinct separate surgical setting from the delivery.	Provider will bill CPT 00851. Reimbursement methodology will be "base units x base conversion factor plus time units x time conversion factor = total.
A bilateral tubal ligation (BTL) is performed under regional or general anesthesia following natural childbirth (no anesthesia utilized for labor).	Provider will bill CPT 00851. Reimbursement methodology will be "base units x base conversion factor plus time units x time conversion factor = total.
A bilateral tubal ligation (BTL) is performed at the time of a Cesarean Section.	No additional reimbursement.
A bilateral tubal ligation (BTL) is performed following vaginal delivery where regional anesthesia was utilized for the labor and delivery. OR An urgent hysterectomy is performed following delivery.	The provider will bill for both the labor epidural/delivery (CPT 01967) and the BTL (CPT 00851 or urgent hysterectomy (CPT 01962). The first procedure (labor epidural /delivery – flat fee) will end and the second procedure (BTL or urgent hysterectomy- base plus time reimbursement) will begin utilizing the following criteria: (A) If the delivery occurs in a different room and table than where the BTL procedure or urgent hysterectomy will be performed, the anesthesia start time on the second procedure begins when the patient is moved onto the operation table for the BTL procedure or urgent hysterectomy. (B) If the delivery occurs in the same room and table where the BTL procedure or urgent hysterectomy will be performed, the anesthesia start time will begin when the surgical nurse begins to prepare the patient for the BTL procedure or urgent hysterectomy.

Continued on next page

(Anesthesia Reimbursement continued from page 4)

Modifiers

In addition to reporting modifiers AA, GC, QX, or QZ, for maternity anesthesia, providers must also bill modifier TH with the procedure. Modifier TH replaces maternity type of service "B" formerly used in the legacy MMIS system. HIPPA requirements eliminated this type of service code. In order for providers to have an identifier to bypass PRO certification requirements on 3-day vaginal delivery or 5-day cesarean section admissions, the Division of Medicaid is utilizing modifier TH. Modifier TH should be reported **after** the modifier AA, GC, QX, or QZ for 3-day vaginal delivery or 5-day cesarean section admissions. The utilization of modifier TH is applicable to all codes in the CPT 01958 through 01969 range.

In addition, modifier TH should be reported with the code for Bilateral Tubal Ligation (CPT 00851) when performed during 3-day vaginal delivery or 5-day cesarean section admissions.

All Other Codes In The CPT 00100 through 01999 Range

Providers will continue to bill for all other covered anesthesia services in the CPT 00100 through 01999 range by reporting the appropriate CPT code and time units.

(1) The provider must NOT include base units when reporting the time units. The base units for each procedure code are already set in the Medicaid Envision system.

(2) The time units must be reported in field 24G of the CMS 1500 claim form.

(3) Anesthesia time units are reported by number of minutes. One minute of anesthesia time equals one unit.

(4) The current anesthesia conversion factor (2003) for each base unit is $14.24.

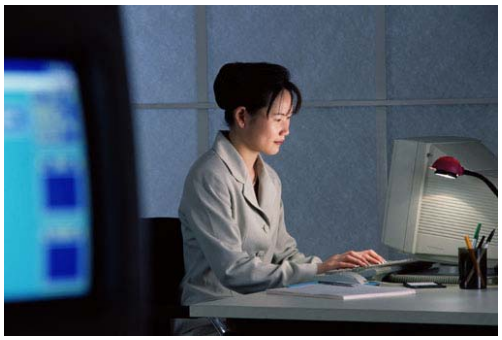
(5) The current anesthesia conversion factor (2003) for each time unit is $0.95.

(6) Anesthesia providers must report modifier AA, GC, QX, or QZ with each anesthesia code.

(7) The 5% reduction authorized in House Bill 1200 of the 2002 Legislative Session will be applied to the total Medicaid allowable.

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.



Refund of Medicaid Overpayments

Unless otherwise advised, it is the responsibility of the provider to refund overpayments to the Division of Medicaid (DOM). Providers have the following options to refund money to DOM:

1. Complete an Adjustment/Void Request form to have overpayments taken from future claims payments.
2. Complete an Adjustment/Void Request form and attach a check payable to The Division of Medicaid for the amount of the overpayment.
3. Send a check to satisfy credit balances created from cash advances rather than having the balance recouped from future claims payments. The provider should make the check payable to The Division of Medicaid and mail it to: ACS Banking Department, P. O. Box 6014, Ridgeland, MS 39158.

Currently only duplicate Medicare crossover payments that occurred between 10/1/03 and 2/23/04 are being recovered. For any other overpayments, the provider should refund the money to DOM as addressed above.

The Adjustment/Void Request form is available from the following website: www.dom.state.ms.us. Using the bar on the left of the page, scroll to Medicaid Provider Information and then select Adjustment Void Form.

Conversion to X12…Just Around the Corner

If you are one of the approximately 30% of providers still sending claims in the old format, your time may be 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.

Billing Tip!

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

Guidelines for Adjusting/Voiding Claims After October 1, 2003

These guidelines apply to claims that must be adjusted or voided regardless of the original date the claims were submitted.

- A claim originally submitted on paper can be adjusted electronically or by using a paper request.
- A claim originally submitted on paper can also be voided electronically or by using a paper request.
- A claim originally submitted electronically must be adjusted electronically.
- A claim originally submitted electronically can be voided electronically or by using a paper request; however, an electronic claim cannot be adjusted on a paper request.
- If you want to adjust a claim that was originally submitted electronically using a paper request, you must file a void request. Once the void has processed, you can resubmit the claim either on paper or electronically with correct information. Please do not attach a corrected claim to a void request.

Providers Billing Electronically

Providers now have the ability to electronically adjust and void claims submitted electronically. Providers can either use the standard functionality in an 837 claim format or providers can use WINASAP2003 to void or adjust a claim. For providers using WINASAP2003, see the information below for guidance on submitting an adjustment or void electronically. These same guidelines apply for providers who need to adjust or void claims that were originally submitted using NECS or WINASAP2000. WINASAP2003 can be used to submit electronic adjustments or voids of claims originally submitted using NECS or WINASAP2003.

The procedures for adjusting and voiding electronically submitted claims using WINASAP2003 are as follows:

Adjustment Procedures for Nursing Facility, Hospice, and Home Health:

- Copy claim that was originally submitted
- On the "Claim Data" screen locate and select the "Type of Bill" field and enter the bill type
- Click on "Next Page" and the "Claim Code" screen will be displayed
- Go to the "Additional Claim Information" section (located at the bottom of the screen) and click on "Other Reference Information"
- Tab down to ICN/DCN and enter the TCN on this line
- Click "OK" and then click "Next Page"
- The "Claim Line Items" screen will be displayed. On this screen make the necessary corrections in the appropriate fields.
- Click "Save" and then transmit the claim

Void Procedures for Nursing Facility, Hospice, and Home Health:

- Copy claim that was originally submitted
- On the "Claim Data" screen locate and select the "Type of Bill" field and enter the bill type
- Click on "Next Page" and the "Claim Code" screen will be displayed
- In the "Additional Claim Information" section, click on "Other Reference Information"
- Tab down to ICN/DCN and enter the TCN on this line
- Click "OK"
- Save and then transmit the claim

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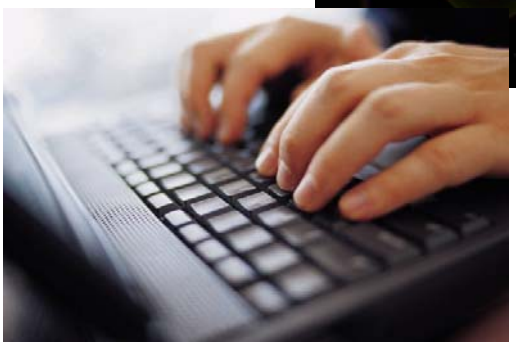
(Guidelines continued from page 7)

Bill Type Codes

Nursing Facility – Void Bill Type Code 898
Adjustment Bill Type Code 897

Hospice – Void Bill Type Code 818
Adjustment Bill Type Code 817

Home Health – Void Bill Type Code 338
Adjustment Bill Type Code 337



Adjustment/Void Procedures for Dental claim

- Copy the claim to be adjusted/voided
- The "Claim Data" screen will be displayed
- Locate the "Claim Frequency Type Code"
- Select "7" for adjustment or select "8" for void
- Then click "Next Page"
- The "Claim Information" screen will be displayed
- Locate the "Claim Original Reference #" field and enter the TCN to be adjusted/voided
- For a void, click "Save" and transmit the claim
- For an adjustment, go to the "Claim Line Item" tab and make the necessary corrections. Then click "Save" and transmit the claim

Adjustment/Void Procedures on HCFA claim

- Copy the claim to be adjusted/voided
- The "Claim Data" screen will be displayed
- Locate the "Claim Frequency Type Code"
- Select "7" for adjustment or select "8" for void
- Then click "Next Page"
- Click on "Claim Level Numbers"
- Enter the TCN on the "Claim Original Reference Number Line"
- Click "OK"
- For a void, click "Save" and transmit the claim
- For an adjustment, click "Next Page" twice
- The "Claim Line Items" page will be displayed to make the necessary corrections
- Save and then transmit the claim

If you are a non-WINASAP2003 user, please reference the article entitled "Voiding and Adjusting Claims (Non-WINASAP2003 users)." This article contains the latest information regarding your claims transmittal process.

Voiding and Adjusting Claims (Non-WINASAP2003 users)

If you are currently using a software vendor, billing agent or clearinghouse to submit your Mississippi Medicaid claims, please read the following about voiding/adjusting your claims.

If you submit a claim electronically and need to make an adjustment, it can only be done electronically. An electronic claim can be voided using a paper void, but that is not the preferred method.

In order for Mississippi Medicaid to process the void/adjustment correctly, certain information must be sent. Please contact your software vendor, billing agent or clearinghouse and provide to them the information below about voiding and adjusting claims.

Information needed to void a claim electronically:

1. Claim frequency type code -for Professional and Dental this must be an 8. This information should be populated in the 2300 loop in the CLM05-3 segment. For institutional claims, the last digit of the type of bill must be an 8. The type of bill is populated in the 2300 loop in the CLM05 segment.
2. Original TCN- The original TCN is needed for all claim types. This information should be populated in the 2300 loop in the Ref02 segment, with the qualifier of F8 in the Ref01 segment.
3. In addition to the above, you must send all the original information that was on the claim. Copy the original claim and add the items from steps 1 and 2.

Information needed to adjust a claim electronically:

1. Claim frequency type code -for Professional and Dental this must be a 7. This information should be populated in the 2300 loop in the CLM05-3 segment. For institutional claims, the last digit of the type of bill must be a 7. The type of bill is populated in the 2300 loop in the CLM05 segment.
2. Original TCN- The original TCN is needed for all claim types. This information should be populated in the 2300 loop in the Ref02 segment, with the qualifier of F8 in the Ref01 segment.
3. Make the necessary adjustments on the line items.
4. In addition to the above, you must send all the original information that was on the claim. Copy the original claim and add the items from steps 1, 2, and 3.

Paper Claim Submission

Effective February 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.

VISION AND HEARING FEE SCHEDULE

The vision and hearing codes fee schedule is now available on The Division of Medicaid website www.dom.state.ms.us under the heading of Medicaid Fee Schedules.

Assistance from Provider Representatives

Provider representatives are available to assist providers with billing and claims issues. You may also contact your provider representative with other inquiries. The representatives are assisting providers by telephone with as many issues as possible. Due to the high volume of calls, our representatives are currently on the phone a large portion of the day. Please leave a voice mail message and allow the representative an opportunity to return your call. If the issues cannot be resolved by telephone, a provider visit may be scheduled at a time that is convenient for you. Prior to all provider visits, providers must submit a list of issues to be covered at the visit. This will allow the provider representative an opportunity to research the issues and be prepared to provide the needed assistance.

These representatives may be reached by contacting them at the phone numbers listed on the chart below.

County	Provider Representative	Telephone #
Adams	Charleston Green	601.359.9804
Alcorn	Machelle Dorman	601.206.3025
Amite	Charleston Green	601.359.9804
Attala	Justin Griffin	601.206.3023
Benton	Machelle Dorman	601.206.3025
Bolivar	Clint Gee	662.453.1053
Calhoun	Rhonda Evans	601.359.1370
Carroll	Clint Gee	662.453.1053
Chickasaw	Rhonda Evans	601.359.1370
Choctaw	Rhonda Evans	601.359.1370
Claiborne	Charleston Green	601.359.9804
Clarke	Pamela Williams	601.359.9575
Clay	Rhonda Evans	601.359.1370
Coahoma	Clint Gee	662.453.1053
Copiah	Charleston Green	601.359.9804
Covington	Pamela Williams	601.359.9575
Desoto	Machelle Dorman	601.206.3025
Forrest	Pamela Williams	601.359.9575
Franklin	Charleston Green	601.359.9804
George	Pamela Williams	601.359.9575
Greene	Pamela Williams	601.359.9575
Grenada	Rhonda Evans	601.359.1370
Hancock	Mariam May-Clayton	601.359.6673
Harrison	Mariam May-Clayton	601.359.6673
Hinds	Jose Johnson Randy Ponder	601.206.2996 601.206.3026
Holmes	Loretta Green	601.359.6129
Humphreys	Loretta Green	601.359.6129
Issaquena	Loretta Green	601.359.6129
Itawamba	Rhonda Evans	601.359.1370
Jackson	Mariam May-Clayton	601.359.6673

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(Provider Representative continued from page 10)

County	Provider Representative	Telephone #
Jasper	Justin Griffin	601.206.3023
Jefferson	Charleston Green	601.359.9804
Jones	Justin Griffin	601.206.3023
Kemper	Justin Griffin	601.206.3023
Lafayette	Machelle Dorman	601.206.3025
Lamar	Pamela Williams	601.359.9575
Lauderdale	Charleston Green	601.359.9804
Lawrence	Charleston Green	601.359.9804
Leake	Justin Griffin	601.206.3023
Lee	Jose Johnson	601.206.2996
Leflore	Clint Gee	662.453.1053
Lincoln	Charleston Green	601.359.9804
Lowndes	Rhonda Evans	601.359.1370
Madison	Loretta Green	601.359.6129
Marion	Pamela Williams	601.359.9575
Marshall	Machelle Dorman	601.206.3025
Monroe	Rhonda Evans	601.359.1370
Montgomery	Rhonda Evans	601.359.1370
Neshoba	Justin Griffin	601.206.3023
Newton	Justin Griffin	601.206.3023
Noxubee	Rhonda Evans	601.359.1370
Oktibbeha	Rhonda Evans	601.359.1370
Panola	Clint Gee	662.453.1053
Pearl River	Pamela Williams	601.359.9575
Perry	Pamela Williams	601.359.9575
Pike	Charleston Green	601.359.9804
Pontotoc	Rhonda Evans	601.359.1370
Prentiss	Machelle Dorman	601.206.3025
Quitman	Clint Gee	662.453.1053
Rankin	Mariam May-Clayton	601.359.6673
Scott	Justin Griffin	601.206.3023
Sharkey	Loretta Green	601.359.6129
Simpson	Charleston Green	601.359.9804
Smith	Justin Griffin	601.206.3023
Stone	Pamela Williams	601.359.9575
Sunflower	Clint Gee	662.453.1053
Tallahatchie	Clint Gee	662.453.1053
Tate	Clint Gee	662.453.1053
Tippah	Machelle Dorman	601.206.3025
Tishomingo	Machelle Dorman	601.206.3025
Tunica	Clint Gee	662.453.1053
Union	Jose Johnson	601.206.2996

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(Provider Representative continued from page 11)

County	Provider Representative	Telephone #
Walthall	Charleston Green	601.359.9804
Warren	Loretta Green	601.359.6129
Washington	Clint Gee	662.453.1053
Wayne	Pamela Williams	601.359.9575
Webster	Rhonda Evans	601.359.1370
Wilkinson	Charleston Green	601.359.9804
Winston	Justin Griffin	601.206.3023
Yalobusha	Rhonda Evans	601.359.1370
Yazoo	Loretta Green	601.359.6129

Out of State Assignments		
Alabama	Randy Ponder	601.206.3026
Louisiana	Cindy Brown Justin Griffin	601.206.2981 601.206.3023
Tennessee	Machelle Dorman	601.206.3025

Dental Provider Update: D8670

Since October 1, 2003, some claims billed with procedure code D8670 for orthodontia services denied for Exception 0617, Authorized Line Item Unit/Amount Used. ACS resolved this issue and claims are now paying correctly. Inappropriately denied claims have been reprocessed and appeared on the March 29, 2004 remittance advice. If you have claims that did not reprocess, please contact your provider representative.

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. Currently, we are seeking suggestions for areas and topics for which the providers desire training. The deadline for submitting suggestions is Friday, May 14, 2004. If you have suggestions, please complete and detach the enclosed form and fax it to (601) 206-3199 or mail it to:

ACS State Healthcare
Provider Services Department
P.O. Box 23078
Jackson, MS 39225

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.

Spring 2004
Workshop Suggestions

In an effort to plan for future provider workshops, please list below the area(s), in which you would like to receive training. Please detach this form and fax it to (601) 206-3199 or mail it to: P.O. Box 23078, Jackson, MS 39225. All suggestions must be received by Friday, May 14, 2004.

Optional:

Contact Name:	
Contact Number:	
Provider Name:	
Provider Number:	
Email Address:	

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Web Portal Eligibility Upgrade

Since the new *Envision* web portal became active on October 6, 2003, the Mississippi Division of Medicaid and ACS have received a tremendous number of responses and participation. Currently, there are approximately 2500 registered providers using the secure transactions available on the web portal. As of March 8, the eligibility status inquiry feature of the web portal was upgraded. As a result of this latest enhancement, providers now have the ability to view the beneficiary's service limits, eligibility program description, and lock-in information when requesting eligibility status. The implementation of this feature was created to mirror the response that providers receive when using a swipe card device to obtain eligibility information. The Mississippi Medicaid provider community initiated this upgrade by communicating to the Mississippi Division of Medicaid and ACS the need for this information. Please continue to use the web portal and provide feedback. Due to HIPAA regulations, not all suggested updates can be implemented but all will be considered.

WINASAP2003 v5.00 Corrections and Enhancements

The latest version of WINASAP2003 was made available on April 5, 2004, to all WINASAP users. To upgrade to the latest version, visit the following site: 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.

- Covered days will be auto-populated based on the billing period for NF claims. This would keep providers from going into each claim to change the covered days. If you were billing for January it would populate 31 covered days. Changes will have to be made in the claims for partial covered days.
- Supernumerary tooth numbers were added to the list of tooth numbers.
- The alignment of the reports was corrected.
- Issues concerning Novell users (involves admin rights) will be corrected.
- On nursing facility claims, the admit date is now situational.

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

Timely Filing and Place of Service Reminder

Claims processed on and after October 1, 2003, will be assigned a 17-digit Transaction Control Number (TCN). The TCN is basically the same as the 13-digit Internal Control Number (ICN).

Use the original ICN/TCN on the first remittance advice (RA) from the first time the claim adjudicated as the **timely filing ICN/TCN** when re-submitting claims. The *Envision* system will accept the old 13-digit Timely Filing ICN and will automatically convert it to the new format for further claim adjudication. For all new claims received after October 1st, the system will automatically assign a 17-digit Timely Filing TCN.

The simple rule to remember on timely filing is: Use a 13-digit ICN number or the 17-digit TCN number, whichever appeared on the RA from the original adjudication of the claim.

Providers must use the two-digit, standard place of service code when submitting professional claims. Reference the September 2003 Provider Bulletin for a complete listing of acceptable place of service codes. The Division of Medicaid (DOM) is required to accept all of the listed place of service codes. However, payment is not required for services rendered in settings not covered by DOM in accordance with DOM policy and procedures.

Use of Modifiers to Bill Monthly and Daily Rental of DME

This is a reminder to use appropriate modifiers when submitting certification requests and claims for rental of DME. The modifiers that must be used for DME, medical supplies, prosthetics, and orthotics are:

RR Rental (use the 'RR' modifier when DME is to be rented)
KR Rental item, billing for partial month
NU New equipment
RP Replacement and repair
MS Six-month maintenance and servicing fee (for MS Medicaid, use of this modifier is restricted to patient-owned ventilators)
UE Used durable medical equipment
SC Medically necessary service or supply

Use a code with modifier RR for full monthly rentals. Use a code with modifier KR for a partial monthly rental. For example, if a rental item is for a total of 45 days, the rental should be coded twice, with modifier RR to cover the first 30 days and modifier KR for the remaining 15 days.

REMEMBER – providers must bill the same modifier on the claim as is on the Treatment Authorization Number (TAN) issued by HealthSystems of Mississippi (HSM). If these do not match, the claim will deny. Providers should also bill the appropriate number of units. If the claim is for a monthly rental, there should be one unit billed per month. If the claim is for a partial monthly rental, there should be one unit billed per day.

Manual Pricing of DME and Medical Supplies

The Division of Medicaid has posted updated information on the website at www.dom.state.ms.us regarding manual pricing of DME and medical supplies. Please call the Bureau of Medical Services at (601) 359-5683 or 1-800-421-2408 extension 5683 if you have any questions.

DME Medicaid Claims for Newborns

DME providers are reminded to submit claims for newborns with the same Medicaid ID number as is listed on the Treatment Authorization Number (TAN) for the item. If the TAN was issued with the baby's own Medicaid ID number the claim must be submitted with the same number. If the claim is submitted with the mother's Medicaid ID number and a K, the claim will not pay since it does not match the number on the TAN.

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.

Changing Vendors? Let Us Know

If you are a provider and are changing vendors, whether a new software vendor, billing agent or clearinghouse, you need to let ACS know. When your enrollment form is processed, you are linked with the vendor that you indicate on the enrollment form. Any reports that you want delivered to that vendor are also linked. If you change vendors but do not notify ACS, your reports will not go to the correct location. You or your vendor may also encounter submission problems if you are not correctly linked.

In order to notify ACS of the change, you must complete a new EDI enrollment form. Enrollment forms are located at:

http://www.acs-gcro.com/Medicaid_Accounts/Mississippi_Medicaid/Enrollment/enrollment.htm

It is very important that you notify ACS whenever you make a change that affects either the submission of your claims or retrieval of your reports. If you have any questions or problems contact EDI at 866.225.2502.

"Stand-alone" CPT Codes

The following CPT codes price from a general fee schedule and should not be billed with the 26 or TC modifier. Claims submitted with the 26 or TC modifier will be denied. Claims that were submitted for these procedures that denied or paid the incorrect amount will be reprocessed.

76150	77261	77262	77263	77336	77370	77401	77402	77403	77404	77406	77407	77408
77409	77411	77412	77413	77414	77416	77417	77420	77427	77430	77431	86490	86510
86580	86585	89350	89360	92547	92552	92553	92555	92556	92557	92561	92562	92563
92564	92565	92567	92568	92569	92571	92572	92573	92575	92576	92577	92582	92583
92584	92589	92596	93005	93010	93012	93014	93017	93018	93041	93042	93225	93226
93227	93231	93232	93233	93236	93237	93721	93722	94760	94761	94762	95010	95015
95024	95027	95028	95056	95060	95065	95075	95078					

"Web Wise"

In an effort to better serve the provider community, several websites are available with current and pertinent information. Please take a moment and visit the following websites:

www.dom.state.ms.us
Provider manuals may be accessed or printed from this site.

http://mississippimedicaid.acs-inc.com
Remittance advices may be accessed and downloaded from this site.

http://msmedicaid.acs-inc.com
This site is often referred to as the "Web Portal". You may check eligibility, claim status, and view the latest updates on Late Breaking News.

www.hidmsmedicaid.com
Drug Prior Authorization forms are available at this site.

www.hsom.org
Plan of Care forms can be downloaded from this site.

Provider Quick Contact List

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**

Policy Manual Reminder

This bulletin is a document for the Mississippi Medicaid Provider Policy Manual and must be placed in Section 88 of the manual. All providers are held accountable for all policies in the monthly Mississippi Medicaid Bulletins.

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ACS
P.O. Box 23078
Jackson, MS 39225

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

May

May 2004

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	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	24 CHECKWRITE	25	26	27 EDI Cut Off 5:00 p.m	28	29
30	31 DOM and ACS closed Memorial Day CHECKWRITE					

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.