

Mississippi Medicaid

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Bulletin

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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 will 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.

Deferred Comp Billing Instructions Post October 1, 2003

The Division of Medicaid installed a new claims processing system on October 1, 2003, called Envision. Envision resulted in several changes for providers. Listed below are changes providers who wish to participate in the Mississippi Deferred Compensation program will need to make in order to comply with requirements that are based on Internal Revenue Code Section 457(b):

- 1) Effective October 1, 2003, a provider can no longer have a Social Security Number (SSN) and a Federal Tax Identification number (TIN) or Employer Identification number (EIN) for one Medicaid provider number. Each IRS reporting number will have to have its own Medicaid provider number.
- 2) For providers that use both numbers currently and only have one Medicaid provider number, a second provider number will have to be obtained. To get this number, contact ACS Provider Enrollment.
- 3) If a provider already has both numbers and would like to continue to participate in the Deferred Compensation program, the provider will have to bill Medicaid using the provider number that is associated with his/her SSN.

If you have any questions regarding the Medicaid changes, please contact ACS Provider Enrollment at 1-800-884-3222 or 601-206-3000. For any Deferred Compensation Plan questions, please contact the MS Deferred Compensation Plan at 1-800-846-4551 or 601-969-2064.



REOMB Roster

In May 2004, Medicaid beneficiaries began receiving a "Statement of Medicaid Benefits" on a monthly basis from the Division of Medicaid. This statement summarizes benefits paid by the Division of Medicaid on behalf of the beneficiary during the previous month. For example, the statement received in May 2004 summarizes benefits that were reimbursed in April 2004. Beneficiaries should contact the Provider and Beneficiary Services Call Center at 1-800-884-3222 if services are listed which were not received, or if they have questions about the Medicaid explanation of benefits.

Attention Providers Who Bill Evaluation and Management Procedure Codes

The Division of Medicaid does not reimburse for Evaluation and Management office visits billed with the ICD 9 V20.2 code (routine infant or child health check) for beneficiaries under 21 years of age. This may include examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury. Providers should refer to the Provider Policy Manual Section 2.03, Benefits/Exclusions, or the Physician Manual Section 1.14 General Exclusions.

Assistant Surgeons and Cesarean Sections

A problem has been identified that caused assistant surgeon claims to deny incorrectly as duplicates when billing modifier -80 and TH with Cesarean section CPT codes. The problem has been corrected to allow the primary and assistant surgeon to receive reimbursement as outlined in DOM policy.

RhoGAM Billing for Maternity Patients



It is the policy of the Division of Medicaid that physicians or nurse practitioners billing for RhoGAM for maternity patients may bill a hard copy CMS-1500 form using either CPT code 90384 or 90385 and provide the name of the drug, the strength, and dosage. If available, the NDC (National Drug Classification Number)

should also be reported to assist the fiscal agent in identifying the specific drug. A copy of the current invoice showing purchase price should also be attached for review. These claims will be manually priced through Medical Review at the fiscal agent.

HCPCS code J2790 should only be used for non-maternity cases when the description of the code specifically identifies the name, strength, and dosage of the drug. If J2790 is not specific, HCPCS code J3490 should be billed with the name of the drug, strength, and dosage.

Federally Qualified Health Centers (FQHC's) and Rural Health Clinics (RHC's) should also follow these billing instructions if administering RhoGAM to receive fee-for-service reimbursement when no encounter is provided. If RhoGAM is administered during an encounter, the injection is inclusive in the encounter rate.

Timely Filing Guideline Tip

When filing for regular Medicaid, claims must be filed within one year from the date of service. For Medicaid claims that have Medicare as primary payer, claims must be filed within 180 days from the Medicare payment date.

The Benefits of Utilizing the Web Portal

The web portal of the Mississippi Division of Medicaid *Envision* system was designed to assist the Mississippi Medicaid provider with the ability to search for and retrieve information. Access to the web portal is available 24 hours a day, 7 days a week, 365 days a year via the internet at <http://msmedicaid.acs-inc.com>. It is your one-stop resource for answers to common Medicaid questions, contact information, provider bulletins, banner messages, online provider enrollment or enrollment status inquiry and more. In addition, there is a "Late Breaking News" section on the Publications page which provides pertinent information to the provider. You are encouraged to visit the web portal and explore all it has to offer. In order to access secure features such as interactive beneficiary eligibility verification, interactive claim status, and interactive provider enrollment status inquiry, you must register to create a web account. Registration is quick and easy at <http://msmedicaid.acs-inc.com/general/userreg.jsp>. Register today.



Questions Regarding Credit Balances

Providers typically want to know the following:

Q. Why was the credit balance generated?

A. Credit balances are typically created when providers submit an "Adjustment/Void" request form to adjust or void previously paid claims. In addition, credit balances may also be created when system reprocessings, mass voids, or mass adjustments occur on already processed claims.

Q Are providers required to send a check to the Division of Medicaid, or can they have the credit balance satisfied through future claims payments?

A Preferably, providers should send a check to satisfy their credit balance. If the providers know for certain that they will be submitting claims under that providers' number with the credit balance soon after receiving first and second notice letters, then credit balances could be satisfied through future claims payments.

Q To whom should the check be made out and to what address should it be sent if the provider chooses to send a check?

A The check should be payable to the State of Mississippi and sent to ACS State Healthcare, PO Box 6014, Ridgeland, MS 39158-6014. The notice letters that are sent to the providers inform them of this in the last paragraph of the letter. Also, when sending refund payments, attach a copy of the notice letter so payment can be applied appropriately.

Q In some instances, why are the credit balance letters generated on claims that paid over two years ago?

A Usually, a system reprocessing, mass void or mass adjustment occurred and created the credit balance which generated the credit balance letters.

Continued Extension of Hospital Cost Report Filing Due Dates

Due to the continued 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 through December 2003. The new extended due date is June 30, 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.

Guidelines for Adjusting/Voiding Claims After October 1, 2003

This article is an amended version of the article that ran in the May 2004 bulletin. That particular article only addressed adjustment procedures for Nursing Facilities, Hospice, Home Health, Dental, and HCFA claims. Inpatient and Outpatient claims are now included. Please see the information below for further details:

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, Home Health, Inpatient, and Outpatient:

- 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, Home Health, Inpatient, and Outpatient:

- 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

Continued on next page

(Guidelines continued from page 4)

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

Inpatient – Void Bill Type Code 118
Adjustment Bill Type Code 117

Outpatient – Void Bill Type Code 138
Adjustment Bill Type Code 137

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

Guidelines for Pre-Admission Screening and Resident Review (PASRR)

Listed below are some guidelines for PASRR that helps to ensure that the preadmission screening process is followed. This information is useful to all those delivering services related to the PASRR process including, but not limited to: Community Mental Health Centers (CMHCs); Regional Centers (RCs); Nursing Facilities (NFs); Intermediate Care Facilities for the Mentally Retarded (ICF/MRs); and others who assist with applications to a NF or ICF/MR. Because the Division of Medicaid has a system in place to monitor the PASRR process, we are able to determine whether the PASRR process is followed and completed in a timely manner. If additional information is needed regarding the following guidelines, please contact Mental Health Services at the number listed below in the contact information.

1. The timelines required for completing Level II Evaluations are listed below. For a flowchart of the PASRR Process, please contact Mental Health Services.
 - a) Referral for Level II Evaluation is received by the CMHC/RC
 - b) Level II Evaluation is conducted by the CMHC/RC within 5 business days of referral
 - c) CMHC/RC submits completed Level II to State PASRR Coordinator/Department of Mental Health (DMH) within 2 days of evaluation
 - d) State PASRR Coordinator/DMH receives Level II and makes determination within 2 days of receipt
 - e) Related parties are notified
2. The CMHCs/RCs are solely responsible for conducting and submitting Level II Evaluations. **Immediately** upon completion of a Level II Evaluation, the CMHCs/RCs should submit the Level II to the State PASRR Coordinator/DMH. These evaluations should not be held by the CMHC/RC or their staff until the end of the month. The CMHCs/RCs should provide a copy of the Level II Evaluation to the proper facility with appropriate releases.
3. At the beginning of the next month, a billing roster for the previous month can be submitted to the Division of Medicaid for reimbursement for all the Level II Evaluations completed within that month. The billing rosters must be completely filled out and adhere to the guidelines published in our June 2003 Medicaid Provider Bulletin. These billing rosters should also be submitted in a timely manner, preferably within sixty (60) days of service.
4. Procedures and requirements for payment of Level II Evaluations were outlined in our June 2003 Medicaid Bulletin. You can find this document by accessing our MS Medicaid website (www.dom.state.ms.us). After getting to the website, click on Medicaid Provider Information in the left hand column and then on Provider Bulletins to get to the monthly Medicaid bulletins.
5. The CMHCs/RCs should submit the name of the individual serving as the PASRR Coordinator for their facility. This person serves as the contact person for all PASRR related issues and is responsible for supervising and ensuring that the PASRR process is followed and that all pertinent materials have been submitted to the State PASRR Coordinator/DMH and/or Division of Medicaid. If a PASRR Coordinator has not been selected for your facility, please do so and submit their name to the Bureau of Long Term Care/Mental Health Services.
6. Contact information

| | |
|--|--------------|
| Division of Medicaid 239 North Lamar Street Robert E. Lee, Suite 801 Mental Health Services—ORP Jackson, MS 39201-1399 | 601-359-9547 |
| State PASRR Coordinator P.O. Box 157, Building 22 Whitfield, MS 39193 | 601-351-8267 |

Pharmacy Notes

Reminder

A written, faxed or telephoned prescription may be refilled, in compliance with the prescribed order *and* pharmacy regulations up to a limit of eleven times.

Change in PA form

Cialis, Levitra and Viagra require prior authorization. The beneficiary must be male, 21 years of age or older, or receiving no contraindicated medications. A maximum of **2 tablets cumulative per class per month** is allowed.

A new prior authorization form is in this bulletin. It can also be found on the DOM web site at www.dom.state.ms.us, Pharmacy Services or HID's site at www.hidmsmedicaid.com.



Maximum Quantity Limits

Effective July 1, 2004, the Division of Medicaid will limit the maximum quantity limitation per prescription (a month's supply is the maximum Mississippi Medicaid-covered days' supply per prescription) to **actual recommended maximum daily dose** as recommended by the manufacturer and/or FDA for substances with the potential for misuse, abuse, or diversion. Drug categories included are controlled substances, such as hydrocodone and acetaminophen combinations, propoxyphene and acetaminophen combinations, hypnotics, stimulants and benzodiazepines. Also included are carisprodol and tramadol.

A listing of these products is available on DOM's website at www.dom.state.ms.us, Pharmacy Services, What's New, and Products with Quantity Limits. This listing is subject to change.

Cost Containment and Pharmacy Claim billing for other third party insurers

Pharmacy providers will soon be required to verify and pursue beneficiaries' liable third party payers and to submit pharmacy claims to primary insurers for Medicaid beneficiaries who have coverage under another insurance carrier as noted in Federal Regulation, 42 CFR §433.139. The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

Third-party resources include private health insurance, CHAMPUS, Medicare, worker's compensation or any other source available to pay all or part of medical expenses. When a drug claim is submitted to Medicaid for a beneficiary having other pharmacy insurance coverage, the claim will deny, posting an edit stating that Medicaid is not the primary payer for the claim. A carrier code will post, if available, to identify the primary payer on record. To assist providers, insurance carrier code information will be provided on DOM's website.

Refer to DOM's website, <http://www.dom.state.ms.us> and link Pharmacy Services for updated information on this matter.

FAX TO : 1-800-459-2135

Health Information Designs, Inc.
P.O. Box 320506
Flowood, MS 39232
Phone 800-355-0486

**ERECTILE DYSFUNCTION
ORAL AGENTS**

PRIOR AUTHORIZATION REQUEST FORM
Beneficiary Must be Male and 21 Years of Age or Older
Maximum of 2 Tablets per Class per Month (Cumulative)

BENEFICIARY INFORMATION

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

DOB: _____ City _____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ Medicaid ID # _____

City _____ State _____ Phone #: _____

FAX #: _____

Physician's signature and date _____

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

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider # _____

City _____ State _____ Phone #: _____

FAX #: _____

DRUG/CLINICAL INFORMATION

Drug Name and Strength: _____

Daily dose: _____ NDC# (IF KNOWN): _____

Diagnosis: _____

Please indicate the medical etiology for erectile dysfunction (impotence) by history and medical exam.

Spinal Cord Injury _____ Is patient currently taking any form of nitrate/nitrite medications?

Diabetic Neuropathy _____ YES NO

TURP associated neurological damage _____ *IF YES, please note that Cialis/Levitra/Viagra are contraindicated in patients on nitrates/nitrites.*

Prostatectomy (radical) _____ Is patient currently taking alpha blockers?

Cardiovascular disease (CHF, PVD, HTN) _____ YES NO

Other: _____ *IF YES, please note that Cialis and Levitra are contraindicated in patients on alpha blockers. Consult the manufacturer's literature for specific recommendations.*

Supporting documentation must be available in the patient record

FOR HID USE ONLY

Eligibility Verified by _____

Approved _____

Denied/Code: _____

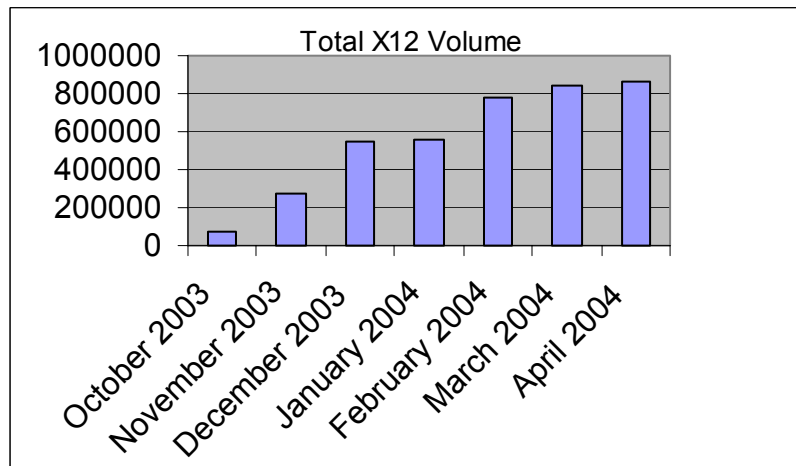
From Date _____ Thru Date _____

Reviewed by _____

HID# _____ PA# _____

Confidentiality Notice: This communication, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply telephone (1-800-355-0486) or fax (1-800-459-2135) and destroy all copies of the original message.

Conversion to X12... percentages increasing



If you are one of the approximately 20% of users still sending claims in the old format, your time may be running out. Currently 80% of the electronic submitters for MS Medicaid are now 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 for conversion to ANSI X12N format.
- ✓ Find out if they have been in contact with EDI to begin testing the new format.
- ✓ Provide your vendor with the following telephone number (850-558-1630, option 6) for questions about testing.
- ✓ 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.

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 nursing facility 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.
- On nursing facility claims, the admit date will now be situational. This was a required field on a previous version.
- 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.

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

Mississippi Division of Medicaid Billing Instructions

Home Health Services: Medical Supplies

For claims with dates of service on and after October 1, 2003:

1. Effective for dates of service on and after October 1, 2003, Home Health providers are not reimbursed for medical supplies as a per-item fee.
2. Reimbursement for medical supplies that are included in the medical supplies cost center of the Medicare cost report will be included in the payment for each visit as an add-on and will be applied to each discipline's rate outside the ceiling for that discipline. For example, if the medical supply add-on is \$1.50, the total payment rate for a physical therapy visit would be \$66.50 (\$65.00 + \$1.50).
3. Home health agency providers should report charges and number of units billed for medical supplies under revenue code 270 on the UB92 claim. Mississippi Medicaid policy does not require HCPCS codes for medical supplies for dates of services on and after October 1, 2003.
4. Supplies billed with revenue code 270 must be:
 - a. Relevant to the beneficiary's home health plan of care
 - b. Directly identifiable furnished to individual patients for which a separate charge is made.
5. Supply charges reported on the UB92 claim under revenue code 270 will be used to calculate the medical supply add-on in subsequent years.
6. Routine medical supplies furnished by a home health agency that are not directly identifiable to individual patients are reported in the administrative and general cost center on the Medicare cost report – do not report under revenue code 270.
7. This reimbursement methodology is not the same as the Medicare prospective payment system for home health.

For claims with dates of service prior to October 1, 2003:

1. Effective for dates of service prior to October 1, 2003, Home Health providers are reimbursed for medical supplies as a per-item fee.
2. Home health agency providers should report charges and number of units billed for medical supplies under revenue code 270 on the UB92 claim AND list each supply code individually using the appropriate procedure code from the list included in the Mississippi Medicaid Home Health Agency Provider Manual, Appendix N, 1996.

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.

Top Ten Reasons Individual Claims Are Returned To Providers:

1. Provider Signature Missing
2. Group or Pin Number Missing
3. Billing Date Missing
4. Total Charges Missing
5. Service Dates Missing
6. Missing Attachments (EOMBs, EOBs, TPLs)
7. Wrong Claim Type
8. Beneficiary ID number Missing
9. Correction Fluid/Correction Tape
10. Procedure Codes do not match EOMB or EOB

Attendance at Delivery

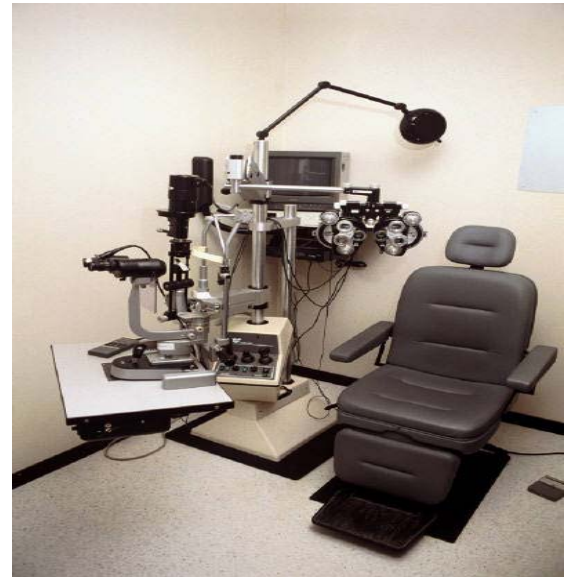
Current policy requires that providers bill CPT 99360 with the V23.9 diagnosis code for "Standby at High Risk Delivery". Because V23.9 is restricted to females, providers are having difficulty getting claims through clearinghouses which have the sex restriction on the V23.9. Therefore, the Division of Medicaid is revising its coding requirements as listed below:

Dates of Services Prior to June 1, 2004

Providers must bill CPT code 99360 with the appropriate ICD-9 diagnosis code instead of V23.9. CPT code 99360 will be closed and not longer used by the Division of Medicaid for dates of services on and after June 1, 2004.

Dates of Services On and After June 1, 2004

Providers must bill CPT code 99436 for "Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn". The appropriate ICD-9 diagnosis code should be reported for the service. The Mississippi Medicaid allowable will be \$110.00.



Attention Eyeglass Providers

When billing for tinted lenses please use the appropriate HCPCS code. Procedure Codes V2740, V2741, V2742 and V2743 have been deleted and are no longer valid as of 3/31/04. Claims billed for tinted lenses with Dates of Service on or after 4/1/04 must be billed using V2745.

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.

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

Policy Manual Additions/ Revisions

The following policies and policy sections of the DOM Provider Policy Manual have been added and/or revised. Providers of these services may view these changes by accessing the DOM website at www.dom.state.ms.us and clicking on “Provider Manuals” in the left window.

| Section | Policy | Effective Date | New | New Section | Revised | Revised Sections |
|---------|---------------------------|----------------|-----|----------------|---------|---|
| 53.0 | General Medical | 06/01/04 | | | X | 53.12 |
| 1.0 | Introduction | 07/01/04 | | | X | 1.05 1.07 1.09 1.11 |
| 2.0 | Benefits | 07/01/04 | | | X | 2.01 2.02 |
| 3.0 | Beneficiary Information | 07/01/04 | | | X | 3.08 |
| 10.0 | Durable Medical Equipment | 07/01/04 | X | 10.93 10.94 | | |
| 25.0 | Hospital Inpatient | 07/01/04 | | | X | 25.11 25.14 |
| 28.0 | Transplants | 07/01/04 | X | 28.18 | X | 28.01 28.02 28.04 28.10 28.15 |

Retroactive Rate Adjustments

Retroactive rate adjustments for the providers listed below occurred on the following dates:

04/12/04 – 04/19/04 Home Health Providers

04/19/04 – 04/26/04 Long Term Care

04/26/04 – 05/10/04 Clinics (FQHCs, RHCs, SDH)

05/17/04 – 05/31/04 Hospitals

A negative adjustment will be reflected on the remittance advice of providers who received a rate decrease. A supplemental payment will be reflected for providers who received a rate increase.

Billing Tip!

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

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 Bureau of Eligibility 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 |

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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>

June

June 2004

| <i>Sunday</i> | <i>Monday</i> | <i>Tuesday</i> | <i>Wednesday</i> | <i>Thursday</i> | <i>Friday</i> | <i>Saturday</i> |
|---------------|-------------------------|----------------|------------------|---------------------------------------|---------------|-----------------|
| | | 1 | 2 | 3 EDI Cut Off 5:00 p.m. | 4 | 5 |
| 6 | 7 CHECKWRITE | 8 | 9 | 10 EDI Cut Off 5:00 p.m. | 11 | 12 |
| 13 | 14 CHECKWRITE | 15 | 16 | 17 EDI Cut Off 5:00 p.m. | 18 | 19 |
| 20 | 21 CHECKWRITE | 22 | 23 | 24 EDI Cut Off 5:00 p.m. | 25 | 26 |
| 27 | 28 CHECKWRITE | 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.