Mississippi Medicaid Bulletin

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Points of Interest:

Medicaid Identification Card

It is the responsibility of the Medicaid provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service. The provider is also responsible for confirming that the person presenting the card is the person to whom the card is issued. This can be done by requesting a picture ID, such as a driver's license, school ID card, or verifying the Social Security number and/or birth date. It is preferred that providers verify the identity of the person presenting for service with a picture ID when possible. If it is found that the person presenting for services is not the Medicaid beneficiary to whom the card was issued, the provider is responsible for refunding any monies paid by Medicaid to the provider for those services provided.

Additional information regarding the Division of Medicaid's policy regarding the Medicaid identification card is in Section 3.05 of the Provider Policy Manual. Providers are reminded that they should review this policy periodically with their office staff.

Cash Advances and Recoupment Percentages

The Division of Medicaid is currently recouping emergency cash advances for all providers. The Division of Medicaid and ACS State Healthcare have received many inquiries from providers regarding the recoupment percentage. All cash advances will be recouped at 100% of the total amount advanced on a weekly basis until the entire cash advance has been recouped. The recoupment percentage is based on the total cash advance and is not a percentage of claims paid. If the total claims paid in a payment cycle is not enough to cover the recoupment percentage, any remaining balance is applied to the next payment in addition to the recoupment for that payment cycle.

Requests for a lesser percentage must be submitted in writing to Hugh Smith, Division of Medicaid, Executive Division by 3:00 on Tuesday of each week. Any requests received after that time will be considered the following week. The request may be sent by fax to 601-359-6264 or 601-359-6048. The request must include justification of Medicaid claims issues that necessitate a lesser recoupment amount.

Paper Claim Submission

Effective February 16, 2004, Optical Character Recognition (OCR) was implemented to facilitate more efficient processing of paper claims. OCR technology allows for more timely and accurate processing of provider claims.

In order for this technology to work effectively, accurately, and in a timely manner, providers are encouraged to use typewritten "red dropout" forms for all UB92 and CMS-1500 paper claim submissions. Utilization of "red dropout" forms allows for faster processing of paper claims.

Providers are also encouraged to make certain that information is in the correct location on the claim. Failure to place the information in the correct location will cause the incorrect capture of data. Examples of information which should be in correct fields includes, but is not limited to, TPL amounts, timely filing TCN's, prior authorization numbers and servicing provider numbers.

Local Code Conversion Table

The Division of Medicaid and ACS State Healthcare have been receiving many inquiries from providers regarding local codes and their corresponding national codes. Providers may reference the October 2003 Medicaid Provider Bulletin for the local code conversion table, which may be found on pages 7 through 13. The bulletin may be accessed on the Mississippi Envision Web Portal at the following address: http://msmedicaid.acs-inc.com.

Crossover Pilot Program

As noted in the April 2004 bulletin, the Division of Medicaid authorized the Medicare Crossover Pilot program for submission of crossover claims on the standard billing form, CMS-1500. The Medicare EOMB is still required when submitting crossover claims for processing; however, providers are required to circle the applicable beneficiary information on the EOMB. Providers are encouraged not to highlight the information on the EOMB; this will cause the image to darken when scanned and makes it unreadable to the keyers.

As a result of eliminating the Crossover Form, providers are required to submit only one claim per EOMB. Failure to submit one claim per EOMB will result in all claims being returned to the provider.

ACS is currently working on the implementation of the Medicare A Crossover Program. Providers are encouraged to watch the Medicaid monthly bulletins for articles relating to the Medicare A crossover pilot implementation process.

If you have questions regarding the Crossover Pilot Program, please contact ACS Customer Service at 1-800-884-3222.

Envision System Certification

The Division of Medicaid and ACS State Healthcare are pleased to announce that the Envision Claims Processing System has been certified by the Centers for Medicare and Medicaid Services retroactive to October 6, 2003. Certification of the Envision Claims Processing System means that Envision is compliant with all federal laws guiding the operation of the Medicaid Management Information System and is compliant with the Health Insurance Portability and Accountability Act.

Reminders for Billing DME and Medical Supplies – DME Providers

These are some helpful tips for DME providers when billing DME and medical supplies:

- Use procedure codes that are valid for the date the service was provided. For dates prior to October 1, 2003, use the local or HCPCS code that was valid on the date the service was provided. For services provided on October 1, 2003, or after, use only national valid HCPCS codes – local codes are not allowed.

- Use the national valid modifiers for all claims processed on and after October 1, 2003. The local modifiers (1-7) are NOT accepted any longer. The national valid modifiers are as follows:
  -RR Monthly rental
  -KR Daily rental
  -NU New purchase
  -RP Repair
  -MS Monthly ventilator maintenance (beneficiary owned)
  -UE Used purchase
  -SC Medical supply

- Use E1399 only when there is no national valid HCPCS code that accurately describes the item. If there is a specific HCPCS code for the item, but it is currently closed on the DME fee schedule, the provider may not use E1399. If the item is covered by Medicaid policy, DOM will consider opening the code.

- HCPCS code changes will be added to the MS Medicaid Envision MMIS as they are issued by CMS. New codes will be added, deleted codes will be deleted, and description changes will be made in accordance with CMS directives.

- Codes will NOT be automatically crosswalked by DOM or HSM when code changes are made. If a HCPCS code is deleted by CMS, providers will have to request a new TAN with a different appropriate code to continue to provide that item.

- Providers will have to determine which HCPCS code is appropriate for the item being supplied. Neither DOM nor HSM can make that determination for the provider.

- Medicare should ALWAYS be billed as the primary payer for DME and medical supplies when a beneficiary has both Medicare and Medicaid. The only exceptions to this are for these items only for dually eligible beneficiaries: bath benches; diapers for beneficiaries under age 21; insulin syringes; diabetic urine test strips or tablets; alcohol prep pads; and asthma spacers (Medicaid Provider Policy Manual, Section 10.04).

All Nursing Facilities, Psychiatric Residential Treatment Facilities, and Intermediate Care Facilities for the Mentally Retarded

During the 2004 session, the Mississippi Legislature mandated (HB1434) the Division of Medicaid to increase licensed bed assessment from $4 per bed per day to $6 per bed per day. This change will become effective with the July 2004 billing statement. If you have questions, please contact Ms. Bertha Logan at (601) 359-6115.

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

WINASAP2003 v 5.03 Corrections and Enhancements

The latest version of WINASAP (the free software provided by the ACS EDI Gateway to submit X12 claims to Mississippi Medicaid) was made available on July 16, 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.

WINASAP2003 v.5.03 includes the following corrections and enhancements:

- Apostrophes are now allowed in fields indicated throughout the software.
- The issue regarding converting a blank data element to a date and receiving an error is fixed.
- Code was implemented to password protect database backup files.
- Code was implemented to allow users to edit the Provider and Patient ID's minimum length, maximum length, and mask in the Payer Table.
- Software allows user to choose destination of installation.
- Encounter message added. User has the option to turn message off by checking "Please do not show this message again" box and selecting either "yes" or "no."

If you encounter any problems or have questions, please contact the EDI Support Unit at 1-866-225-2502.

Information on Legislative Changes

The Division of Medicaid and ACS State Healthcare have received many inquiries from providers regarding legislative changes. Specific information regarding these changes can be found at the following links:

www.governorbarbour.com/MedicaidForums.htm

www.governorbarbour.com/MFA.htm

www.governorbarbour.com/Drugs.htm

www.governorbarbour.com/PAP.htm

These website links and additional information can be found on the governor's website at:

www.governorbarbour.com.

Ambulatory Surgical Center Facility Rates Effective July 1, 2004

CMS has issued a directive regarding changes in the Ambulatory Surgical Center (ASC) Facility Rates resulting from the December 8, 2003, enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The Mississippi State Plan directs the Division of Medicaid ASC rates to be 80% of the current Medicare rates. Below are the rate changes effective July 1, 2004.

	New Rate
Group 1	$ 251.70
Group 2	$ 337.12
Group 3	$ 385.50
Group 4	$ 476.20
Group 5	$ 541.96
Group 6	$ 630.98
Group 7	$ 752.10
Group 8	$ 742.09
Group 9	$ 1012.12

Adjusting and Voiding Claims

Field 2e (line number) of the Adjustment/Void Form is for submitting adjustments only. This field is not required when voiding a claim.

Please note that single lines of a claim cannot be voided, only adjusted. Any void request for a paid claim will void the entire claim.

Checking Eligibility

Eligibility may also 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.

Billing Tip

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

Notice to all Providers Regarding Changes to the Pharmacy Program

Some changes will be occurring in the Pharmacy program as a result of recent legislation. For example, all Medicaid beneficiaries who are not in a nursing home or institution will be limited to four brand-name drugs per month. Generic drugs are exempt from this limit. In addition, the use of a Preferred Drug List will be required. Program details are being developed. Therefore, please note that these changes did **not** take place July 1, 2004. We will provide more details with implementation dates as they are established. Please watch the DOM website, bulletins and RA banners for further details.

Maximum Quantity Limits

Effective July 1, 2004, the total maximum quantity dispensed per prescription for drugs with the potential of abuse, misuse or diversion were limited to the maximum daily dose recommended by the manufacturer. Drugs included, but not limited to the following:

- Acetaminophen/Hydrocodone combinations
- Benzodiazepines
- Carisoprodol
- Hypnotics
- Stimulants
- Tramadol

This listing may be accessed on Medicaid's website at www.dom.state.ms.us. Link Pharmacy Services and click on "Products With Quantity Limits."

Risperdal Consta

Risperdal Consta is a drug that is not covered through the pharmacy point-of-sale system. This injectable product is to be administered in clinics or physician's offices, and such injectables are to be billed by the clinic or physician's office. If a pharmacist is requested to supply Risperdal Consta for a Medicaid beneficiary, please consult with the Division of Medicaid's Bureau of Pharmacy as there are specific situations in which assistance can be provided.

Claritin

Claritin prescriptions must be billed with the correct NDC number. Legend Claritin products are no longer available from most wholesalers. Claritin OTC NDC numbers must be used when submitting prescription claims after all stock of the legend product has been exhausted. The Division of Medicaid is monitoring claims and invoices for Claritin and may request verification of claims billed using legend NDC numbers.

Medicaid Counterfeit-Proof Prescription Blank Program

New legislation requires the Division of Medicaid to develop and implement a program that requires practitioners who prescribe drugs to use counterfeit-proof prescription blanks when writing prescriptions for controlled substances to Medicaid beneficiaries. The counterfeit-proof prescription blanks cannot be erased, altered, or fraudulently reproduced. Medicaid will reimburse only hard copy prescriptions written on counterfeit-proof prescription blanks. Prescriptions sent via facsimile or telephones are exempt.

After October 1, 2004, hard copy prescription orders on traditional blanks will no longer be reimbursed. The following Questions and Answers have been developed to help providers understand the program.

Medicaid Counterfeit-Proof Prescription Blank Program Questions and Answers

Question: What is a counterfeit-proof prescription blank and what are the features?

Answer: This type of hard copy prescription blank includes features that resist duplication and changes.

Question: Are all prescription orders under the new program required to be written as a hard copy?

Answer: No. Prescription orders that are written via hard copy must be written on the counterfeit-proof prescription blank. Prescriptions presented by other modes of transmission, e.g., facsimile, electronic, telephone, transfers, are exempt from this requirement.

Question: Does a prescription order written on a counterfeit-proof prescription blank automatically make the prescription order compliant or valid?
Answer: No. As with all prescription orders, the pharmacist should exercise professional judgment and take appropriate measures necessary to ensure the validity of any prescription received. As always, the pharmacist should comply with laws and regulations when dispensing.

Question: Can anyone produce the counterfeit-proof prescription blanks for the program?
Answer: Yes.

Question: Is there a required uniform layout, format, or style used by vendors when producing the blanks?
Answer: No. A uniform layout, format, or style is not required. Prescribers may choose to customize the layout and may use the blank for non-Medicaid patients.

Question: Who is required to use the counterfeit-proof prescription blank?
Answer: Licensed medical practitioners who write prescriptions for Medicaid beneficiaries for controlled substances that are covered under the Mississippi Medicaid Prescription Drug Program. Prescriptions presented via fax, electronic or telephones are not affected.

Questions: Who is responsible for obtaining the counterfeit-proof prescription blanks?
Answer: Licensed medical practitioners who prescribe for Medicaid beneficiaries are responsible for ordering the blanks.

Question: Is it a requirement to comply with the counterfeit-proof prescription program?
Answer: Yes. Medical practitioners and pharmacists are required to comply with Mississippi statutes and laws. Pharmacy providers may accept hard copy prescription orders on traditional blanks through September 30, 2004. The intent of this program is to reduce forged and altered prescriptions and to deter drug abuse. It is not the intent of the program to substantially inconvenience a person seeking to have a valid prescription filled. Beginning October 1, 2004, any pharmacist receiving a hard copy prescription for a Medicaid beneficiary not written on a counterfeit-proof prescription blank must, for compliance purposes, verify the prescription order with the prescriber or facility and record on the original prescription the person contacted and the date verified. If a prescriber continues to use non counterfeit-proof blanks, the pharmacist should report the prescriber to the Bureau of Pharmacy Services at (601) 359-5253.

Question: Does the new requirement apply to prescription refills which were authorized prior to October 1, 2004?
Answer: No.

Question: Who should I contact if I have other questions?
Answer: Contact the Bureau of Pharmacy Services at (601) 359-5253.

Provider Fee Schedules

The following fee schedules are available for download via DOM's internet website at http://www.dom.state.ms.us/:

- Ambulatory Surgical Centers
- Dental
- EPSDT Payment Schedule
- DME
- Hearing and Vision Services
- Hospice

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.

Policy Manual Additions/ Revisions

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

Section	Policy	Effective Date	New	New Section	Revised	Revised Sections
27.0	Nursing Services	08/01/04			X	27.03
51.0	Anesthesia	08/01/04			X	All

Resubmitting Claims

The Division of Medicaid and the fiscal agent, ACS State Healthcare, have identified many problems resulting from providers resubmitting claims repeatedly, sometimes daily, as a means of following up on claims on which processing has not been completed. The Division of Medicaid is directing that claims not be resubmitted as a means of following up on claims. Claims must be submitted only once. If providers need to check on the status of claims that are in process, they may use the web portal or contact the fiscal agent for a status report. If, upon completion of processing, the claim is rejected for a reason that justifies resubmission, then providers resubmit claims.

"Helpful Hints"

1. All hard copy claims should be submitted on red "drop out" CMS-1500 or UB-92 claim forms. Photocopied claims are not acceptable.
2. All claims should be coded appropriately. Consult your ICD-9 and CPT-4 manuals for code definitions.
3. All place of service codes should be two digits. See September 2003 bulletin for the one to two digit place of service crosswalk.
4. If Medicare is the primary payor, timely filing guidelines state that providers have 180 days from Medicare's payment date to file the claim with Medicaid.
5. Remember to utilize the AVRS and web portal for eligibility inquiries!

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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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

August

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Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2 CHECKWRITE	3	4	5 EDI Cut Off 5:00 p.m.	6	7
8	9 CHECKWRITE	10	11	12 EDI Cut Off 5:00 p.m.	13	14
15	16 CHECKWRITE	17	18	19 EDI Cut Off 5:00 p.m.	20	21
22	23 CHECKWRITE	24	25	26 EDI Cut Off 5:00 p.m.	27	28
29	30 CHECKWRITE	31				

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