Mississippi Medicaid Bulletin

Volume 10, Issue 9

September 2004

Correspondence Mailing Address

Beginning October 1, 2004, all correspondence that is generated from ACS, except for your remittance advice (RA), will be sent to your address noted as "other". This correspondence includes claims returned to the provider, any written correspondence from the Provider Services Department, provider bulletins and any information sent from the Provider Enrollment Department. Your RA will continue to be mailed to the Remittance Advice mailing address. If there is no mail other address on your provider file, correspondence from ACS will be mailed to your service location address.

> *If you wish to change your correspondence mailing address, please complete a change of address form.*

If you wish to change your correspondence mailing address (mailing other address), please complete a change of address form and return it to:

ACS Provider Enrollment
PO Box 23078
Jackson, MS 39225

Change of Address forms are located on the MS Envision Web Portal publications page located at http://msmedicaid.acs-inc.com.

Quality Assurance Calls

The Quality Management Department of ACS State Healthcare is conducting random customer service satisfaction surveys with the Medicaid provider community. These surveys are conducted monthly via telephone. Currently, the emphasis of these surveys is related to the quality of service provided by the ACS Provider and Beneficiary Services Call Center and Provider Field Representatives. If you receive one of these calls, please provide the individual conducting the survey with as much feedback as possible. Your feedback is extremely important to us as we strive to provide the best customer service that we can!

Mississippi Medicaid Disease Management
Recognizing One Year of Quality Health Care

April 15, 2004, marked one year of the Mississippi Medicaid Disease Management program which helps Medicaid beneficiaries with asthma, diabetes, and hypertension manage their condition according to nationally recognized evidence-based guidelines. The purpose of the program is to prevent or delay complications of these chronic diseases and to reduce health care cost.

Mississippi Division of Medicaid contracted with McKesson Health Solutions to provide comprehensive disease management services statewide in Mississippi. McKesson and their partners, Specialty Disease Management Inc., Health Alliance, University of Mississippi Medical Center, Jackson Medical Mall, Hinds County Health Alliance, and the Mississippi Primary Care Association are delivering these services to over 73,000 beneficiaries.

Beneficiaries participating in the program receive pertinent information regarding their illnesses via triage or face-to-face contact with field nurses. This program assists beneficiaries in finding a primary care provider and gives them tools to understand and manage their conditions. Not only is this program designed to assist beneficiaries, but it also assists providers by keeping them abreast of assessments made on beneficiaries. Beneficiaries enrolled in the Disease Management program will be educated on the various warning signs which may threaten their condition. With this approach and the availability of a 24-hour 7 day-a-week nurse call center, beneficiaries are able to determine when it is or is not necessary to seek emergency room care for the disease management covered chronic illnesses.
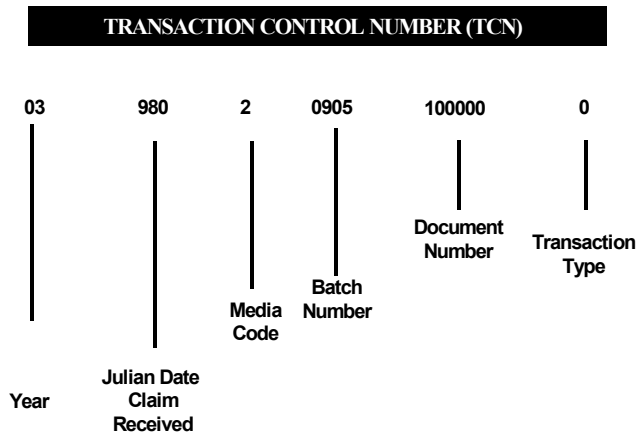
The Disease Management (DM) program is divided into two populations: DM Active and Nurseline. All beneficiaries enrolled in the program have access to the nurse help line and have the option to receive their medications and supplies from Health Alliance via home delivery. The Active Disease Management group receives educational materials in the mail related to their condition, receives periodic calls from a nurse for assessment and instruction, may receive nurse visits in their home, receives care coordination and referral to needed services as appropriate, and may have follow-up information sent to their physician if indicated.

Number of Enrollees Segmented By Group as of May 2004:

Program	Population
Asthma	30,417
Diabetes	9,719
Hypertension	5,082
DM Active Total	**45,218**
Nurseline	28,558
Total	**73,776**

Disease Management programs are widely recognized for their ability to optimize health care. Working with physicians and other health care providers, Disease Management organizations are able to ensure that individuals are knowledgeable of all available resources. The Disease Management program works with providers to provide beneficiaries the fundamentals needed to stabilize their conditions. The help of Mississippi providers is vital in making this program a success. Disease Management programs nationwide are setting the trend to transform health care as we know it.

If you want more information about this program, or have questions and comments, please call the Bureau of Medical Services at (601) 359-5683.

TRANSACTION CONTROL NUMBER (TCN)

03	980	2	0905	100000	0

Year | Julian Date Claim Received | Media Code | Batch Number | Document Number | Transaction Type

When claims come into ACS State Healthcare, they are assigned a transaction control number (TCN). Following is a breakdown of the TCN for your information. All of the numbers have meaning, but the most important to providers are as follows:

- Year - tells the last two digits of the year for which the claim was received
- Julian date - tells the month and day in Julian date format for when the claim was received
- Media code - tells the format of the claim. For example, was this claim a paper claim or electronic?

Media Codes

> 2=Electronic Crossover claim
> 3=Electronic Claims claim
> 4=System Generated claim
> 6=Special Batch claim
> 8=Paper claim
> 9=Paper claim with Attachment

- Transaction Type – tells the transaction type. For example, was this claim an original claim?

Transaction Type

> 7=Original
> 8=Void/Credit
> 9=Debit

Fall 2004 Medicaid Provider Workshops

The Division of Medicaid and ACS State Healthcare are in the process of planning provider workshops for Fall 2004. Once the workshops are scheduled, more specific information will be included on your remittance advice, banner messages, and the MS Envision Web Portal "Late-Breaking News" at http://msmedicaid.acs-inc.com. Please check future banner messages and the web portal for dates, times, and locations.

2004 Anesthesia Rate Update

The Division of Medicaid has updated the rates for anesthesia services according to the Mississippi State Plan based on the Centers for Medicare & Medicaid Services (CMS) revised rates and wage indices. The new rates that are effective for dates of service on and after July 1, 2004 are:

Base Rate $15.03
Time Unit $1.00

Maternity Anesthesia Codes

01961	$393.14
01967	$425.38
01968	$131.58
01969	$219.30

The current Anesthesia Base Units/Fee Schedule is now available on the Division of Medicaid website at www.dom.state.ms.us under the heading of Medicaid Fee Schedules.

Anesthesia Providers and Billing Groups

When billing anesthesia units for surgical procedures in field 24G of CMS-1500, enter time units only. Providers must not add base unit values or any additional modifying units to this field. (Reference Provider Manual Section 51.07 under Anesthesia—page 11 and Mississippi Medicaid Bulletin Sept. 2003—page 17). Some software programs being utilized for billing have been found to be automatically adding base unit values to the time units field when completing the billing form.

Hospital Leave in a Nursing Facility - Policy Manual Correction Notice

Section 36.10 of the Nursing Facility Manual states that hospital leave is limited to thirty (30) days per fiscal year. This change in the policy manual was unintentional and is incorrect. Please note that nursing facility residents are allowed fifteen days of hospital leave for each hospital stay. There is no maximum number of hospital leave days for nursing facility residents each year. Hospital leave applies to acute-care hospital stays in a licensed hospital, including geri-psychiatric units.

Injectable Drug Reimbursement Fee Update

The Division of Medicaid has updated the reimbursement fees on the following HCPCS drug codes according to the Mississippi State Plan based on the Centers for Medicare & Medicaid Services (CMS) revised rates from the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) Drug Payment Limits Pricing Files. The new rates are listed below and are effective for dates of services on and after August 1, 2004.

J0835	75.06
J1335	21.24
J2280	9.30
J9395	81.57

The updated HCPCS Drug Fee Schedule is now available on the Division of Medicaid website at www.dom.state.ms.us under the heading of Medicaid Fee Schedules.

Intrauterine Contraceptive Devices

Currently, the Division of Medicaid covers intrauterine contraceptive devices on HCPCS codes J7300, J7302, and S4989.

> J7300   Intrauterine copper contraceptive
> J7302   Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
> S4989   Contraceptive intrauterine device (e.g., Progestacert IUD), including implants and supplies

Effective for dates of service on and after August 1, 2004, providers must submit a paper claim with an invoice which documents the cost of the item.   The Division of Medicaid has authorized the fiscal agent to allow cost plus 10% for each of the codes.

Physicians will be reimbursed at 100% of the allowable amount less the 5% reduction authorized in Miss. Code Ann. Section 43-13-117 (1972, as amended), and nurse practitioners will be reimbursed at 90% of the allowable amount less the 5% reduction. For Rural Health Clinics, Federally Qualified Health Centers, and Mississippi State Department of Health clinics, the cost of the IUD and the insertion is covered in the encounter rates.

Effective for dates of service on and after August 1, 2004, providers must submit a paper claim with an invoice which documents the cost of the item.

DME/Medical Supply Miscellaneous Codes

Currently, the Division of Medicaid only accepts HCPCS Code E1399 for DME items for which there is no specified code. Effective immediately, the unspecified codes are being expanded to those listed below. Providers must use the appropriate unspecified code rather than using E1399 for any unspecified item. All items billed under these codes must have prior authorization and will be manually priced.

Miscellaneous Codes		Age Range	Price	Units
A4421	Ostomy supply; miscellaneous	0-999	PA	9999
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code	0-999	PA	9999
A9999	Miscellaneous DME supply or accessory, not otherwise specified	0-999	PA	9999
B9998	NOC for enteral supplies	0-999	PA	9999
B9999	NOC for parenteral supplies	0-999	PA	9999
E1399	Durable medical equipment, miscellaneous	0-999	PA	1
L1499	Spinal orthosis, not otherwise specified	0-20	PA	1
L2999	Lower extremity orthosis, NOS	0-20	PA	2
L3999	Upper limb orthosis, NOS	0-20	PA	2
L5999	Lower extremity prosthesis, not otherwise specified	0-20	PA	2
L7499	Upper extremity prosthesis, NOS	0-20	PA	2
L8039	Breast prosthesis, NOS	0-20	PA	2
L8239	Gradient compression stocking, NOS	0-20	PA	2
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code	0-20	PA	1
S8189	Tracheostomy supply, not otherwise classified	0-999	PA	9999
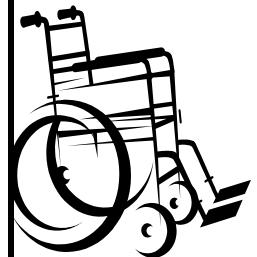
Unspecified or miscellaneous codes must be used for any items with no specific codes.

Check Medicaid Eligibility
on the Envision Web Portal

Access to the same beneficiary eligibility information that can be received from the AVRS or a Medicaid swipe card is available on the Envision Web Portal at no charge to the provider. This access is provided through the Envision Web Portal located at http://msmedicaid.acs-inc.com. To use the eligibility inquiry function the provider must first register his/her provider number with the secure section of the web portal. Registration is easy and only takes about five minutes.

Before you register, please make sure you have the following information available.

1. Your provider name.
2. The tax ID or social security number that is used to report income to the IRS.
3. Your provider number.
4. The last five digits of the bank account used for direct deposit with Medicaid.
   If you do not have an active direct deposit you cannot register.
5. Your EDI submitter ID and password are required if you intend to submit X12 files using the web portal. If you do not intend to submit X12 files using the web portal, this information is not required. If you do not have this information, contact ACS EDI Gateway Services by phone at (866) 225-2502 or online at http://acs-gcro.com .

IMPORTANT: The first person to register for a provider will be designated the master administrator for that provider number's web account. Only ACS can reset the master administrator's password. The master administrator must reset passwords for other registered users.

To register your provider number with the web portal, go to the Envision Web Portal located at http://msmedicaid. acs-inc.com and select "Web Account Registration" from the provider enrollment selections on the left side of the screen. This will bring you to the "Web Account Registration" page of the web portal. First, choose whether you will be registering an individual provider or a group/facility provider. Second, enter the provider name and tax-reporting ID. This ID is either the provider's SSN for individuals or the Employer Identification Number for group/facility providers. Third, enter your eight-digit Medicaid provider number. In the account number fields, enter the last five digits of your provider's bank account number. If you intend to use the EDI exchange features

of the web portal, enter your submitter ID and your EDI password. Once you have entered this information, click on "Submit" to continue the registration process.

This will bring you to the "Choose User ID" page. On this screen, the provider or representative will select their initial account setup information. Enter the master administrator's last name, first name and middle initial. Next, enter the e-mail address for the master administrator. When the registration process is complete, the web portal will send a temporary password to the e-mail account that is entered in this step. Then enter the phone number and/or extension where the master administrator can be reached. Finally, select a user ID that the master administrator will use when logging into the web portal. Write this user ID down. It will be needed at a later time. This user ID must be at least six characters, and it must be unique in the web portal. If the ID selected is not unique, an error message will appear when the submit button is clicked. Click "Submit".

Now you will be directed to a "registration complete" page. At this time the web portal will send a temporary password to the e-mail address provided at the time of registration. Click on "Log In" on the left side of the screen to be directed to the log in page. Here you will enter your user name that you selected at the time of registration and the password that was sent to your e-mail address by the web portal. Both the user name and password are case sensitive. Once the information has been entered, click on "Log In". This will bring you to a "change your password" screen where you must change your temporary password to a password that you select. Key in your temporary password for the old password, then key in the password that you selected in the new password and the confirm new password fields. Click "Submit'. Congratulations. You have successfully registered for the web portal.

If you experience any problems registering on the web portal, please contact your provider field representative.

Billing Influenza and Pneumonia Immunizations for Adults

The Division of Medicaid (DOM) is continuing efforts to educate Medicaid providers and beneficiaries on the benefits of receiving influenza and pneumonia immunizations prior to the influenza season. DOM encourages providers to assist in the effort to increase influenza and pneumonia protection in the state.

To receive maximum reimbursement for providing these services, physicians, nurse practitioners and physician assistants should bill for flu and pneumonia vaccines administered to beneficiaries age 19 and over as indicated below:

- For beneficiaries who come in for these immunizations only, the physician, nurse practitioners, and physician assistants may bill E&M procedure code 99211, the vaccine codes(s), and the appropriate CPT administration code. E&M procedure code 99211 will not count toward the12-office visit limit for beneficiaries.

- For beneficiaries who are seen by the physician, nurse practitioner, or physician assistant for evaluation or treatment and receive these immunizations, the provider may bill the appropriate E&M procedure code, the vaccine code(s), and the CPT administration code(s). The E&M procedure code billed in this instance will count toward the 12-office visit limit for beneficiaries.

- Providers must bill 90471 if one vaccine is administered and 90472 if a second vaccine is administered. CPT Codes 90471 and 90472 may be billed <u>only</u> with the administration of flu and pneumonia vaccines.

- Rural health clinic (RHC) and federally qualified health center (FQHC) providers will count the visit under current procedures. Providers will not count or bill visits when the only service involved is the administration of influenza or pneumonia vaccine.

Reimbursement rates effective July 1, 2004, for vaccines and administration for beneficiaries age 19 and older are as follows:

Influenza Vaccines		Pneumonia Vaccine		Administration Fee	
CPT Code	**Fee**	**CPT Code**	**Fee**	**CPT Code**	**Fee**
90656	$9.95	90732	$18.62	90471	$6.84
90658	$9.95			90472	$4.66
90660	$9.95				

<u>All immunizations for children age 18 and younger must be handled through the Vaccines for Children Program (VFC).</u>

- Mississippi Medicaid will reimburse physicians $9.95 for the FluMist influenza vaccine (CPT 90660) when given to beneficiaries ages 5 through 49. <u>There will be no separate administration fee paid for the FluMist vaccine</u>. Rural Health Clinics and Federally Qualified Health Centers will be reimbursed in accordance with the methodology applicable to their provider type.

Pharmacy Billing for Influenza and Pneumonia

In the Pharmacy program, influenza and pneumonia immunizations are covered services for Medicaid beneficiaries ages 19 to 64 who are not residents of long-term care facilities. As with other pharmacy services a hard copy prescription must be on file. Immunizations provided from a credentialed pharmacist will count against the service limit and co-payments are applicable. If a beneficiary has Medicare and Medicaid, Medicare is to be billed first.

These are the only vaccines/immunizations available via the Pharmacy program.

Counterfeit-proof Prescription Blank Program

The effective date for the Division of Medicaid's Counterfeit-proof Prescription Blank Program has been postponed. Information regarding the implementation of this program will be forthcoming at a later date.

Pharmacy Point of Sale - Cost Avoidance

Effective October 1, 2004, when beneficiaries are covered by both Medicaid and other third party insurance, pharmacy providers are required to bill prescription drug claims to private third party insurance carriers before billing Medicaid. All Medicaid policies and procedures such as prior authorization requirements and limits are still applicable.

MS Medicaid Electronic Billing Procedure for Cost Avoidance

   A.   Beneficiaries whose data on file with Medicaid indicates other third party coverage:

        1.   Pharmacy sends electronic claim to fiscal agent and it is rejected with NCPDP Reject Code "41" which will display the message, "Submit Bill to Other Processor or Primary Payer". The text of the rejection message (NCPDP Field # 504-F4) will also state the Third Party payer information including name, address and telephone number.

        2.   Pharmacy sends claim to Third Party Payer.

   a.   Third Party Payer _pays 100%_ of the Medicaid allowable charge--Claim must be resubmitted to Medicaid, but no payment will result.

   b.   Third Party Payer _pays less than 100%_ of the Medicaid allowable- Claim should be resubmitted to Medicaid.

        i.   **Enter the total amount paid by Third Party Payer in the "TPL Amount Paid" field (NCPDP Field # 431-DV -'Other Payer Amount Paid').**

        ii.   **Enter '02' in 'Other Coverage Code' Field** (#308-C8- Other Coverage Exists- Payment Collected)

        iii.   Submit claim to Medicaid fiscal agent for the full usual and customary account

        iv.   Resulting payment will be Medicaid allowable minus TPL Amount Paid.

   c.   Third Party Payer sends back a _$0.00 Paid_ Amount* (Rejection or Denial)

            *Valid Values for 'Other Payer Reject Codes' (Field # 472-6E) received from other insurance are:

              40= Pharmacy Not Contracted with Plan on Date of Service

(Pharmacy - Continued from page 8)

> 65= Patient is Not Covered
> 67= Filled Before Coverage Effective
> 68= Filled After Coverage Expired
> 69= Filled After Coverage Terminated
> 70= Product/Service Not Covered
> 73= Refills are Not Covered
> 76= Plan Limitations Exceeded

  i. **Enter $0.00 in the TPL Amount Paid** Field 431-DV
  ii. In Field #**308-C8**,**Other Coverage Code**'one of the following applicable values **should** be entered:
   01= **No Other Coverage Exists** (Ex: Claim denies due to coverage expired)
   03= Other Coverage Exists-Claim Not Covered (Ex: Claim denies due to non-coverage of drug by insurance and drug is covered by Medicaid)
   04= **Other Coverage Exists**-Payment Not Collected

Examples:

> Beneficiary has insurance coverage (ex: 70-30) which requires the beneficiary to pay for the prescriptions then the insurance company would reimburse the beneficiary a certain percentage of the claim.

> Pharmacy submits claim to other payer. The beneficiary must meet a deductible before benefits pay for pharmacy claims. The other payer applies the claim to the beneficiary's deductible for the other insurance. The provider then submits the usual and customary charge to Medicaid.

> Other insurance company is a mail order only company.

> Other insurance requires prior authorization for claim submitted. The prior authorization process should be initiated by the provider. Should the access of the beneficiary's prescription be delayed due to this process, the pharmacy may submit the claim to Medicaid. Once the prior authorization is acquired, the claim **must** be reversed then coordinated with the insurance carrier.

   06= **Other Coverage Denied**- Not Participating Provider (Ex: Beneficiary has insurance coverage but the pharmacy and/or prescriber is out of the insurance company's network).
   07= **Other Coverage Exists**- Not in Effect on Date of Service

  iii. Submit claim to Medicaid fiscal agent.
  iv. Claim will pay Medicaid allowable.

B. Beneficiaries whose data on file indicates no other coverage but provider is aware of other insurance coverage.

1. Follow steps under "A 2" above.
2. Provider **must** report the beneficiary's other insurance to Medicaid Third Party Liability Bureau. Notification form is provided in this bulletin. Fax 1-601-359-6632 (Please note facsimile is preferred) or telephone 1-601-359-6095.

Notes:

Pharmacy providers must maintain the explanation of benefits (EOB) from other insurance companies. These records must be available to Medicaid upon request.

Medicaid policy states "The provider should obtain a signed statement from the beneficiary which includes the name of the insurance company, the policy number, and the ending date of coverage." The signed statement should be forwarded to the Division of Medicaid Bureau of Third Party Recovery.

Remember, Medicaid is always the payer of last resort.

NOTIFICATION OF OTHER INSURANCE COVERAGE

Name of Medicaid
Beneficiary

_____

Date of Birth

_____

Medicaid ID

_____

Insurance Carrier
Name

_____

Telephone Number

_____

Policy Number

_____

Group Number

_____

Relationship to
Cardholder

_____

Cardholder's Name   _____

Pharmacy Name   _____

Pharmacy Phone   _____

Date   _____

FAX TO Division of Medicaid Third Party Liability: 1-601-359-6632

**Billing Bedhold for Inpatient Hospital Days
for Nursing Facility Residents (July 2004 Bulletin)- Further Clarification**

1. Nursing facility residents are allowed up to 15 days hospital leave for each hospital stay.
2. If the resident is transferred to the hospital as a Medicaid resident, the resident is not discharged from the Nursing Facility unless the hospital stay exceeds 15 days bedhold.
3. If that resident returns as a skilled resident (Medicare-Part A), that resident must be discharged from the Nursing Facility for Medicaid billing. (1st Claim, Scenario #1) (2nd Claim, Scenario #2)
4. If that resident returns to the hospital while continuing as a skilled resident, that resident must be re-admitted as a Medicaid resident for the hospital stay, not to exceed 15 days bedhold. (2nd Claim Example)
5. If that resident returns to the Nursing Facility as a Medicaid resident, that resident is re-admitted to the nursing facility for Medicaid billing. (2nd Claim, Scenario #1)
5A. If that resident returns to the Nursing Facility as a <u>Medicare</u> resident, that resident is re-admitted to the nursing facility as a skilled resident (Medicare-Part A).
(2nd Claim, Scenario #2)

Scenario #1

*   Patient admitted to NF on 01/01/04
*   7/1/04 - patient in NF (1st Claim)
*   7/2/04 - 7/9/04 - patient was in hospital (Item #2 above) (1st Claim)
*   7/9/04 - 7/15/04 - patient returned to NF in a Medicare paid bed (2nd Claim)
  <u>(Bill Medicare. If appropriate, claim will electronically crossover to Medicaid)</u> (Item #3 above)
*   7/15/04 - 7/20/04 - patient returned to hospital. (The resident is re-admitted to the nursing facility as a Medicaid resident) (Item #4 above) (2nd Claim)
*   7/20/04 - 7/31/04 - patient returned to NF in Medicaid bed. (Item #5 above) (2nd Claim)

1st claim is as follows:
*   Use bill type 894 and patient status code 03
*   7/1/04 revenue code 101   1 unit
*   7/2/04 - 7/9/04 revenue code 181 7 units

2nd claim for Scenario #1 is as follows:
*   Use bill type 892 and patient status code 30
*   7/20/04 - 7/31/04 revenue code 101 12 units
*   7/15/04 – 7/20/04 revenue code 181   5 units

Scenario #2

*   Patient admitted to NF on 01/01/04
*   7/1/04 - patient in NF (1st Claim)
*   7/2/04 - 7/9/04 - patient was in hospital (Item #2 above) (1st Claim)
*   7/9/04 - 7/15/04 - patient returned to NF in a Medicare paid bed (2nd Claim)
  <u>(Bill Medicare. If appropriate, claim will electronically crossover to Medicaid)</u> (Item #3 above)
*   7/15/04 - 7/20/04 - patient returned to hospital. (The resident is re-admitted to the nursing facility as a Medicaid resident) (Item #4 above) (2nd Claim)
*   7/20/04 - 7/31/04 - patient returned to NF in Medicare bed. (Item #5A above) (2nd Claim)
  <u>(Bill Medicare. If appropriate, claim will electronically crossover to Medicaid)</u> (Item #3 above)

1st claim is as follows:
*   Use bill type 894 and patient status code 03
*   7/1/04 revenue code 101   1 unit
*   7/2/04 - 7/9/04 revenue code 181 7 units

2nd claim for Scenario #2:
*   Use bill type 891 and patient status code 03
*   7/15/04 - 7/20/04 revenue code 181   5 units

1st Claim Scenario 1

2		3 PATIENT CONTROL NO.	4 TYPE OF BILL
			894

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM — THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	7-1-04 7-9-04	8				

12 PATIENT NAME   13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.
			1-1-04					03	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
101				1			1
181				7			2
001					$xxx xx		3

2nd Claim Scenario 1

2		3 PATIENT CONTROL NO.	4 TYPE OF BILL
			892

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM — THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	7-15-04 7-31-04	17				

12 PATIENT NAME   13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.
			7-15-04					30	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
101				12			1
181				5			2
001					$xxx xx		3

Claim 1 Scenario 2

2		3 PATIENT CONTROL NO.	4 TYPE OF BILL
			894

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	7-1-04 7-9-04	8				

14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.
			1-1-04					03	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
101				1			
181				7			
001					$xxx xx		

Claim 2 Scenario 2

2		3 PATIENT CONTROL NO.	4 TYPE OF BILL
			891

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	7/15/04 7/20/04	5				

14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION 18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.
			7-15-04					03	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
181				5			
001					$xxx xx		

Provider Re-Enrollment Ending

The Division of Medicaid and ACS have completed the review of all provider re-enrollment applications and mailed letters to providers that had did not have a re-enrollment application on file. If you received a letter, in order to continue your participation as a Mississippi Medicaid provider, you will need to submit a re-enrollment application to ACS by September 15, 2004. If you did not receive a letter regarding re-enrollment, your re-enrollment application should have been received.

Re-enrollment may be done in one of the following ways:
- Online re-enrollment though the web portal at http://msmedicaid.acs-inc.com
- Download an application from the web portal at http://msmedicaid.acs-inc.com
- If you submitted a re-enrollment application that has been lost or misplaced and you kept a copy, you can send a copy of all pages except pages which require a signature. For the signature pages, an original signature is required. You can copy the signature pages and sign again in blue or other color ink so that it is clear these are original signatures. Another option is to print the pages from the web portal, sign and send original signature pages.

Your re-enrollment application should be sent to ACS at the following address:

> ACS
> Provider Enrollment
> P. O. Box 23080
> Jackson, MS 39255

Your re-enrollment application must be received by September 15, 2004, or your provider number will be closed effective September 30, 2004.

If you submitted your re-enrollment application and ACS has no record of it, we apologize for this. During this re-enrollment period, which began in March 2003, we have handled over 10,000 re-enrollment applications as well as several thousand initial applications.

The cooperation of all providers who have participated in this re-enrollment process is greatly appreciated.

If you need additional information, please contact Provider Enrollment at ACS at 1-800-884-3222 or 601-206-3000.

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.

Instructions for Billing Claims with TPL in WINASAP2003

Following are the instructions for billing claims with third party liability insurance using WINASAP2003. The first set of instructions is for institutional providers. The second set of instructions is for professional providers. Instructions for dental providers are forthcoming and will be in a later bulletin and placed on the MS Envision Web Portal Late-Breaking News at http://msmedicaid.acs-inc.com when they are available.

Submitting TPL Claim Information for Institutional Claims

Notes:
1. Providers who use WINASAP2003 exclusively for adjusting, voiding, and submitting TPL claims, must create the following databases found within the "Reference" menu before proceeding with claims entry: Provider, patient, procedure, diagnosis, revenue code, occurrence code, ICD-9 surgical code, and value codes.
2. Click on the "Insured's Data" tab from the "Patient Data" screen and change the "Payer Responsibility Sequence Code" for Medicaid to "Secondary" when submitting TPL claims.

The procedures for submitting TPL claim information for institutional claims using WINASAP2003 are as follows:

1. From the Claims menu, select "Institutional" claim form
2. The "Institutional Claim List" window will be displayed
3. Click <Add> button located at the bottom of the screen
4. On the "Claims Data" tab, complete the appropriate fields and click the <Next Page> button
5. The "Claims Code" tab will be displayed and complete the appropriate fields with applicable information.
6. Click on the <Other Subscriber Info> button
7. The "Other Subscriber Page 1" will be displayed.
8. Select the appropriate patient relationship to insured.
9. Select the appropriate "Entity Type".
10. Enter the name of the policyholder.
11. Enter the home address of the insured.
12. For the "Insured's primary ID type", select "Member Identification Number".
13. In the "Insured's Primary ID" field, enter the insured's primary ID number.
14. Click on "Other Subscriber Page 2" tab
15. Enter "Group or Policy #" for the insured
16. In the "Group or Plan Name" field, enter the employer's name.
17. For the "Claim Filing Indicator" field, select the appropriate insurance entity. If the insurance carrier is not listed select one that is applicable.
18. In the "Release of Information Code" field, select applicable response.
19. Place a check mark in the box next to "Assignment of Benefits Indicator"
20. Click on the <COB Amounts> button

(TPL instructions continued from page 15)

21. In the "Other Payer Patient Paid Amount" field, enter the amount paid by TPL and click the <OK> button.
22. Under the "Other Payer Information" section, the following fields must be completed:
    - Payer Name: enter name of insurance carrier
    - Payer Responsibility Sequence Code: select "primary"
    - Payer Primary ID Type: select "Payor Identification"
    - Payer Primary ID: enter the ID number for the insurance carrier
    - Payer Address fields: enter all applicable address information for the insurance carrier
    - Claim Adjudication Date: enter the TPL paid date

23. Click the <OK> button
24. Proceed to the "Claim Line Items" tab and enter all applicable claim specific information.
25. Click <Save> button and enter the next claim or transmit the claim if all claim entries are complete.

Submitting TPL Claim Information for Professional Claims

Notes:
1. Providers who use WINASAP2003 exclusively for adjusting, voiding, and submitting TPL claims, must create the following databases found within the "Reference" menu before proceeding with claims entry: provider, patient, procedure, diagnosis.
2. Click on the "Insured's Data" tab from the "Patient Data" screen and change the "Payer Responsibility Sequence Code" for Medicaid to "Secondary" when submitting TPL claims.

The procedures for submitting TPL claim information for professional claims using WINASAP2003 are as follows:

1. From the Claims menu, select "Professional" claim form
2. The "Professional Claim List" window will be displayed
3. Click <Add> button located at the bottom of the screen
4. On the "Claims Data" tab, complete the appropriate fields and click the <Next Page> button.
5. The "Claims Code" tab will be displayed and complete the appropriate fields with applicable information.
6. Click on the <Next Page> button at the bottom of the screen.
7. The "Claims Information" tab will display. Click on the <Other Subscriber Info> button.
8. The "Other Subscriber Page 1" will be displayed.
9. Select the appropriate patient relationship to insured.
10. Select the appropriate "Entity Type".
11. Enter the name of the policyholder.
12. Enter the home address of the insured.
13. For the "insured's primary ID type", select "Member Identification Number".
14. In the "Insured's Primary ID" field, enter the insured's primary ID number.
15. Click on "Other Subscriber Page 2" tab.

(TPL instructions continued from page 16)

16. Enter "Group or Policy #" for the insured.
17. In the "Group or Plan Name" field, enter the employer's name.
18. In the "Insurance Type Code" field, select the appropriate response.
19. For the "Claim Filing Indicator" field, select the appropriate insurance entity. If the insurance carrier is not listed, select one that is applicable.
20. In the "Release of Information Code" field, select applicable response.
21. Tab down to the "Patient Signature source Code" field and select the applicable response.
22. Place a check mark in the box next to "Assignment of Benefits Indicator."
23. Click on the <COB Amounts> button.
24. In the "Paid Amount" field, enter the amount paid by TPL and click the <OK> button.
25. Under the "Other Payer Information" section, the following fields must be completed:
     - Payer Name: enter name of insurance carrier
     - Payer Responsibility Sequence Code: select "primary"
     - Payer Primary ID Type: select "Payor Identification"
     - Payer Primary ID: enter the ID number for the insurance carrier
     - Claim Adjudication Date: enter the TPL paid date

26. Click the <OK> button.
27. Proceed to the "Claim Line Items" tab and enter all applicable claim specific information.
28. Click <Save> button and enter the next claim or transmit the claim if all claim entries are complete.

Elimination of 90-Day Grace Period for ICD-9, CPT, and HCPCS Code Sets

As a result of the Health Insurance Portability and Accountability Act (HIPAA), the 90-day grace period for the phase-in of updated codes sets has been eliminated. This means that providers must bill using the updated codes beginning on the effective date of the change. In the past, providers were allowed a 90-day grace period, beginning the effective date of the change where either the updated codes or discontinued codes could be billed.

ICD-9 code additions, changes, and deletions are released in September and become effective on October 1 of each year.

CPT and HCPCS Level II code additions, changes, and deletions are released in October and become effective January 1 of each year.

The Division of Medicaid encourages all providers to purchase updated coding books each year.

Billing tip: Be sure to keep your previous books as they may be needed when reconciling older claims.

Conversion to X12…the percentages are increasing
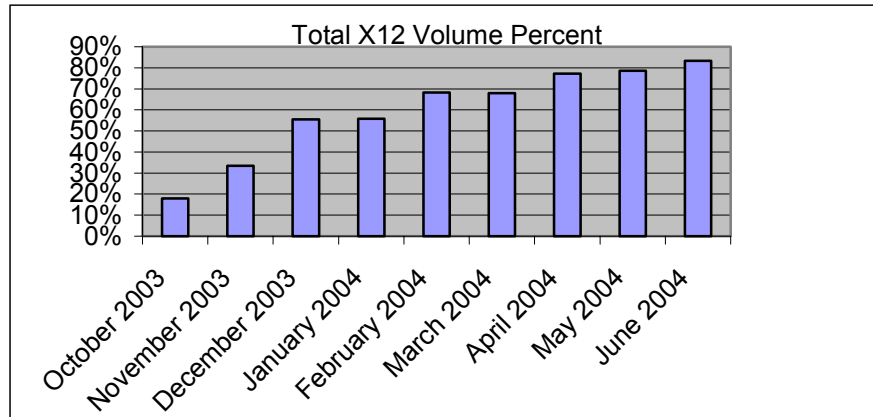
If you are one of the approximately 20% of users still sending claims in the old format, your time may be running out. Currently around 80% of the electronic submitters for Mississippi Medicaid are now sending claims in the ANSI X12N format. As this percentage increases, the Division of Medicaid will 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.
- ✓ Find out if they have been in contact with EDI to begin testing the new format.
- ✓ Provide your vendor with the following number for questions about testing:1-850-558-1630, 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.

Lab Procedure Code 83655

This is to clarify the appropriate billing of lab procedure code 83655 (lead analysis).

It is the policy of the Division of Medicaid to ONLY reimburse laboratories or facilitities that have and utilize an in-house analyzer for lead analysis. Discrepancies identified through the DOM auditing process will be recovered.

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	Revised	Revised Sections
10.0	DME: Specialized Feeders	09/01/04	X		
10.0	DME: Rehabilitative Self Help Items	09/01/04	X		
10.0	DME: Anti-Thumb Sucking Device	09/01/04	X		
10.0	DME: Anal Dilator	09/01/04	X		
10.0	DME: Enuresis/Incontinence Alarms and Sensors	09/01/04	X		

Paper Claim Submission

Providers are encouraged to ensure the information submitted is in the correct location when submitting paper claims. Failure to place the information in the correct location will potentially cause the incorrect capture of data. Examples: TPL amounts, timely filing TCNs, prior authorization and servicing provider numbers.

CMS-1500

- TPL (Block 29)
- Timely filing TCN (Block 22)
- Prior Authorization or TAN numbers (Block 23)
- Servicing provider numbers (Block 24K)

UB92s

- TPL (Block 54)
- Timely filing TCN or TAN numbers (Block 37)
- Prior authorization (Block 63)

Helpful Hint!!!!!!

For hard copy claims, please remember to submit your provider name in the same format that is represented in the Envision system.

Mississippi Medicaid Bulletin

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

September

September 2004

Sunday	**M**onday	**T**uesday	**W**ednesday	**T**hursday	**F**riday	**S**aturday
			1	2 **EDI Cut Off 5:00 p.m.**	3	4
5	6 DOM and ACS closed Labor Day	7	8	9 **EDI Cut Off 5:00 p.m.**	10	11
12	13	14	15	16 **EDI Cut Off 5:00 p.m.**	17	18
19	20	21	22	23 **EDI Cut Off 5:00 p.m.**	24	25
26	27	28	29	30 **EDI Cut Off 5:00 p.m.**		

(Checkwrite notations appear vertically across Tuesday column: Checkwrite Checkwrite Checkwrite Checkwrite Checkwrite 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.