Mississippi Medicaid Bulletin

Volume 10, Issue 12

December 2004

Points of Interest:

X12 Compliance	1
Dental and Eyeglass Services	1
Billing Tips for Providers	2
Adult Diapers	2
Billing Reminder for Rural Health Clinics	2
Where do I put my Medicare Number?	3
Miscellaneous J Codes	3
Notice to Nursing Facilities	4
Reenrollment Continues	4
Scheduling and Reimbursement for EPSDT Periodic Examinations	5
Influenza and Pneumonia Immunizations for Adults	6
Elimination of 90-Day Grace Period for ICD-9, CPT, and HCPCS Code Changes	7
Drug Reimbursement Fee Update	7
Policy Manual Additions/Revisions	7
Hospice Rates	8

X12 Compliance

The Mississippi Division of Medicaid is one of the first Medicaid programs nationwide to move to total x12n transactions.

Since the implementation of HIPAA legislation, states across the country have been working diligently to develop and execute plans for ANSI x12n transactions for electronically filed medical claims. The Centers for Medicare & Medicaid Services made the standard mandatory in 2003 but has allowed states to work under contingency plans until further notice.

Mississippi has been proactive by making it mandatory for all of its electronically filed claims to be x12n compliant by November 1, 2004. By taking this assertive approach, the Mississippi Division of Medicaid can proudly say that it's one of the first states in the nation to have all of its electronic claims filed as ANSI x12.

ACS EDI Gateway is the clearinghouse for MS electronic claims.

Dental and Eyeglass Services Not Covered for Pregnancy-Only Eligibles

Beneficiaries who are eligible for Medicaid only because of pregnancy, as specified in the Mississippi Medicaid State Plan, are covered only for those services that are related to:

- Pregnancy (including prenatal, delivery, postpartum, and family planning services); and
- Other conditions which may complicate pregnancy.

Dental and eyeglass services are **NOT** covered services for this category of eligibility. When verifying eligibility using the Automated Verification Response System (866-597-2675 or 601-206-3090), providers will be alerted if the beneficiary is not eligible to receive dental and eyeglass services. It is the responsibility of the provider to verify a beneficiary's eligibility each time the beneficiary appears for a service.

Billing Tips for Providers Participating in the Medicare Crossover Pilot Program

Providers who are participating in the Medicaid Crossover Pilot Program may submit Medicare B crossover services on the CMS1500.

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

Following are the guidelines for submitting Medicare Part B Crossover Claims on the CMS1500:

- Submit a legible copy of the CMS1500 claim form that was submitted to Medicare. If there is no copy of the Medicare claim or Medicare was billed electronically, please prepare a CMS1500 claim form according to Medicare guidelines.
- In field 1, enter Xs in the boxes labeled "Medicare" and Medicaid."
- Ensure that the beneficiary's nine-digit Medicaid number is in field 1a.
- Enter the eight-digit Medicaid provider number in field 33. If field 33 contains a group provider number, enter the eight-digit Medicaid treating provider number in field 24k.
- Circle the corresponding claim information on the Explanation of Medicare Benefits (EOMB). Attach the EOMB to the back of the claim.

NOTE: Only TPL (carriers other than Medicare and Medicaid) payments should be reported in locator 29 of the CMS1500. If the Medicare paid amount is placed in locator 29 (which is for TPL), it will result in a reduced/zero payment to the provider. Providers who are not participating in the CMS1500 Crossover Pilot Program should continue to submit using the state - specific crossover claim form.

Claims submitted as part of the Crossover Pilot Program should be addressed to:

ACS State Healthcare
ATTN: Crossover Pilot Program
P.O. Box 23076
Jackson, MS 39225

Providers may reference the April 2004 Medicaid Provider Bulletin for the complete article on the Medicare Crossover Pilot Program.

Adult Diapers

As stated in the Mississippi Medicaid Provider Policy Manual, Section 10.32, diapers are covered through the DME program only for beneficiaries ages 3 – 20 years old who meet the criteria outlined in the policy. The age ranges listed on the DME Fee Schedule on the Division of Medicaid web site do not supercede this policy. If the beneficiary is not age 3 – 20 and is not receiving services through the MR/DD Home and Community Based Waiver program or the Home Health program, diapers are not covered by Medicaid.

The MR/DD Home and Community Based Waiver program and the Home Health program have different policies related to age ranges. Providers are responsible for billing diapers according to the policies of the different program areas.

Billing Reminder for Rural Health Clinics

All services for the same beneficiary on the same date of service should be billed on the same claim. Any services filed on separate claim forms for same beneficiary and same date of service will not pay. For additional information, please reference Section 5.06 of the Rural Health Clinic Provider Manual.

Where do I put my Medicare Number?

Medicare issues provider numbers for every location where a Medicaid provider works. An individual Mississippi Medicaid provider can have only one Medicaid provider number that is used for all services locations. The individual Medicaid provider number must be linked to the group number of each service location. (This does not apply to institutions such as pharmacies, hospitals, nursing homes and other such institutions.)

When a provider is issued a Medicare number, it is the provider's responsibility to notify Medicaid. The Medicare number on which you bill must be linked to the Medicaid provider number to which you want the crossover claims paid. To link the Medicare–Medicaid numbers appropriately, the provider must furnish ACS Provider Enrollment with the Medicare number, the Medicaid provider number to which he/she wants this number linked, and the effective date of this linkage.

Help! My crossovers are paying to the wrong Medicaid number. What do I do?

Most electronic Medicare crossover payment problems relate to incorrect Medicare–Medicaid number linkage. When crossovers are not paying correctly, you first need to determine what Medicare number you are billing. The next step is to determine which Medicaid number should be receiving the payments. There are two ways to determine if the Medicare–Medicaid number linkage is incorrect:

1. The individual provider is receiving a remittance advice with crossover payments that should be made to the group.
2. Claims that should be crossing over from Medicare to Medicaid electronically are not appearing on any remittance advice, and they must be billed to Medicaid on paper.

If the provider numbers are linked incorrectly, the provider must write to ACS Provider Enrollment and give the correct Medicare provider number, the Medicaid number to which it should be linked, and the effective date of this linkage. The provider should also request that the Medicare number be removed from all other Medicaid provider numbers except the Medicaid provider number to which the provider wishes the Medicaid payments be made.

In addition, the individual provider or a group member that has been given signature authority must sign all requests for provider file maintenance. These requests can be faxed to ACS Provider Enrollment at 601-206-3015 or mailed to:

ACS State Healthcare
PO Box 23078
Jackson, MS 39225

ACS Provider Enrollment will then remove the Medicare number from the incorrect Medicaid number(s) and add the Medicare number to the correct Medicaid number. Once this has been completed, electronic crossovers should begin to pay systematically to the appropriate provider according to the request.

Miscellaneous J Codes

Effective November 1, 2004, the Division of Medicaid will accept additional HCPCS codes used for billing unclassified injectable drugs and biologicals. The following codes will be accepted:

J3490, Unclassified Drugs
J3590, Unclassified Biologics
J7599, Immunosuppressive Drug, NOC
J9999, NOC, Antineoplastic Drug

Providers must use the appropriate code for drugs that do not have a specific HCPCS code. Claims for unclassified drugs must be submitted on a paper claim with the name of the drug, strength, dosage and method of administration being indicated. Only one (1) unit can be billed with these codes. The claims will be reviewed by the fiscal agent's Medical Services Unit and priced according to the dosage administered to the patient.

Notice to Nursing Facilities

Innovative State Use of the Civil Money Penalty Funds
Incentives for High Quality Care
Enhancement Grant Award and Educational Program Grant Award

The deadline for submission of grant applications for FY 2005 is January 15, 2005. Application requirements are located on the Division of Medicaid website as follows: www.dom.state.ms.us. At the "select a link", choose Civil Money Penalty (CMP) Funds. A summary of each grant is provided below. If you have any questions, contact Evelyn Silas, Division Director, Institutional Long Term Care, at 601-359-6750.

Enhancement Grant Award: The goal is to provide grants for enhancements to nursing facilities that have maintained compliance with the federal requirements for long term care. The purpose of the Enhancement Grant Award is to provide a nursing facility with current and past compliance history of the federal requirements the opportunity to receive funding for innovative programs/projects that will directly and/or indirectly benefit the residents by providing an enhanced quality of life. The grant award should be self-sustaining once implemented. For FY 05, **$250,000** has been set aside to award grants in the range of $5000 -$50,000. The grant proposal application may be obtained on the Division of Medicaid website at www.dom.state.ms.us or by telephone request at 601-359-6750. Deadline for completion and receipt of application by DOM is ***January 15, 2005.*** The grants shall be awarded on or before ***April 1, 2005.***

Educational Program Grant Award: The goal is to assist nursing facilities that have not been in substantial compliance with federal requirements for long-term care facilities to obtain and maintain compliance. The purpose of the Educational Program Award is to provide a nursing facility with current and past noncompliance history of federal requirements the opportunity to receive funding for educational programs/projects that will directly and/or indirectly benefit the residents as well as assist the facility in providing an enhanced quality of life for the residents. This grant award is a one-time award that will benefit the residents. For FY 05, **$100,000** has been set aside to award grants in the range of $5000 - $20,000. The grant proposal application may be obtained on the Division of Medicaid website at www.dom.state.ms.us or by telephone request at 601-359-6750. Deadline for completion and receipt of application by DOM is ***January 15, 2005***. The grants shall be awarded on or before ***April 1, 2005.***

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

As a result of the Health Insurance Portability and Accountability Act (HIPAA), the 90-day grace period for the phase-in of updated code 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.

Scheduling and Reimbursement for EPSDT Periodic Examinations

The following is a clarification of the Division of Medicaid (DOM) policy regarding scheduling and reimbursement for EPSDT periodic examinations.

As soon as possible after the birthday month of the year in which the child is due for periodic rescreens, the EPSDT provider must notify the family member by letter or telephone informing of the appointment for the EPSDT health exam. For example: the child's birthday month is **April**. He/she will be two (2) years old and due for the periodic reassessment according to the periodic examination schedule. He/she should be scheduled for a screening appointment in **May or as soon thereafter as possible,** because the DOM eligibility system does not recognize the Medicaid eligible beneficiary as two years old until the first of the month following his/her birthday.

In order for the EPSDT provider to receive the DOM reimbursement for the EPSDT screening service, the provider must adhere to the above periodic examination scheduling policy and follow the periodicity schedule chart shown below.

EPSDT Periodic Examination Schedule

Screening Code				**Age of Child**	**Period Limits for Allowable Screening**	**Unit**
New Patient	**Rates**	**Established Patient**	**Rates**			
99381-EP	$80.78	99391-EP	$61.58	0 – 1 Months	0 – 45 days	1
99381-EP	$80.78	99391-EP	$61.58	2 Months	46 – 90 days	1
99381-EP	$80.78	99391-EP	$61.58	4 Months	91 -150 days	1
99381-EP	$80.78	99391-EP	$61.58	6 Months	151 – 240 days	1
99381-EP	$80.78	99391-EP	$61.58	9 Months	241 – 330 days	1
99382-EP	$87.40	99392-EP	$69.19	12 Months	331 – 400 days	1
99382-EP	$87.40	99392-EP	$69.19	15 Months	401 – 500 days	1
99382-EP	$87.40	99392-EP	$69.19	18 Months	501 – 731 days	1
99382-EP	$87.40	99392-EP	$69.19	2 – 4 years	Annually*	1
99383-EP	$85.74	99393-EP	$68.54	5 - 11 years	Annually*	1
99384-EP	$93.37	99394-EP	$76.15	12 – 17 years	Annually*	1
99385-EP	$93.37	99395-EP	$76.81	18 - 21 years	Annually*	1

Vision and Hearing*

Screening Code	Rates	EPSDT Description	Age of Child	Period Limitations	Unit
99173-EP	$8.82	Vision Screen	3 – 21 Years	Annually*	1
92551-EP	$8.82	Hearing Screen	3 – 21 Years	Annually*	1

Adolescent Counseling*

Screening Code	Rates	EPSDT Description	Age of Child	Period Limitations	Unit
99401-EP	$18.90	Adolescent Counseling	9 – 21 Years	Annually*	1

Vision, Hearing and Adolescent Counseling must be billed in conjunction with an EPSDT Comprehensive age appropriate screening.

EPSDT providers with questions should contact the EPSDT Division @ 1-800-421-2408 or 601-359-6150.

Helpful Hint………

****When setting up patient information in WINASAP2003, make sure to select "Self" for patient relationship to insured.

Influenza and Pneumonia Immunizations for Adults – Updated Fees

In accordance with changes in Medicare pricing for influenza and pneumonia vaccines, new fees are effective for dates of service beginning October 1, 2004, for beneficiaries age 19 and older as follows:

Influenza Vaccines		Pneumonia Vaccine		Administration Fee	
CPT Code	**Fee**	**CPT Code**	**Fee**	**CPT Code**	**Fee**
90656	$9.95	90732	$23.28	90471	$6.84
90658	$10.10			90472	$4.66
90660	$10.10				

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

- Effective for dates of service on and after October 1, 2004, Mississippi Medicaid will reimburse physicians $10.10 for the FluMist influenza vaccine when given to beneficiaries ages 5 through 49. There will be no separate administration fee paid for the FluMist vaccine. Rural health clinics (RHC) and federally qualified health centers (FQHC) will be reimbursed in accordance with the methodology applicable to their provider type.

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 the 12-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.

- Effective October 1, 2003, HCPCS Codes G0008 and G0009 are no longer valid for billing administration fees for flu and pneumonia vaccine to beneficiaries age 19 and over. For dates of service on and after October 1, 2003, 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 only with the administration of flu and pneumonia vaccines.

- RHC and 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.

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.

Provider Reenrollment Continues . . .

Reenrollment is almost complete, and we want to ensure that providers do not experience an interruption in services or payment. If you have not already reenrolled, it is imperative that you do so as quickly as possible. If you do not already have an application to complete, there are a couple of ways to obtain one. You can visit the web portal @ http://msmedicaid.acs-inc.com and follow the instructions for completing the application or downloading the application. You can also contact the ACS Call Center at 800-884-3222 or 601-206-3000 to request an application. Remember, if you choose to complete your application via the web portal, all required documentation must still be mailed to ACS at the following address:

ACS Provider Enrollment
P.O. Box 23078
Jackson, MS 39225

If you fail to reenroll by 12/31/04, your provider number will be closed. That means you will not be able to access the AVRS, web portal, or have eligibility questions answered by the ACS Call Center. We value you as a provider for Mississippi Medicaid and we want no provider left behind! Please take measures today to ensure you reenroll on time. If you have already reenrolled, we appreciate your cooperation and participation. If you have not reenrolled, we must receive your application soon.

Drug Reimbursement Fee Update

The Division of Medicaid has updated the reimbursement fees on the following HCPCS drug codes 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 October 1, 2004.

J1000	2.33
J9045	135.15
J9310	438.38

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

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 Sections	Revised	Revised Sections
25.0	Hospital Inpatient	12/01/04			X	25.18
19.0	Intermediate Care Facility/ Mentally Retarded	12/01/04			X	All
35.0	Swing Bed	01/01/05			X	35.03
55.0	Physician	01/01/05			X	55.05

Hospice Rates Effective October 1, 2004

The following hospice rates were effective October 1, 2004. These rates will be in effect until September 30, 2005. Please contact the Bureau of Reimbursement at (601) 359-6046 with any questions regarding these rates.

	Revenue Code	651	652	655	656
MSA #	MS Counties	Routine Home Care	Continuous Home Care	Inpatient Respite Care	General Inpatient Care
9925	All other	$107.79	$26.19	$120.53	$483.22
0920	Hancock Harrison Jackson	$118.98	$28.91	$130.11	$529.52
3560	Hinds Madison Rankin	$112.97	$27.45	$124.96	$504.65
3285	Forrest Lamar	$105.36	$25.60	$118.44	$473.15
4920	DeSoto	$118.80	$28.86	$129.96	$528.79

Submission of Adjustment/Void Request

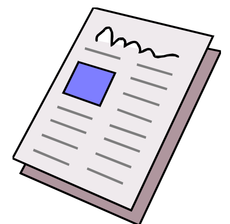
When submitting an Adjustment/Void request, complete boxes 1 through 6 on the Adjustment/Void request form for proper processing. If filing for an adjustment with or without a returned check to Medicaid, attach a corrected claim and any other appropriate documentation that will aid in properly processing your request.

Please mail Adjustment/Void request and appropriate documentation to:

Mississippi Medicaid Program
P.O. Box 23077
Jackson, Mississippi 39225

Acquiring Additional Bulletins

One copy of the monthly Medicaid Bulletin is sent to every provider with an active provider number. If additional copies are needed, the bulletins may be downloaded from the publications page of the web portal at the following address: **http://msmedicaid.acs-inc.com** or providers may call the ACS Provider and Beneficiary Services call center at 1-800-884-3222 to request additional copies.



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 **MA-1148**	**Addendum to Plan of Care** **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

ACS
P.O. Box 23078
Jackson, MS 39225

PRSRT STD
U.S. Postage Paid
Jackson, MS
Permit No. 53

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

December

December 2004

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

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.