Mississippi Medicaid Bulletin

Volume 11, Issue 1

January 2005

Points of Interest:

Cough and Cold Products

Prescription products used for the symptomatic relief of cough and cold are ***NOT*** covered by Medicaid in accordance with the Centers for Medicare and Medicaid (CMS) regulations. Prescription products containing antihistamines or antihistamine/decongestant combination products are covered.

However, the following over-the-counter (OTC) cough and cold products are covered: Delsym, Dimetapp DM*, Robitussin*, Robitussin AC*, Robitussin DAC* and Robitussin DM*. (*available generically.) A complete list of covered OTC items may be viewed at: http://www.dom.state.ms.us/OTCList02132004.pdf.

2005 New Bed Values for Nursing Facilities, ICF-MRs and PRTFs

The new bed values for 2005 for nursing facilities, intermediate care facilities for the mentally retarded (ICF-MRs) and psychiatric residential treatment facilities (PRTFs) have been determined by using the R.S. Means Construction Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

Facility Class	2005 New Bed Value
Nursing Facility	$36,617
ICF-MR	$43,940
PRTF	$43,940

Billing Tip

When billing voids or replacements in WINASAP2003, make sure to enter the TCN from the original claim in the appropriate box for your claim type.

Changes in Diaper Codes and Fees – DME Providers

For dates of service beginning January 1, 2005, CMS changed the HCPCS codes for diapers. Mississippi Medicaid has included these changes in Envision. The new codes and fees for diapers are as follows:

T4521-SC Adult sized disposable incontinence product, brief/diaper, small, each; maximum fee = $0.55
T4522-SC Adult sized disposable incontinence product, brief/diaper, medium, each; maximum fee = $0.65
T4523-SC Adult sized disposable incontinence product, brief/diaper, large, each; maximum fee = $0.95
T4524-SC Adult sized disposable incontinence product, brief/diaper, extra large, each; maximum fee = $0.95
T4529-SC Pediatric sized disposable incontinence product, brief/diaper, small/medium, each; maximum fee = $0.55
T4530-SC Pediatric sized disposable incontinence product, brief/diaper, large, each; maximum fee = $0.55
T4533-SC Youth sized disposable incontinence product, brief/diaper, each; maximum fee = $0.60

The HCPCS codes previously used for these items – A4521, A4522, A4523, A4524, A4529, A4530, and A4533 - were deleted by CMS and are not valid for dates of service after December 31, 2004. Providers with TANs that contain these deleted codes and extend past December 31, 2004, will need to obtain a new TAN using the new codes.

Remember that diapers provided to beneficiaries on the Home and Community-Based waiver for the Mentally Retarded/Developmentally Disabled should be billed with the new HCPCS codes and the –U3 modifier. The fees for these diapers may be different from those listed above.

The Medicaid policy on coverage for diapers has not changed. Providers are encouraged to review it on the DOM web site at www.dom.state.ms.us. 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. 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.

In addition to these changes, the fees for HCPCS codes A4523, A4524, A4529, and A4530 were reversed in error at the time of the Envision conversion in October 2003. These fees have now been corrected and all claims are being reprocessed to pay the correct amount.

Family Planning Program Reminder (published initially in July 2004 Provider Bulletin)

The Division of Medicaid Family Planning Demonstration Waiver Program **does not** cover oral contraceptives through the regular pharmacy program. (Participants in this program have a **YELLOW** Medical Identification Card.) Oral contraceptives are supplied to enrolled providers at no cost through the Mississippi State Department of Health (MSDH) Division of Family Planning. MSDH can be contacted at 601-576-7486. The Division of Medicaid does cover Depo- Provera and Lunelle injections, and Ortho Evra patches for participants in the Demonstration Waiver Program through the pharmacy program.

DME Suppliers
2005 HCPCS Code Update

The Division of Medicaid has updated Envision with the 2005 HCPCS Code changes according to HIPPA requirements. These changes include added codes, deleted codes, and description changes.

The following codes were deleted by CMS and are not valid for dates of service beginning January 1, 2005. Providers with TANS that extend past January 1, 2005, for these codes must request a new TAN using a valid HCPCS code from the 2005 list issued by CMS. Providers are encouraged to purchase a 2005 HCPCS code book for reference.

A4324	B4151	K0116	L0478
A4325	B4156	K0627	L0500
A4347	E0176	K0650	L0510
A4521	E0177	K0651	L0515
A4522	E0178	K0652	L0520
A4523	E0179	K0653	L0530
A4524	E0192	K0654	L0540
A4525	E0454	K0655	L0550
A4526	E0962	K0656	L0560
A4527	E0963	K0657	L0561
A4528	E0964	K0658	L0565
A4529	E0965	K0659	L0600
A4530	E1012	K0660	L0610
A4531	E1013	K0661	L0620
A4532	K0023	K0662	L2435
A4533	K0024	K0663	L5674
A4535	K0059	K0664	L5675
A4536	K0060	K0665	L5846
A4537	K0061	K0666	L5847
A4538	K0081	K0667	L5989
A4609	K0114	K0668	L8490
A4610	K0115	L0476	

Helpful Hints for Anesthesia Providers

1. Zero codes should be used to bill Anesthesia services after 10/01/2003.

2. Anesthesia units after 10/01/2003 are as follows: 1 unit = 1 minute.

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.

Durable Medical Equipment and Medical Supplies – Changes to Manually Priced Items

Effective February 1, 2005, the method used for pricing DME, medical supplies, prosthetics, and orthotics that either are billed with an unspecified code or do not have an assigned fee will change as follows:

- All items, including ostomy supplies, that have a current Medicare fee will be reimbursed according to the methodology established in the Medicaid State Plan: Medicare minus 20% for purchases; up to 50% of the Medicaid purchase price for repairs and used DME.
- Items that do not have a Medicare fee will be reimbursed at the MSRP for the item minus 20%.
- Items that do not have a Medicare fee or MSRP will be reimbursed at cost plus 20%. Cost includes shipping charges if the provider includes a line item for shipping on the invoice, pro-rated by item.

The Division of Medicaid will reimburse for shipping on manually priced items only, from the manufacturer to the supplier and from the supplier to the beneficiary. The provider is totally responsible for pro-rating shipping for bulk items. The provider must submit an itemization of the shipping charges. Shipping charges from the manufacturer to the supplier to the beneficiary cannot be combined.

When requesting manually priced items, the supplier must indicate the name of the product, the product number, and the name of the manufacturer. The provider must also:

- Submit an MSRP on official manufacturer's letterhead. If no MSRP is provided, reimbursement will be cost plus 20%.
- Attach a copy of the current manufacturer invoice indicating the cost to the supplier for the item dispensed.

A copy of the catalog page and/or manufacturer's quote indicating the cost to the supplier is not acceptable as an invoice. A manufacturer's quote on the manufacturer's letterhead may be acceptable. If the manufacturer's invoice is older than one (1) year, the provider must submit written justification for the use of the invoice.

Providers with TAN's that have been manually priced and have dates extending beyond February 1, 2005, will NOT need to obtain a new authorization number. For all manually priced items other than ostomy supplies, the claim will price at the manual price listed on the original TAN. For ostomy supplies that were manually priced and have a TAN that extends beyond February 1, 2005, the claim will pay the lesser of charges or the fee on file beginning with dates of service 2/1/05.

Policy Manual Additions/ Revisions

The following policies and policy sections have been added to and/or revised in 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
4.0	Provider Information	01/01/05	X	4.08	X	4.03
18.0	MH/Psychiatric Residential Treatment Facility	01/01/05			X	18.14
35.0	Swing Bed	01/01/05			X	35.03
55.0	Physician	01/01/05			X	55.05
36.0	Nursing Facility	02/01/05			X	36.02, 36.06, 36.08, 36.09, 36.10, 36.12, 36.18
10.0	Durable Medical Equipment	02/01/05			X	10.02, 10.03
53.0	General Medical	02/01/05			X	53.11

Crossover Processing

The Division of Medicaid and ACS continue to receive inquiries related to crossover claims processing. In researching the inquiries, several factors were identified as contributing to claims being returned to the provider, delays in claim processing, charges paying to the incorrect provider number, and submissions not reporting on the remittance advice.

To help ensure your crossover claims are processed in an accurate and timely manner, please adhere to the following guidelines.

- ✓ Crossover claims submitted via paper must include the appropriate eight-digit Medicaid provider number as well as the nine-digit Medicaid beneficiary number. For CMS1500 paper submissions, the beneficiary number must be reported in field locator 1a. The provider number must be reported in field locator 33. For UB92 paper submissions, the beneficiary number is reported in field locator 60. The provider number is reported in field locator 51 of the UB92.
- ✓ Crossover claims submitted electronically must include the appropriate eight-digit Medicaid provider number as well as the nine-digit Medicaid beneficiary number. The UB92 accommodates multiple payor submission in field locators 50 thru 66 lines A thru C. Providers should consult their respective software vendor for multi-payor reference for electronic submission of the CMS1500.
- ✓ The Medicaid provider file must reflect the appropriate Medicare number for cross-reference. As indicated on the Mississippi Medicaid Enrollment Application, Section 6, "Medicare crossover claims will not be paid unless a Medicare number is supplied. A Medicare number may only be placed on one provider file (group or individual). Crossover claims will pay to the provider number to which the Medicare number is linked."
- ✓ Claims submitted to Medicare in a UB92 format must be submitted to Medicaid via electronic crossover from the Medicare Intermediary or state specific crossover A claim form.
- ✓ Claims submitted to Medicare in a CMS1500 format must be submitted to Medicaid via electronic crossover from the Medicare Carrier, state specific crossover B claim form, or CMS1500 claim form.
- ✓ Paper crossover submissions must be accompanied by a legible copy of the Explanation of Medicare Benefits (EOMB). Circle the corresponding claim information on the EOMB.
- ✓ Do not highlight information on the Explanation of Medicare Benefits (EOMB) as this adversely affects image quality of scanned documents. Highlighted claims and/or attachments will be returned to the provider.

  Note: The Explanation of Medicare Benefits (EOMB) must be completely legible and copied in its entirety. The only acceptable alterations or entries on the EOMB are as follows.
  - The provider may line out patient data not applicable to the claim submitted.
  - The provider may line out any claim line that has been previously paid by Medicaid.
  - The provider may line out any claim line that has been paid in full by Medicare.
  - The provider may line out any claim line that is not to be billed to Medicaid.
  - If claim lines on the EOMB have been lined out, the claim total line of the EOMB must be re-calculated and modified to reflect the actual lines submitted.

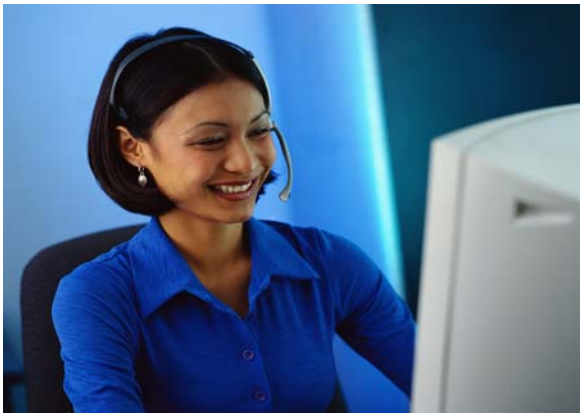
- ✓ Submit one claim per one Explanation of Medicare Benefits (EOMB) statement.
- ✓ Use of red drop-out forms is encouraged for providers submitting crossover claims via paper CMS1500 forms. Do not use red ink for claim data.
- ✓ Only TPL (carriers other than Medicare and Medicaid) payments should be reported in field locator 29 of the CMS1500 and field locator 54 of the UB92. Placing prior payments from Medicare and/or Medicaid in field locator 29 of the CMS1500 and field locator 54 of the UB92 will result in a reduced or zero payment.
- ✓ Medicaid policy requires crossover claims be submitted within 180-days of the Medicare paid date. Claims submitted in excess of 180-days from the Medicare paid date will be denied for timely filing.

Providers that require further clarification regarding the submission of crossover claims and/or Medicare linkage to active Medicaid provider numbers may contact ACS Customer Service at 1-800-884-3222.

Watch for articles related to the implementation of the Medicare A Crossover Pilot Program in future editions of the Mississippi Medicaid Provider Bulletin.

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

******Fun Fact:*** Did you know the ACS Provider Services call center takes an average of 3,000 calls per day?

Generic Mandate for Prescription Drugs

Pharmacy Manual, refer to Section: 31.11: Mississippi law requires that the provider shall not prescribe, the pharmacy shall not bill, and DOM shall not reimburse for a brand name drug if an equally effective generic equivalent is available and the generic equivalent is the least expensive. The only exceptions to this policy are:

· Observed allergy to a component of the generic drug; or
· An attributable adverse event; or
· Drugs generally accepted as narrow therapeutic index (NTI) drugs.

In the absence of a specific request for the brand name drug from the prescriber to the pharmacist, the pharmacist must follow standard practice guidelines for the State of Mississippi and fill the prescription with the generic equivalent. The prescriber must indicate the following on a written or faxed prescription:

· Brand name medically necessary **or**
· Dispense as written **or**
· Do not substitute.

Also, a prior authorization (PA) is required for any brand name multiple source drug that has a generic equivalent except NTI drugs. If a beneficiary requires a brand name multi-source drug, the prescriber must request a prior authorization **before dispensing** by seeking approval from DOM's Pharmacy Benefits Manager. The following medications are identified as NTI drugs:

· Coumadin®
· Dilantin®
· Lanoxin®
· Synthroid®
· Tegretol®

U.S. Department of Health and Human Services' FDA Safety Information and Adverse Event Reporting Program for prescriber use in reporting adverse reactions.

U.S. Department of Health and Human Services

MEDWATCH

The FDA Safety Information and Adverse Event Reporting Program

For VOLUNTARY reporting of adverse events and product problems

Page ____ of ____

Form Approved: OMB No. 0910-0230 Expires: 09/30/05
See OMB statement on reverse

FDA Use Only

Triage unit sequence #

PLEASE TYPE OR USE BLACK INK

A. Patient information

1. **Patient identifier** In confidence
2. **Age at time of event:** or **Date of birth:**
3. **Sex** ☐ female ☐ male
4. **Weight** ____ lbs or ____ kgs

B. Adverse event or product problem

1. ☐ **Adverse event** and/or ☐ **Product problem** (e.g., defects/malfunctions)
2. **Outcomes attributed to adverse event** (check all that apply)
   - ☐ death ____ (mo/day/yr)
   - ☐ life-threatening
   - ☐ hospitalization - initial or prolonged
   - ☐ disability
   - ☐ congenital anomaly
   - ☐ required intervention to prevent permanent impairment/damage
   - ☐ other: ____
3. **Date of event** (mo/day/yr)
4. **Date of this report** (mo/day/yr)
5. **Describe event or problem**
6. **Relevant tests/laboratory data**, including dates
7. **Other relevant history, including preexisting medical conditions** (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.)

C. Suspect medication(s)

1. **Name** (give labeled strength & mfr/labeler, if known) #1 / #2
2. **Dose, frequency & route used** #1 / #2
3. **Therapy dates** (if unknown, give duration) from/to (or best estimate) #1 / #2
4. **Diagnosis for use** (indication) #1 / #2
5. **Event abated after use stopped or dose reduced** #1 ☐ yes ☐ no ☐ doesn't apply / #2 ☐ yes ☐ no ☐ doesn't apply
6. **Lot #** (if known) #1 / #2
7. **Exp. date** (if known) #1 / #2
8. **Event reappeared after reintroduction** #1 ☐ yes ☐ no ☐ doesn't apply / #2 ☐ yes ☐ no ☐ doesn't apply
9. **NDC #** (for product problems only) - -
10. **Concomitant medical products** and therapy dates (exclude treatment of event)

D. Suspect medical device

1. **Brand name**
2. **Type of device**
3. **Manufacturer name & address**
4. **Operator of device** ☐ health professional ☐ lay user/patient ☐ other: ____
5. **Expiration date** (mo/day/yr)
6. model # ____ catalog # ____ serial # ____ lot # ____ other # ____
7. **If implanted, give date** (mo/day/yr)
8. **If explanted, give date** (mo/day/yr)
9. **Device available for evaluation?** (Do not send to FDA) ☐ yes ☐ no ☐ returned to manufacturer on ____ (mo/day/yr)
10. **Concomitant medical products** and *therapy* dates (exclude treatment of event)

E. Reporter (see confidentiality section on back)

1. **Name & address** **phone #**
2. **Health professional?** ☐ yes ☐ no
3. **Occupation**
4. **Also reported to** ☐ manufacturer ☐ user facility ☐ distributor
5. **If you do NOT want your identity disclosed to the manufacturer, place an " X " in this box.** ☐

Mail to: **MEDWATCH** 5600 Fishers Lane Rockville, MD 20852-9787 or FAX to: 1-800-FDA-0178

FDA Form 3500 (11/02)

Submission of a report does not constitute an admission that medical personnel or the product caused or contributed to the event.

ADVICE ABOUT VOLUNTARY REPORTING

Report adverse experiences with:

- medications (drugs or biologics)
- medical devices (including in-vitro diagnostics)
- special nutritional products (dietary supplements, medical foods, infant formulas)
- cosmetics
- medication errors

Report product problems – quality, performance or safety concerns such as:

- suspected contamination
- questionable stability
- defective components
- poor packaging or labeling
- therapeutic failures

Report SERIOUS adverse events. An event is serious when the patient outcome is:

- death
- life-threatening (real risk of dying)
- hospitalization (initial or prolonged)
- disability (significant, persistent or permanent)
- congenital anomaly
- required intervention to prevent permanent impairment or damage

Report even if:

- you're not certain the product caused the event
- you don't have all the details

How to report:

- just fill in the sections that apply to your report
- use section C for all products except medical devices
- attach additional blank pages if needed
- use a separate form for each patient
- report either to FDA or the manufacturer (or both)

Confidentiality: The patient's identity is held in strict confidence by FDA and protected to the fullest extent of the law. FDA will not disclose the reporter's identity in response to a request from the public, pursuant to the Freedom of Information Act. The reporter's identity, including the identity of a self-reporter, may be shared with the manufacturer unless requested otherwise.

If your report involves a serious adverse event with a device and it occurred in a facility outside a doctor's office, that facility may be legally required to report to FDA and/or the manufacturer. Please notify the person in that facility who would handle such reporting.

Important numbers:

- 1-800-FDA-0178 to FAX report
- 1-800-FDA-1088 to report by phone or for more information
- 1-800-822-7967 for a VAERS form for vaccines

To Report via the Internet:
https://www.accessdata.fda.gov/scripts/medwatch/

The public reporting burden for this collection of information has been estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to:

DHHS Reports Clearance Office
Paperwork Reduction Project (0910-0291)
Hubert H. Humphrey Building, Room 531-H
200 Independence Avenue, S.W.
Washington, DC 20201

Please DO NOT RETURN this form to this address.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service • Food and Drug Administration

FDA Form 3500-back **Please Use Address Provided Below – Just Fold In Thirds, Tape and Mail**

Department of Health and Human Services
Public Health Service
Food and Drug Administration
Rockville, MD 20857

Official Business
Penalty for Private Use $300

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES OR APO/FPO

BUSINESS REPLY MAIL
FIRST CLASS MAIL PERMIT NO. 946 ROCKVILLE, MD

POSTAGE WILL BE PAID BY FOOD AND DRUG ADMINISTRATION

MEDWATCH
The FDA Safety Information and Adverse Event Reporting Program
Food and Drug Administration
5600 Fishers Lane
Rockville, MD 20852-9787

Provider Quick Contact List

There are several resources designed to address your questions concerning Medicaid claims processing, billing, mailing, policy procedures and more. To effectively assist you with these needs, the following information will serve as a guide to contacting the proper resource.

Contact Name	Contact Address/Phone Number/Website (if applicable)
ACS Medicaid Web Portal	http://msmedicaid.acs-inc.com
ACS Provider and Beneficiary Services	P.O. Box 23078 Jackson, MS 39225 **1-800-884-3222 or 601-206-3000**
• **Claims**	P.O. Box 23078 Jackson, MS 39225
• **Adjustment/Void Requests**	P.O. Box 23077 Jackson, MS 39225
• **Financial Correspondence (Mail with Checks)**	P.O. Box 6014 Ridgeland, MS 39158-6014
Automated Voice Response System (AVRS)	**1-866-597-2675 or 601-206-3090**
ACS Prescription Benefits Services	ACS State Healthcare 385 B Highland Colony Pkwy, Suite 300 Ridgeland, MS 39157 **1-866-759-4108**
Health Information Designs (HID)- To obtain pharmacy prior authorization	**1-800-355-0486** **or** **601-709-0000**
Health Systems Mississippi (HSM) (Peer Review Organization – conducts certification reviews of some Medicaid services.)	**1-888-204-0221** **or** **601-352-6353**
ACS EDI – For assistance with transmission of electronic claims	www.acs-gcro.com **1-866-225-2502**
Division of Medicaid – • Third Party Liability • EPSDT Services	801 Robert E. Lee Bldg. 239 N. Lamar St. Jackson, MS 39201 **601-359-6050** www.dom.state.ms.us
Division of Medicaid – • Provider and Beneficiary Services	801 Robert E. Lee Bldg. 239 N. Lamar St. Jackson, MS 39201 **601-359-6133**

TOP TEN REASONS 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 (EOMB's, EOB's, TPL's)
7. Wrong Claim Type
8. Beneficiary ID Number Missing
9. Correction Fluid/Correction Tape
10. Highlighted Documents (Unable To Image)

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

ACS
P.O. Box 23078
Jackson, MS 39225

If you have any questions related to the topics in this bulletin, please contact ACS at 1-800 -884 -3222 or 601 -206 -3000

Mississippi Medicaid Manuals
are on the Web
www.dom.state.ms.us
and
Medicaid Bulletins are on the Web Portal
http://msmedicaid.acs-inc.com

January

January 2005

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

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.