Mississippi Medicaid Bulletin

Volume 11, Issue 2

February 2005

Points of Interest:

Where Are My Transmitted Claims?

While ACS hears this question frequently, the answer isn't the same for any two situations. Circumstances may be similar, but the outcomes vary for each unique situation.

If the claims were submitted via vendor software or WINASAP, ACS can use the file identification number or the trading partner identification number to resolve the issue. If claims are submitted through a clearinghouse, ACS requests that you contact your clearinghouse and obtain the file identification number.

Once we have identified the file containing the claims in question, we review the 997 for that file. We want to determine if the file rejected from EDI or if there was a reject that happened when the file transmitted to the fiscal agent. If the file rejected at EDI, a Business Analyst can explain the reason for the file rejecting and methods for correcting the error. If the file rejects at the MMIS level, the Provider Services team will provide assistance.

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

Extension of Crossover Pilot Program

Effective immediately, ACS will accept UB92 claim forms submitted with the Medicare Explanation of Benefits for crossover processing. The procedure is an extension of the Crossover Pilot Program currently underway for CMS-1500 crossover claims. Claims submitted as part of the Crossover Pilot Program should be addressed to:

ACS State Healthcare
Attn. Crossover Pilot Program
PO Box 23076
Jackson, MS 39225

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. If field locator 33 contains a group provider number, the servicing provider number must be provided in field locator 24K of the CMS1500. 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 information 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, state-specific crossover A claim form, or UB92 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 or UB92 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.
- ✓ Charges that are denied by Medicare must be billed as a separate submission on the appropriate claim form.

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.

Billing Medical Supplies for Beneficiaries Participating in Medicaid's Mentally Retarded/Developmentally Disabled HCBS Waiver

The following medical supplies are covered under the MR/DD waiver program.

Blue Pads: A4554
Adult Catheters: A4338, A4340, A4344 and A4346
Adult Diapers: ***A4521, *A4522, *A4523 and *A4524** for dates of service between October 1, 2003 and December 31, 2004.
Adult Diapers: **T4521, T4522, T4523 and T4524** for dates of service beginning January 1, 2005.

When billing these supplies for beneficiaries participating in the MR/DD waiver, a U3 modifier is required. The provider must be a DME provider.

If you have any question regarding billing for the Medicaid Home and Community-Based Waiver Services (HCBS), please contact the HCBS Division at 601-359-6141 or contact your provider representative.

Policy Manual Additions/ Revisions

The following policies and policy sections have been added 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
2.0	Benefits	02/01/05			X	2.03
10.0	Durable Medical Equipment	02/01/05			X	10.02, 10.03
36.0	Nursing Facility	02/01/05			X	36.02, 36.06, 36.08, 36.09, 36.10, 36.12, 36.18
53.0	General Medical	02/01/05	X	53.16 53.18	X	53.11
1.0	Introduction	03/01/05			X	1.11
6.0	Third Party Recovery	03/01/05			X	6.02
10.0	Durable Medical Equipment	03/01/05			X	10.32, 10.84, 10.91
31.0	Pharmacy	03/01/05			X	31.24

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.

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

February

February 2005

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