Mississippi Medicaid Bulletin

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Implantable Programmable Baclofen Drug Pump

Since July 1, 2001, the cost of implantable programmable baclofen drug pumps used to treat spasticity that are implanted in an inpatient hospital setting can be reimbursed outside the hospital Medicaid per diem rate. Hospitals must remove the cost of these pumps from the cost report filed with Medicaid. Reimbursement is limited to $10,000 per state fiscal year (July 1 – June 30) per Medicaid beneficiary.

In order to receive reimbursement for this pump in addition to the regular per diem, the hospital must:

- Submit a paper UB-92 inpatient hospital claim to the fiscal agent
- Bill the pump using revenue code 220 only, separate from all other charges
- Attach a written copy of the invoice to the claim that verifies the cost of the pump to the hospital

The Division of Medicaid will not reimburse for implantable programmable pumps for beneficiaries whose inpatient hospital days are not certified by the Quality Improvement Organization (QIO) or for beneficiaries age 21 and over who have used all their inpatient hospital days for the year.

Attention Pharmacy Providers

Diabetic and asthma supplies are covered under Medicaid's DME/Medical Supply program. Pharmacy providers wishing to dispense diabetic and asthma supplies must obtain a DME/Medical Supply provider number. Diabetic and asthma supplies cannot be billed through the Point of Sale (POS) System. DME and medical supplies are billed on the CMS-1500 either electronically or on paper.

Excluded and Sanctioned Providers

In order to meet Federal requirements regarding public notification of sanctioned Medicare/Medicaid providers, as provided in 42 CFR Section 1002.212, the Mississippi Division of Medicaid has posted on its website at www.dom.state.ms.us a list of providers that have been excluded from participation in the Medicaid programs.

The effect of an exclusion (not being able to participate) is:

- No payment will be made by any Federal health care program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees' Health Benefits Plan). For exclusions implemented prior to August 4, 1997, the exclusion covers the following Federal health care programs: Medicare (Title XVIII), Medicaid (Title XIX), Maternal and Child Health Services Block Grant (Title V), Block Grants to States for Social Services (Title XX) and State Children's Health Insurance (Title XXI) programs.

- No program payment will be made for anything that an excluded person furnishes, orders, or prescribes. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider where the excluded person provides services, and anyone else. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

- There is a limited exception to exclusions for the provision of certain emergency items or services not provided in a hospital emergency room. See regulations at 42 CFR 1001.1901(c).

Medicaid Card Abuse

Medicaid card abuse means the misuse or misappropriation of the Medicaid card and/or Medicaid identity. The Bureau of Program Integrity, within the Division of Medicaid, investigates reports of suspected card abuse. The most common form of misuse occurs when eligible beneficiaries "lend" their cards to persons not Medicaid eligible.

According to Section 3.05 of the Provider Policy Manual, "It is the responsibility of the provider to verify that a person presenting a Medicaid card for payment of services is the actual Medicaid beneficiary." If a provider suspects that someone other than the actual cardholder is using a Medicaid card, the provider should request a picture ID or some other form of positive identification. If another form of identification is not available, the provider should compare signatures with a signature on file or contact ACS at 1-800-884-3222 to obtain identifying information. The provider should also verify beneficiary eligibility at every visit prior to providing any service.

Providers should also notify local law enforcement authorities and the Division of Medicaid, Bureau of Program Integrity, if they have reason to believe that a person is misusing a Medicaid card. For example, a provider should suspect that there is misuse of a Medicaid card if the provider is familiar with the beneficiary and realizes that the person presenting the Medicaid card does not match the identifying information available through ACS.

An example of a case investigated by the Bureau of Program Integrity involved the use of a false identity at a pharmacy. In this case, an individual had posed as a Medicaid beneficiary over a period of about two years. The imposter had obtained numerous prescriptions on several different occasions. During this time period, the pharmacy failed to obtain positive identification and therefore was required to reimburse the Division of Medicaid for services obtained by the imposter.

Call the Medicaid Fraud Hotline at 1-800-880-5920 to report suspected card abuse. When you call, be ready to provide as much information as possible, including:

- The name on the Medicaid beneficiary card presented
- The Medicaid I.D. number on the card presented
- The name of the doctor, hospital, pharmacy, or other health care provider
- The date of service
- A description of the acts that you suspect involve fraud and abuse

Pharmacy Updates

Prescription Quantity Limitations

If a prescription for a Medicaid beneficiary exceeds the authorized quantity limit, the prescriber or pharmacist must request an override for the prescribed quantity. If the override is not approved, then the excess number above the authorized quantity limit is considered non-covered and the pharmacist may charge the beneficiary for the quantity in excess of the Medicaid authorized limit. A provider's (prescriber or pharmacy) failure or unwillingness to go through the process of obtaining an override does not constitute a non-covered service. Pharmacy providers should document any changes to the original prescription, such as physician-approved changes in dosage, on the original prescription. Documentation must be retained, including payment sources, for audit purposes. In addition, Medicaid policy regarding quantity limits is applicable in cases where the beneficiary has other third party insurance coverage.

> Example: A prescription is written for 90 units. Prior authorization is requested for 90 units; however, upon review of the request, an approval is given for only 60 units based on medical necessity. In this case, the only covered Medicaid service that is eligible for reimbursement is 60 units. Can the beneficiary pay cash for the other 30 units? Yes.

Use of Dispense as Written (DAW) codes

- DAW 7 – Only used when dispensing a brand name drug in lieu of a generic drug that the Division of Medicaid has designated as a narrow therapeutic index (NTI) drug such as Synthroid, Lanoxin, Tegretol, Dilantin, and Coumadin.
- DAW 5 – Only used if the drug is considered a generic yet the claim denies with a "generic required" message. It may be that this is an older brand name product that is priced as a generic. In this case the reimbursement rates must be documented in the prescription file.

The use of these codes is monitored for inappropriate utilization.

Do you have questions about the Preferred Drug List (PDL) and drug coverage?

Medicaid's website at www.dom.state.ms.us provides the most current, up-to-date information about the Medicaid Pharmacy Program and related topics such as Pharmacy and Therapeutics Committee meetings, Retrospective Drug Utilization Review Board meetings, covered over-the-counter products, and Frequently Asked Questions (FAQ) pertaining to the PDL.

Recent additions to the website provided to help you and your patients:

- Preferred Drug List (PDL) - *04/01/2005 effective date*
- Preferred/Non-preferred Drug List (indicates preferred or non-preferred status of all drugs within a therapeutic drug class)
- List of Antihistamines/Decongestants covered in the Medicaid program that do not require prior authorization. Two lists have been provided with one list designed for pharmacies indicating the NDC of each covered item and one list for prescribers. Please share these lists with your staff, colleagues, and your prescribers.

Institutional Provider Assessments

The new bed assessment rates, created when House Bill 1104 was passed by the Legislature and signed into law by Governor Haley Barbour, will be applied to Long-Term Care Facilities and Hospitals beginning April 1, 2005. Details of the new assessment rates will be sent to each Long-Term Care Facility and Hospital in May 2005.

Brand Name Drug vs. Generic Drug Cost Comparison

Being knowledgeable about drug costs can help prescribers determine the most cost effective therapy for their beneficiaries. In March 2005, the Division of Medicaid paid approximately $55.5M for drug expenditures. Approximately 75% of the expenditures were for **brand name (single source) drugs** with an average price paid of **$112.87,** yet the utilization rate was 42%. **Generic drugs** accounted for 22% of the expenditures with an average price paid of **$ 27.21** and a utilization rate of 51%. The remaining expenditures were for those brand name drugs with a generic equivalent and require prior authorization to be dispensed.

Brand name/ strength	Quantity	Brand cost *	Generic cost *	Generic name	Generic savings	Annual savings
Cardizen CD 240 mg	30	$68.40	$30.00	Diltiazem hcl	$38.40	$461
Paxil 20 mg	30	$84.00	$76.50	Paroxetine	$7.50	$90
Neurontin 300 mg	30	$40.80	$33.30	Gabapentin	$7.50	$90
Glucotrol XL 10mg	60	$53.64	$40.38	Glipizide	$13.26	$159
Zestril 20 mg Prinivil 20 mg	30 30	$36.21 $31.50	$19.17 $19.17	Lisinopril	$17.04 $12.33	$204 $148
Darvocet N 100	120	$124.20	$21.60	PropoxyN/APAP	$102.60	$1231
Climara weekly patch .005	4	$33.52	$23.10	estradiol	$10.42	$125
Adderall 10 mg	30	$55.44	$36.21	Amphe asp/ amphet/d-tamine	$19.34	$232
Glucovance 5:500	90	$92.70	$76.77	Glyburide/ metformin	$15.93	$191
Xanax 0.5 mg	90	$110.70	$4.44	Alprazolam	$106.26	$1275
Zantac 150 mg	60	$130	$20.40	Rantidine	$109.60	$1315
Lasix 40 mg	30	$8.70	$1.80	Furosemide	$6.90	$83

* based on DOM's maximum allowable costs

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
29.0 Vision	Lens Coating	05/01/05	X	29.07		
31.0 Pharmacy	Prior Authorization Preferred Drug List	06/01/05			X	31.12 31.24
25.0 Hospital Inpatient	Prior Authorization of Inpatient Hospital Services	06/01/05			X	25.25

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.

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	**Addendum to 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

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

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

May

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

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