Mississippi Medicaid

Volume 12, Issue 2

February 2006 Bulletin

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Clarification of Information for Crossover Claims

The information below is intended to clarify and expand on the article entitled, "Crossover Processing," from the January 2005 Mississippi Medicaid Bulletin:

If your Medicare claims are not electronically crossing over to Medicaid, you may need to update your Medicaid provider file with your Medicare group and individual numbers. The provider numbers listed on your Medicare Explanation of Medicare Benefits (EOMB) (Provider Number and PERF.PROV) are the numbers that must be loaded on your Medicaid file if your Medicare claims are to cross over electronically to Medicaid.

On CAHABA Medicare EOMB, PERF.PROV identifies the individual number that needs to be added to your Medicaid provider file. This may or may not be different on other Medicare intermediary EOMBs.

You can update your Medicaid file by providing the information below:

Medicaid Provider Number, Name,
Contact Name & Number
Medicare Provider Number (Group)
Medicare PERF.PROV Number

Co-Payments

The Division of Medicaid (DOM) and ACS have experienced a high volume of calls regarding increased co-payments. The current co-payment amounts are listed below:

Ambulance	$3.00 per trip
Dental	$3.00 per visit
Federally Qualified Health Center	$3.00 per visit
Home Health *	$3.00 per visit
Hospital Inpatient	$10.00 per day
Physician	$3.00 per visit
Prescription	$3.00 per prescription
Rural Health Clinic	$3.00 per visit
Eyeglasses	$3.00 per pair
DME, Orthotics, and Prosthetics (excludes medical supplies)	up to $3.00
MSDH (Mississippi Department of Health) Clinic	$3.00 per visit

Please note that the Home Health co-pay applies to state plan service HH visits only, **not the extended HH visits (after the first 25) covered by HCBS Elderly and Disabled (E&D) waiver.*

Healthier Mississippi Section 1115 Waiver

Beneficiaries who were in the Poverty Level Aged & Disabled (PLAD) class of eligibility prior to January 1, 2006 and who **DO NOT** have Medicare have been placed in the Healthier Mississippi Section 1115 Waiver Program. These beneficiaries will remain in this Waiver Program as long as the following apply:

- Income for each month stays at or below $1,077 for an individual and $1,444 for a couple; and,
- Resources remain under $4,000 for an individual or $6,000 for a couple; and,
- The beneficiary **DOES NOT** have Medicare. When the beneficiary becomes eligible for Medicare, he/she will no longer qualify for the Healthier Mississippi Section 1115 Waiver Program. The beneficiary's file will be reviewed to see if he/she can qualify for another Medicaid class of eligibility.

The following services **ARE COVERED** under the Healthier Mississippi 1115 Waiver Program:

- Inpatient hospital
- Outpatient hospital
- Lab and x-ray
- Physician services
- Drugs
- Home health
- Transportation services
- Dialysis services
- Community mental health center services
- Federally qualified health center services

The following services **ARE NOT COVERED** under the Healthier Mississippi Section 1115 Waiver Program:

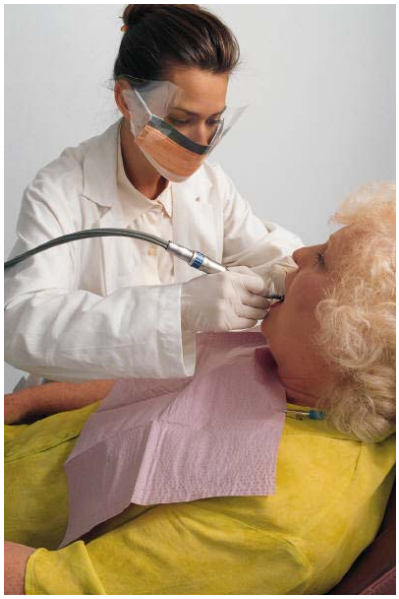
- Chiropractic services
- Podiatry services
- Dental
- Eyeglasses
- Hospice
- Therapy at a free-standing clinic
- Long term care services (nursing home services)

Regular Medicaid co-payments and service limits apply. Providers can contact ACS Provider/Beneficiary Support at 1-800-884-3222 or the AVRS and Envision web portal at http://msmedicaid.acs-inc.com to check eligibility prior to performing services.

Reminder for Providers Seeing Beneficiaries Under Age 21

Effective January 1, 2006, office visits are limited to 12 and ER visits are limited to 6 for children under age 21. According to Section 73.09 of the provider manual, Providers may request approval for expanded EPSDT services which "include any necessary Medicaid reimbursable health care to correct or ameliorate illnesses and conditions found ***on EPSDT screening."*** Providers must submit a Plan of Care (MA-1148) to the Division of Medicaid Bureau of Maternal and Child Health. Providers may contact ACS Provider/Beneficiary Support at 1-800-884-3222 to request Plan of Care forms (MA-1148).

Code D9110 - Palliative (Emergency) Treatment of Dental Pain, Minor Procedure



The Division of Medicaid has detected improper billing of code D9110. Some providers are using code D9110 to be compensated for the dispensing of fluoride rinse, e.g. Gelkam. The Mississippi Division of Medicaid has never authorized the use of code D9110 for the dispensing of fluoride rinse. Code D9110 should be used only when there is documented pain, a documented oral condition causing pain that requires an immediate treatment to ameliorate the symptoms until a more definitive treatment can be given, and a documented procedure performed that provides a measure of pain relief.

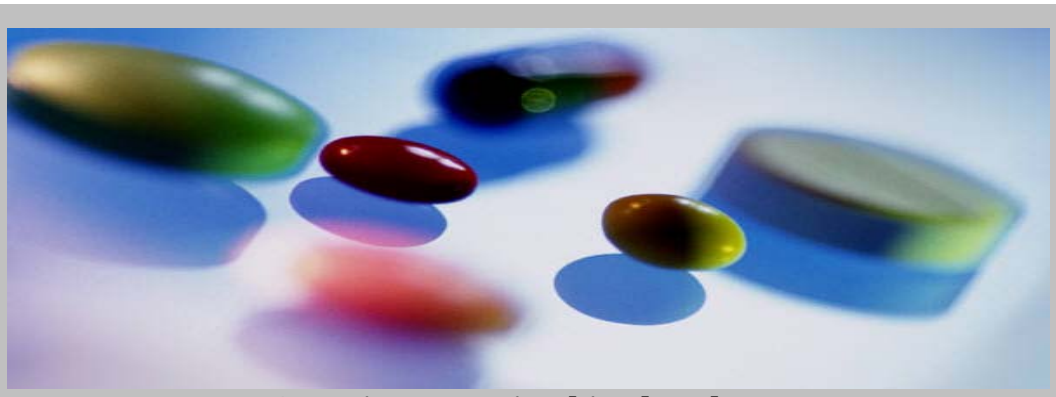
Additionally, if a more definitive treatment is provided at the time of presentation, that code and not code D9110 should be billed. Please reference Section 11.02 of the Mississippi Division of Medicaid Dental Manual for additional information on the appropriate use of this code.

This matter will be monitored closely, and the Division of Medicaid will address any fraud/abuse identified.

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.

Manual Section	Policy Section	New	Revised	Effective Date
15.0 MH/ Community Mental Health	15.30 Billing Guidelines		X	02/01/06
26.0 Hospital Outpatient	26.15 Outpatient Therapies		X	02/01/06
47.0 Outpatient Physical Therapy	All	X		02/01/06
48.0 Outpatient Occupational Therapy	All	X		02/01/06
49.0 Outpatient Speech-Language Pathology (Speech Therapy)	All	X		02/01/06
53.0 General Medical Policy	53.21 Blepharoplasty	X		02/01/06
46.0 Radiology	46.03 Positron Emission Tomography (PET) Scans		X	03/01/06
65.0 HCBS/Elderly & Disabled Waiver	All	X		03/01/06
75.0 Early Intervention/ Targeted Case Management	All	X		03/01/06
76.0 EPSDT/ School Health Related Services	All	X		03/01/06
79.0 School Based Administrative Claiming	All	X		03/01/06



Frequent Questions Received in the Pharmacy Bureau

Question: What is happening when a new generic product is billed and the NCPDP short message returned is "54-non-matched product/serviceID" or "non-matched NDC not on drug file"?
Response: This message means that the new generic product is not found on Medicaid's master drug reference file**.** Medicaid's drug file is updated weekly on Tuesdays. The drug file update includes new to the market drug information or price changes.

Question: What benzodiazepines and barbiturates does Medicaid cover?
Response: As of January 1, 2006, Medicaid covers the following for all Medicaid beneficiaries:

- Benzodiazepines-coverage is limited to the generic formulations of these agents;
- Barbiturates-coverage of single entity barbiturates is limited to phenobarbital and mephobarbital (Mebaral).

Question: What drugs will Medicaid continue to cover for the dually eligible beneficiary through point-of sale or POS?
Response: Medicaid will continue to pay for a limited or for very specific drugs that Medicare will not cover for dual eligibles:

- Benzodiazepines-limited to generic formulations only;
- Barbiturates-limited to Phenobarbital and mephobarbital (Mebaral) only;
- Certain over-the-counter (OTC) drugs as covered by the Division of Medicaid except OTC insulin products which are covered in the Medicare Part D plans.

A comprehensive listing of the OTC formulary is available on the DOM website at www.dom.state.ms.us, Pharmacy Services, What's New and OTC Formulary. Note that this listing is subject to change.

Question: Does Medicaid have access to Medicare Part D plan information for the dually eligible beneficiary?
Response: No**.** Medicaid does not have access to Medicare files and/or drug plan coverage. To determine a beneficiary's Medicare Part D plan, pharmacies may contact Medicare at 1-800-Medicare or submit an E1 query**.**

Question: Why do some dual eligibles no longer have Medicaid drug coverage for Part D exclusions such as benzodiazepines, OTCs and barbiturates?
Response: Prior to January 1, 2006, all Medicaid beneficiaries who had Medicare and Medicaid were categorized as dually eligible**.** The Medicaid PLAD category of eligibility, which was an optional category of eligibility, ended on December 31, 2005. Beneficiaries previously classified as PLADs who have Medicare were converted to the Medicare Savings Program. These beneficiaries are no longer dually eligible and have no Medicaid outpatient drug benefit**.**

Question: Cough and cold products are not covered by Medicare. What cough products are reimbursed by Mississippi Medicaid?
Response: The following cough products are reimbursed by DOM:

- **promethazine with codeine** *(compares to Phenergan with codeine)*
- **guaifenesin** *(compares to Robitussin*)
- **guaifenesin with dextromethorphan** *(compares to Robitussin DM)*
- **guaifenesin with codeine** *(compares to Robitussin AC)*
- **guaifenesin, pseudoephrine, and codeine** *(compares to Robitussin DAC)*

Question: Does Medicaid pay Part D drug co-pays?
Response: No.

Question: Can a prior authorization or override be issued by Medicaid for a Part D non-formulary drug?
Response: No.

Non-Coverage of Erectile Dysfunction Agents Effective January 1, 2006

The Centers for Medicare and Medicaid Services prohibit Medicaid reimbursement for drugs used for the treatment of sexual or erectile dysfunction, with respect to drugs dispensed on or after January 1, 2006. All prior authorizations for erectile dysfunction drugs used for the treatment of sexual or erectile dysfunction became null and void effective January 1, 2006.

New Drug Quantity Limits Effective February 1, 2006

New quantity limits for controlled substances go into effect February 1, 2006.

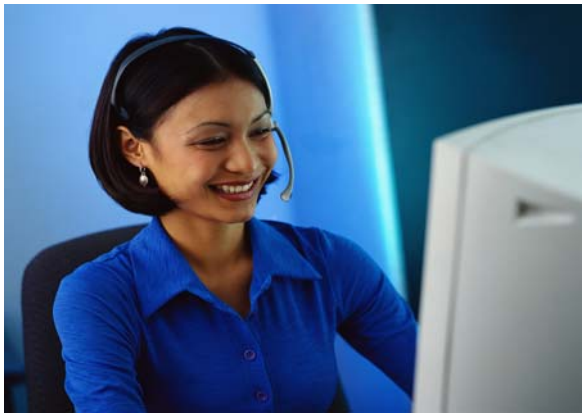
A comprehensive listing of all products with quantity limits is available on the DOM website at www.dom.state.ms.us, Pharmacy Services, What's New and Products with Quantity Limits. Note that this listing is subject to change.

ACS Customer Service

For quicker, more efficient service, please have all pertinent information ready when contacting Provider/Beneficiary Support 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/Beneficiary Support call center takes an average of 3,000 calls per day?

Sanctioned/Excluded 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.

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.

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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

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

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.