Mississippi Medicaid Bulletin

Volume 12, Issue 10

October 2006

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ICD9-CM Code Update

As a result of the Health Insurance Portability and Accountability Act (HIPPA), providers are required to bill with current code sets. The Division of Medicaid has updated our system to accept new and deny invalid ICD9-CM codes effective October 1, 2006.

Please remember that ICD-9-CM is composed of codes with either 3, 4, or 5 digits. A code is invalid if it has not been coded to the full number of digits required for that code. You must, therefore, use a current version of ICD-9-CM which is updated October 1 of each year. Be sure to keep your previous books as they may be needed when reconciling older claims.

Time Limit for Filing Claims

Claims for covered services will be paid only when received by the fiscal agent within twelve (12) months of the **through** date of service. Providers are encouraged to submit claims on a timely basis.

The following are the only reasons allowed consideration for overriding the timely filing edit.

1. Claims filed within twelve (12) months from the date of service, but denied can be resubmitted with the transaction control number (TCN) from the original denied claim recorded in the appropriate field on the resubmitted claim.
2. Claims over twelve (12) months can be processed if the beneficiary's Medicaid eligibility has been approved retroactively by the Division of Medicaid, Department of Human Services or the Social Security Administration through their application processes. Proof of retroactive determination or the appropriate documentation from the determining agency should accompany the claim and be filed within (12) months from the date of the retroactive letter.
3. The 12-month filing limitation for newly enrolled providers begins with the date of issuance of the provider eligibility letter.
4. The 6-month filing limitation for Medicare/Medicaid crossover claims will be determined using the Medicare payment register date as the date of receipt by Medicaid. Claims filed after the 6-month timely filing limitation will be denied.

Claims submitted two (2) years from the date of service are not reimbursable, unless the beneficiary's Medicaid eligibility is retroactive.

Web Portal Features

The Mississippi Division of Medicaid and ACS are committed to assisting the provider community in its endeavor to become as efficient as possible when billing Medicaid. One of the tools that is available to providers is the Envision Web Portal at http://msmedicaid.acs-inc.com.

There are vast advantages of being familiar with the Envision web portal. The site has secured and unsecured features. The unsecured features include access to FAQs, which is a good resource to see if other providers have some of the same questions or concerns as your facility. A billing tips segment is available which offers very good information that is universal to all providers that bill Mississippi Medicaid. Some of the billing tip instructions that are included are the processes for verifying beneficiary eligibility, billing crossover claims that have not been sent to ACS from Medicare electronically, coinsurance balances, timely filing guidelines and much more.

The publications segment offers providers access to much of the written documentation that is disbursed by Medicaid. This information includes many of the forms that are necessary for Medicaid billing, a compilation of banner messages printed within remittance advises, pharmacy payor sheets, several years of monthly provider bulletins that are available for your reference, and many other tools including the WINASAP software that is used for billing electronically.

An interactive fee schedule is also available for your benefit. Although several providers are billing according to various reimbursement methodologies based on their provider type, provider who may be reimbursed by procedure codes may enter a code along with the date and service in order to view what modifiers may be billed with the procedure code and the appropriate reimbursement.

Through the secured portion of Envision, providers may verify beneficiaries' eligibility, look of the payment status of billed claims and send questions to the provider enrollment and claims research departments. The master administrator may also download printable copied of remittance advises that are available electronically to providers on Mondays.

To obtained access to the secured segment of the Envision web portal, providers may select the web account registration link and complete the required enrollment criteria in order to assign a user ID and receive a password electronically. This information is available in the packet for Medicaid provider enrollment. Providers who have already received their Mississippi Medicaid provider ID# and who receive electronic payments, may identify themselves as a group or individual provider, enter their provider ID number and the last five digit of the bank account number that is registered with the provider ID# in order to receive access to their secured environment.

The Mississippi Division of Medicaid and ACS are excited about upcoming enhancements to the web portal. The Mississippi Medicaid provider community has been heard. In the near future, the Envision password will be reset every 90 days instead of every 30 days. Also, within the secured portion of the claims detail, the denial edits and descriptions will be made available for your review online later in 2007.

For password resets, difficulty downloading remittance advices, or any other web portal questions, please contact the EDI helpdesk by calling 800.884.3222 and selecting option 5.

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.

NPI Deadline – 7 Months and Counting!

NPI: Get It. Share It. Use It.

The National Provider Identifier (NPI) compliance date is May 23, 2007. This means that providers must use their NPI as of May 23, 2007. If you have not obtained your NPI, please do so immediately. If you have already obtained your NPI, please report it to Mississippi Medicaid immediately. Please review the following information to learn more about obtaining your NPI and reporting it to Mississippi Medicaid.

"If you have not obtained your NPI, please do so immediately."

What is NPI?

The National Provider Identifier (NPI) is the standard unique numeric identifier for health care providers. It is a 10-digit identifier that will be used to identify health care providers billing claims using the HIPAA standard transactions. The NPI eliminates the need for health care professionals to use different numbers when conducting transactions with multiple commercial and government health plans.

Who is responsible for obtaining and using an NPI?

The NPI must be used by HIPAA covered entities which include health plans (examples: Medicare, Medicaid, and private health insurance issuers), health care clearinghouses, and health care providers (individuals and organizations) that conduct electronic transactions.

There are two types of health care providers in terms of NPIs:

- Type 1 – Health care providers who are individuals, including physicians, dentists, and **ALL** sole proprietors. An individual is eligible for only one NPI.
- Type 2 – Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

> *Organizations must determine if they have "subparts" that need to be uniquely identified in HIPAA standard transactions with their own NPIs. A subpart is a component of an organization that furnishes health care and is not itself a separate legal entity.*
>
> *For more information on subparts, the Centers for Medicare and Medicaid (CMS) has published a document on Medicare Subpart Expectations. This document is available on CMS' website at http://www.cms.hhs.gov. Once the homepage is accessed, click on the link entitled, "Medicare NPI Implementation" which is on the left-hand side of the homepage. Under downloads, click on "Medicare Subpart Expectations" to view the document in its entirety.*

- If you are an individual who is a health care provider and are incorporated, you may need to obtain an NPI for yourself (Type 1) and an NPI for your corporation or LLC (Type 2).

When am I required to use my NPI?

You must use your NPI as of May 23, 2007. HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use **ONLY** the NPI to identify covered healthcare providers in standard transactions by this date. CMS recommends that providers obtain their NPI at least six months prior to this date to provide ample time to test the NPI and share it with all of their health care partners, including payers, clearinghouses, vendors, and other providers.

NOTE: You should continue to use your Mississippi Medicaid provider number until April 27, 2007. Additional information regarding when, where, and how to use NPIs will be provided in subsequent provider bulletins.

How do I obtain an NPI?

Providers can obtain an NPI by:

- Completing an on-line application at the National Plan and Provider Enumeration System (NPPES) website at (https://NPPES.cms.hhs.gov/NPPES/Welcome.do). When the homepage is accessed, the provider should click on "National Provider Identifier (NPI)" which is highlighted in blue. This will take the provider to the page where an online application can be completed. Or,

- Contacting 1-800-465-3203 to request a paper NPI Application/Update Form and mailing the completed, signed application to the NPI Enumerator, P.O. Box 6059, Fargo, ND 58108-6059.

How do I report my NPI to Mississippi Medicaid?

If you have obtained your NPI with the certification form from CMS, then you are ready to report your NPI to MS Medicaid. Please prepare a facsimile cover page and include the following information in transmitting your NPI information to the ACS Provider Enrollment fax number, 601-206-3015:

NPI Information Checklist

- ☐ Provider Name
- ☐ The name of a representative in your organization to be contacted
- ☐ Servicing address if NPI is for a group or facility
- ☐ A direct telephone number
- ☐ A fax number
- ☐ Email address
- ☐ The 8 digit MS Medicaid Provider Number which corresponds to the NPI
- ☐ A copy of the NPI CMS certification form

You may also email the information requested above to msnpi.provider@acs-inc.com. A copy of the NPI CMS certification form must be attached in the portable document format (pdf) to your email.

Once the required information is received, the provider NPI information will be entered into the Mississippi Medicaid Management Information system (MMIS) and cross-referenced to the 8-digit Mississippi Medicaid Provider Number.

In the event one of the eight required elements stated above is omitted from the facsimile or email received, ACS will notify the contact representative by phone, email or facsimile to obtain the necessary information to complete the NPI Medicaid enrollment process.

Where can I obtain more information?

Additional information will be published in future Mississippi Medicaid Bulletins, remittance advice banner messages, the Division of Medicaid website at www.dom.state.ms.us, and on the MS Envision Web Portal at http://msmedicaid.acs-inc.com. You may also contact ACS Provider/Beneficiary Support at 800-884-3222 if you have questions or visit http://www.cms.hhs.gov/NationalProvIdentStand/ for additional information.

In the near future, ACS will also broadcast bulletins and provider alerts through a mass fax communication.

Timeframes for NPI Implementation

The Division of Medicaid's implementation involving acceptance and processing of your NPI transactions will occur in separate stages, as shown in the table below:

October 2006 - April 26, 2007	• Submit Medicaid claims using only your existing 8-digit Medicaid numbers. Do not use your NPI number(s) during this time period. • The *Envision* claims processing system will deny any claim that includes an NPI during this phase.
April 27, 2007- May 22, 2007	• *Envision* will accept your existing 8-digit Medicaid provider number or your NPI on claims. • If there is any issue with your NPI, the claim will be rejected. • Any issues with your NPI will be re-searched. If the issue requires extensive research, you will be able to resubmit the claim using the 8-digit MS Medicaid provider number for processing.
May 23, 2007– forward	The Division of Medicaid will only accept NPI numbers by HIPAA covered entities.

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:

Please fax a request to link the Medicare group number to appropriate Medicaid group number. **A Medicare number should only be linked to one (1) Medicaid number**. Please include the following information: 1) Medicaid number, 2) Medicare number, 3) Clinic/Group Name, 4) Address, 5) Contact Person and Telephone Number.

All information should be faxed to Provider Enrollment at 601-206-3015.

ATTENTION: Hospital Providers!

Hospital Inpatient APR-DRG Workshops – November 2006

The Division of Medicaid and ACS Government Healthcare Solutions will host the final workshops for hospital providers prior to implementation of APR-DRG on January 1, 2007. The purpose of these workshops is to fully prepare hospitals participating in Mississippi Medicaid for the change to the APR-DRG payment method. The workshops will occur as follows:

November 6, 2006	9:00 am – 3:30 pm	Allied Nursing Health Center 1750 Chadwick Drive, Jackson, Mississippi 39204
November 9, 2006	9:00 am – 3:30 pm	Greenville Higher Education Center 2900A Highway 1 South, Greenville, Mississippi 38701
November 10, 2006	9:00 am – 3:30 pm	Oxford Conference Center 102 Ed Perry Boulevard, Oxford, Mississippi 38655
November 13, 2006	9:00 am – 3:30 pm	Hattiesburg Lake Terrace Convention Center One Convention Center Plaza, Hattiesburg, MS 39401
November 14, 2006	9:00 am – 3:30 pm	Beau Rivage Conference Center 875 Beach Boulevard, Biloxi, Mississippi 39530
November 15, 2006	9:00 am – 3:30 pm	Allied Nursing Health Center 1750 Chadwick Drive, Jackson, Mississippi 39204

Each hospital has been scheduled to attend a workshop at a specific location. Please refer to the list on the following pages to determine the date and location of the workshop for your facility. There will be two sessions in each workshop designed for different attendees. The information on each session is provided below.

General Session	9:00 am – 12:00 pm	The morning session is intended for CEOs, case managers, utilization review manager and billing managers. This session will cover final payment policies, pricing calculations, prior authorization, and remittance advice information.
Simulation Session	1:00 pm – 2:30 pm	The afternoon session is intended for CEOs and CFOs who are interested in the details of how the hospital-specific payment simulations were done.

Registration will begin at 8:30. The workshops are free of charge. Lunch will be provided (excluding the workshop on November 14, 2006). It is imperative that you RSVP as soon as possible and no later than **October 20, 2006** to confirm your attendance at your designated workshop and the number of persons attending each session from your facility. Please contact Tamara Cry at 601-206-3028 or email at tamara.cry@acs-inc.com to RSVP.

We look forward to meeting with you in November and working with you on a successful implementation of APR-DRG.

NOVEMBER APR-DRG WORKSHOP HOSPITAL LISTING

This is the listing of the specific workshop location and date for each hospital. We have assigned hospitals to specific locations in an effort to balance group size. Please contact Tamara Cry at 601-206-3028 or email at tamara.cry@acs-inc.com to RSVP as soon as possible and no later than October 20, 2006.

NOTE TO PROVIDERS ATTENDING BILOXI WORKSHOP:

*Beau Rivage has a special group guest room rate of $109 on Monday, November 13. You must call the Beau Rivage Reservations Department at 1-888-567 -6667 and request the **ACS State Healthcare rate by October 20** to get this special rate.*

Provider ID	Provider Name	Workshop Location	Date
00020237	ALLIANCE HEALTH CENTER	Jackson	11/6/2006
00220621	ALLIANCE HEALTHCARE SYSTEM	Oxford	11/10/2006
06077742	ATHENS-LIMESTONE HOSPITAL	Oxford	11/10/2006
00020084	BAPT MEM HOSP-BOONEVILLE	Oxford	11/10/2006
00020374	BAPTIST MEMORIAL HOSPITAL - Memphis	Oxford	11/10/2006
00220576	BAPTIST MEMORIAL HOSPITAL - Collierville	Oxford	11/10/2006
00020016	BAPTIST MEMORIAL HOSPITAL NORTH MS	Oxford	11/10/2006
00020010	BAPTIST MEM HOSP-UNION COUNTY	Oxford	11/10/2006
00020441	BATON ROUGE GEN HOSP	Biloxi	11/14/2006
00020043	BEACHAM MEMORIAL HOSPITAL	Jackson	11/06/2006
00020182	BILOXI REGIONAL MEDICAL CENTER	Biloxi	11/14/2006
00020143	BMH DESOTO	Oxford	11/10/2006
00220698	BMH FOR WOMEN	Oxford	11/10/2006
00220136	BMH GOLDEN TRIANGLE	Oxford	11/10/2006
00220606	BOLIVAR MEDICAL CENTER	Greenville	11/09/2006
00220625	BRENTWOOD HEALTH MGMT OF MS	Jackson	11/06/2006
00220630	CENTRAL MISSISSIPPI MEDICAL CENTER	Jackson	11/06/2006
00020302	CHILDREN'S HOSPITAL	Biloxi	11/14/2006
00020429	CHILDREN'S HOSPITAL OF ALABAMA	Oxford	11/10/2006
02032374	CHOCTAW COUNTY MEDICAL CENTER	Greenville	11/09/2006
00020140	CLAIBORNE COUNTY HOSPITAL	Jackson	11/06/2006
00020079	CLAY COUNTY MEDICAL CENTER	Oxford	11/10/2006
00020133	COVINGTON COUNTY HOSPITAL	Hattiesburg	11/13/2006
00220682	CROSBY MEMORIAL HOSPITAL	Biloxi	11/14/2006
00220610	CROSSROADS REGIONAL HOSPITAL	Hattiesburg	11/13/2006
00020414	DCH REGIONAL MEDICAL CENTER	Oxford	11/10/2006
00220444	DELTA MEDICAL CENTER	Oxford	11/10/2006
00020145	DELTA REGIONAL MEDICAL CENTER	Greenville	11/09/2006
00220411	DIAMOND GROVE CENTER	Jackson	11/06/2006
00220648	EAST ALABAMA MEDICAL CENTER	Hattiesburg	11/13/2006
00220601	EAST JEFFERSON GENERAL HOSPITAL	Biloxi	11/14/2006
00020410	ELIZA COFFEE MEM HOS	Oxford	11/10/2006
00020012	FIELD MEMORIAL COMMUNITY HOSPITAL	Jackson	11/06/2006
00020007	FORREST GENERAL HOSPITAL	Hattiesburg	11/13/2006
00020130	FRANKLIN COUNTY MEMORIAL HOSPITAL	Jackson	11/06/2006
00220734	GARDEN PARK MEDICAL CENTER	Biloxi	11/14/2006

Provider ID	Provider Name	Workshop Location	Date
00020290	GEORGE COUNTY HOSPITAL	Hattiesburg	11/13/2006
00020003	GILMORE MEM REG MEDICAL CENTER	Oxford	11/10/2006
06200741	GREENE COUNTY HOSPITAL	Hattiesburg	11/13/2006
00020025	GREENWOOD LEFLORE HOSPITAL	Greenville	11/09/2006
02278753	GREENWOOD SPECIALTY HOSPITAL LLC	Greenville	11/09/2006
00020026	GRENADA LAKE MEDICAL CENTER	Greenville	11/09/2006
00020226	GULF COAST MEDICAL CENTER	Biloxi	11/14/2006
00020214	H C WATKINS MEMORIAL HOSPITAL	Hattiesburg	11/13/2006
00020166	HANCOCK MEDICAL CENTER	Biloxi	11/14/2006
00020115	HARDY WILSON MEMORIAL HOSPITAL	Jackson	11/06/2006
00020294	HELEN KELLER HOSPITAL	Oxford	11/10/2006
00020213	HILLCREST HOSPITAL	Oxford	11/10/2006
00020124	HUMPHREYS COUNTY MEM HOSPITAL	Greenville	11/09/2006
00220512	JACKSON HOSPITAL & CLINIC	Hattiesburg	11/13/2006
00020177	JASPER GENERAL HOSPITAL	Jackson	11/06/2006
00020046	JEFF ANDERSON REGIONAL MEDICAL CTR	Jackson	11/06/2006
00020193	JEFFERSON COUNTY HOSPITAL	Jackson	11/06/2006
00220441	JEFFERSON DAVIS COMM HOSPITAL	Hattiesburg	11/13/2006
00020147	KILMICHAEL HOSPITAL	Greenville	11/09/2006
00020082	KING'S DAUGHTERS HOSPITAL	Jackson	11/06/2006
00020008	KING'S DAUGHTERS MEDICAL CENTER	Jackson	11/06/2006
04125505	LAIRD HOSPITAL INC	Jackson	11/06/2006
00220643	LAKESIDE BEHAVIORAL HLTH SYS	Oxford	11/10/2006
00020427	LANE MEMORIAL HOSPITAL	Biloxi	11/14/2006
00020170	LAWRENCE COUNTY HOSPITAL	Hattiesburg	11/13/2006
00220809	LEAKE MEMORIAL HOSPITAL	Jackson	11/06/2006
00020138	LEONARD J CHABERT MEDICAL CTR	Biloxi	11/14/2006
04581000	LOUISIANA HEART HOSPITAL, LLC	Hattiesburg	11/13/2006
08087360	MADISON COUNTY HOSPITAL	Jackson	11/06/2006
00020042	MAGEE GENERAL HOSPITAL	Jackson	11/06/2006
00020020	MAGNOLIA REGIONAL HEALTH CENTER	Oxford	11/10/2006
00020116	MARION GENERAL HOSPITAL	Hattiesburg	11/13/2006
00020027	MEMORIAL HOSPITAL AT GULFPORT	Biloxi	11/14/2006
00020469	METHODIST HOSPITALS OF MEMPHI	Oxford	11/10/2006
00220392	MISSISSIPPI BAPTIST MEDICAL CENTER	Jackson	11/06/2006
00220338	MISSISSIPPI STATE HOSPITAL	Jackson	11/06/2006
00020482	MOBILE INFIRMARY MEDICAL CENTER	Biloxi	11/14/2006
00020035	MONTFORT JONES MEMORIAL HOSPITAL	Greenville	11/09/2006
00020223	MS METHODIST REHAB CENTER	Jackson	11/06/2006
00220159	NATCHEZ COMMUNITY HOSPITAL	Jackson	11/15/2006
00020172	NATCHEZ REGIONAL MEDICAL CENTER	Jackson	11/15/2006
00020181	NESHOBA COUNTY GEN HOSPITAL-NUR	Jackson	11/15/2006
00220230	NEWTON REGIONAL HOSPITAL	Jackson	11/15/2006
00020081	NORTH MS MED CTR	Oxford	11/10/2006
00220631	NORTH OAK REGIONAL MEDICAL CENTER	Oxford	11/10/2006
00020364	NORTH OAKS MEDICAL CENTER	Biloxi	11/14/2006
00020118	NORTH SUNFLOWER MEDICAL CENTER	Greenville	11/09/2006

Provider #	Provider Name	Workshop Location	Date
00095306	NORTHSHORE REG MEDICAL CENTER	Biloxi	11/14/2006
02083023	NORTHWEST MEDICAL CENTER	Oxford	11/10/2006
00220380	NORTHWEST MS REG MEDICAL CENTE	Greenville	11/09/2006
00020041	NOXUBEE GEN CRITICAL ACCESS HOS	Jackson	11/15/2006
00020461	OCHSNER FOUNDATION HOSPITAL	Biloxi	11/14/2006
00020219	OKTIBBEHA COUNTY HOSPITAL	Oxford	11/10/2006
00020433	OUR LADY OF THE LAKE REGNL MED CTR	Biloxi	11/14/2006
00220612	PARKWOOD BEHAVIORAL HLTH SYSTEM	Oxford	11/10/2006
00220297	PEARL RIVER COUNTY HOSPITAL	Biloxi	11/14/2006
00020191	PERRY COUNTY GENERAL HOSPITAL	Hattiesburg	11/13/2006
00020305	PICKENS COUNTY MEDICAL CTR	Oxford	11/10/2006
00220692	PIONEER COMM HOSPITAL OF ABERDEEN	Oxford	11/10/2006
00020096	PONTOTOC HEALTH SERVICES INC	Oxford	11/10/2006
00220487	PROVIDENCE HOSPITAL	Biloxi	11/14/2006
07539272	QUITMAN COUNTY HOSPITAL, LLC	Greenville	11/09/2006
00220417	RANKIN MEDICAL CENTER	Jackson	11/15/2006
00020408	RED BAY HOSPITAL	Biloxi	11/14/2006
07603524	REGENCY HOSPITAL OF HATTIESBURG	Hattiesburg	11/13/2006
07176518	REGENCY HOSPITAL OF MERIDIAN LLC	Jackson	11/15/2006
00020421	REGIONAL MEDICAL CTR MEMPHIS	Oxford	11/10/2006
00220174	RESTORATIVE CARE HOSP AT BAPTIST	Jackson	11/15/2006
00220495	RILEY MEMORIAL HOSPITAL	Jackson	11/15/2006
00220467	RIVER OAKS HOSPITAL	Jackson	11/15/2006
00220571	RIVER REGION HEALTH SYSTEM	Jackson	11/15/2006
00020049	RUSH FOUNDATION HOSPITAL	Jackson	11/15/2006
00220324	S E LACKEY MEMORIAL HOSPITAL	Jackson	11/15/2006
00220213	SAINT FRANCIS HOSPITAL	Oxford	11/10/2006
00220144	SCOTT REGIONAL HOSPITAL	Jackson	11/15/2006
00020129	SHARKEY-ISSAQUENA COMM HOSPITA	Greenville	11/09/2006
00020167	SIMPSON GENERAL HOSPITAL	Jackson	11/15/2006
00020059	SINGING RIVER HOSPITAL SYSTEM	Biloxi	11/14/2006
00020424	SLIDELL MEMORIAL HOSPITAL	Biloxi	11/14/2006
00098401	SOUTH BALDWIN HOSP	Biloxi	11/14/2006
00020141	SOUTH CENTRAL REG MED CTR	Hattiesburg	11/13/2006
00020032	SOUTH SUNFLOWER COUNTY HOSPITAL	Greenville	11/09/2006
00220723	SPECIALTY HOSP OF MERIDIAN-HOSPITAL	Jackson	11/15/2006
00220712	SPRINGHILL MEMORIAL HOSPITAL	Biloxi	11/14/2006
00020034	ST DOMINIC-JACKSON MEM HOSP	Jackson	11/15/2006
00020065	ST. JUDE CHILDRENS RESEARCH HOSP	Oxford	11/10/2006
00220714	STONE COUNTY HOSPITAL INC	Biloxi	11/14/2006
00020207	SW MS REGIONAL MEDICAL CENTER	Jackson	11/15/2006
00020161	TALLAHATCHIE GENERAL HOSPITAL	Greenville	11/09/2006
00020111	TIPPAH COUNTY HOSPITAL	Oxford	11/10/2006
00020393	TISHOMINGO HEALTH SERVICES INC	Oxford	11/10/2006
00220448	TOURO INFIRMARY	Biloxi	11/14/2006
00220415	TRACE REGIONAL HOSPITAL	Oxford	11/10/2006
00020229	TRI-LAKES MEDICAL CENTER	Oxford	11/10/2006

Provider #	Provider Name	Workshop Location	Date
00220279	TULANE UNIVERSITY HOSPITAL	Biloxi	11/14/2006
00020156	TYLER HOLMES MEMORIAL HOSPITAL	Greenville	11/09/2006
00220609	UNIV HOSPITAL & CLINICS-HOLMES CO	Greenville	1109/2006
00020395	UNIVERSITY OF ALABAMA HOSPITAL	Oxford	11/10/2006
00020149	UNIVERSITY OF MISS. MED CENTER	Jackson	11/15/2006
02283343	UNIVERSITY OF TENNESSEE MEMORIAL	Oxford	11/10/2006
00020197	USA CHILDRENS & WOMENS HOSPITAL	Biloxi	11/14/2006
00020215	USA KNOLLWOOD PARK HOSPITAL	Biloxi	11/14/2006
00020411	USA MEDICAL CENTER	Biloxi	11/14/2006
00220498	VANDERBILT UNIVERSITY HOSPITAL	Greenville	11/09/2006
00020208	WALTHALL CO GENERAL HOSPITAL	Hattiesburg	11/13/2006
00220616	WASHINGTON COUNTY HOSP ASSOC	Biloxi	11/14/2006
00020131	WAYNE GENERAL HOSPITAL	Hattiesburg	11/13/2006
00020178	WEBSTER GENERAL HOSPITAL	Greenville	11/09/2006
00220462	WESLEY MEDICAL CENTER	Hattiesburg	11/13/2006
00220522	WEST JEFFERSON MEDICAL CENTER	Biloxi	11/14/2006
00020011	WHITFIELD MED SURGICAL HOSP	Jackson	11/15/2006
00220243	WINSTON MEDICAL CENTER	Jackson	11/15/2006
00220466	WOMANS HOSPITAL	Jackson	11/15/2006
00020175	YALOBUSHA GENERAL HOSPITAL	Oxford	11/10/2006

Verifying Beneficiary Eligibility

Providers have a variety of resources for verifying the eligibility of a Medicaid beneficiary. Eligibility can be checked by contacting the Provider and Beneficiary Support Line at 1-800-884-3222, by calling the AVRS at 1-866-597-2675, by utilizing the Mississippi Envision Web Portal at: http://msmedicaid.acs-inc.com and by using a swipe card verification device. You may also access the Web Portal for interactive beneficiary eligibility verification.

When verifying eligibility through the call center, please obtain the call record number (CRN) from the Call Center Associate prior to ending the call. When verifying eligibility through the web portal, please print a copy of the documentation which contains the eligibility information. If verifying eligibility through the use of a swipe card verification device, please keep a copy of the receipt. If verifying eligibility though the use of the AVRS, please document the audit reference number.

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.

Outpatient Physical, Occupational, and Speech Therapy Questions and Answers

Pre-certification Requirements

1. **Why did DOM implement pre-certification requirements for outpatient physical, occupational, and speech therapy services?**

   The decision to pre-certify outpatient therapy services is in keeping with the Division of Medicaid's responsibility to be a prudent purchaser of high quality health care and to ensure that benefits are provided for medically necessary services. DOM implemented the pre-certification process on July 1, 2005. On February 1, 2006, DOM further enhanced the process with policies and standardized forms. DOM's review of the process resulted in the July 1, 2006, revisions to the forms and some policy sections.

2. **What is the role of HealthSystems (HSM) of Mississippi?**

   HealthSystems of Mississippi is the Utilization Management and Quality Improvement Organization (UM/QIO) for the DOM. HSM's scope of responsibility includes the management of the pre-certification process for outpatient therapy services. In addition, HSM handles a process for addressing quality of care issues on therapy services.

3. **Does DOM require pre-certification for all therapy codes billed by a hospital or therapy provider?**

   No. There is a list of specific therapy codes for which DOM requires pre-certification. That list may be accessed on the UM/QIO web site, www.hsom.org. Click on the HSM Provider Manual and Certification Forms link, and then select "Outpatient Physical, Occupational, and Speech Therapy Provider Manual and Certification Forms".

4. **Can a provider bill for a therapy code not on the attached list if the service is covered under Mississippi Medicaid?**

   Yes

5. **If the number of approved units for a period of time is not used, can the therapy provider carry over the unused units to another time period?**

   No. Units cannot be carried over from one period of time to another. The provider must submit a concurrent request if additional therapy is required. Providers are encouraged to document reasons previous approved units have not been utilized. For example, if a child is ill and is unable to participate in therapy for a week, the therapist should document this as it is information that HSM needs to make determinations for further coverage.

6. **How do I handle urgent situations?**

   HSM is authorized to accept retrospective outpatient therapy requests for the following:
   Urgent Services: In rare instances where urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Urgent outpatient physical, occupational, or speech therapy services is defined as the delivery of therapy services resulting from the sudden onset of a medical condition or injury requiring immediate care and manifesting itself by acute symptoms of sufficient severity such that the absence of therapy could result in immediate hospitalization, moderate impairment to bodily function, serious dysfunction of a bodily organ or part, or other serious medical consequences. If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

   Same Day/Non-Urgent Services: In rare instances where same day/non-urgent services are provided, the provider must follow the UM/QIO guidelines for submitting urgent certification requests. Same day/ non-urgent outpatient physical, occupational, or speech therapy services is defined as the delivery of therapy services that do not meet the definition of urgent, but completion of services on the same day as the evaluation significantly impacts the beneficiary's treatment (example: therapeutic activities, such as the use of crutches, on the same day as diagnosis/treatment of leg fracture). If retrospective review reveals that the services do not meet medical necessity criteria, charges will not be reimbursed and cannot be billed to the beneficiary.

   Refer to DOM Provider Policy Manual Sections 47.09, 48.09, and 49.09.

Standardized Form Requirements

1. **Why is the Division of Medicaid requiring that prescribing providers and therapists utilize the standardized forms to submit pre-certification requests to HSM?**

   DOM made the decision to develop and require use of the standardized forms to (1) ensure consistency in reporting, (2) to respond to provider requests to define the information needed for the pre-certification request, (3) to assist in provider education, and (4) to expedite review processes at HSM. The development of the forms was a joint effort between DOM and HSM with input from therapists working with HSM.

   DOM recognizes that the requirement adds additional paperwork; however, it is necessary in order to obtain complete medical information for the review process.

2. **Does DOM / HSM plan to develop an electronic process for submitting the requests?**

   Yes. Electronic submission is a long term goal. Electronic submissions have been successful for pre-certification of inpatient days and home health visits. It is anticipated that this technology can be adapted for pre-certification of therapy services. Currently, providers may access manual or electronic forms through the HSM website (www.hsom.org). The electronic form may be saved to the user's computer. It is a fillable form, but it may not be submitted electronically to HSM at this time.

3. **May providers attach documents and write "see attachments" on the standardized forms?**

   Providers must complete the standardized forms. An addendum page has been added to allow extra space for provider documentation. If the provider utilizes the space on the forms and addendum page, and still needs to continue, the provider may write "see attachment" and add the additional information. The provider may not add attachments in lieu of completing the forms.

Prescribing Provider

1. **What is the role of the prescribing provider (physician, nurse practitioner, physician assistant)?**

   The policies and processes are designed to reflect the traditional role of the prescribing provider's authority and responsibility to direct the care of his/her patients. To maintain the patient-prescribing provider relationship, and to ensure that medically necessary therapy continues to be assessed for effectiveness and quality, the pre-certification policies and processes call for prescribing providers to participate at several levels. This includes the (1) completion of the Certificate of Medical Necessity as the initial referral/orders, (2) approval of the initial and all revised plans of care and (4) a face to face visit with the beneficiary at least every six months. Such oversight and visits give the prescribing provider the opportunity to assess the beneficiary's progress toward therapeutic goals and to either authorize continued therapy or to discharge the beneficiary from therapy. Refer to DOM Provider Policy Manual Sections 47.10, 48.10, and 49.10.

2. **Is DOM/HSM educating providers about their responsibilities?**

   Yes. HSM has conducted an education program with many of the prescribing therapy providers.

3. **How often must a beneficiary be physically seen by the prescribing provider?**

   DOM policy requires that the prescribing provider have a face-to-face visit with the beneficiary at least every six (6) months, and that the encounter be documented. Refer to DOM Provider Policy Manual Sections 47.10, 48.10, and 49.10.

Certificate of Medical Necessity (CMN)

1. **What is the purpose of the Certificate of Medical Necessity (CMN)?**

   The CMN form is the prescribing provider's initial referral/orders. This requirement is consistent with the prescribing provider's authority and responsibility to direct care of his/her patients. The use of the standardized form provides consistency.

2. **Does the CMN form replace the prescribing provider's prescription?**

   Yes. The CMN is accepted as the prescribing provider's prescription for therapy.

3. **Will the Division of Medicaid policy allow a prescription in lieu of the CMN?**

   No

4. **Will the Division of Medicaid policy allow a verbal order in lieu of the CMN?**

   No

5. **Does the CMN have to be completed by the prescribing provider? Will the Division of Medicaid policy allow a prescribing provider to dictate the information and order to an office, staff member, or therapy provider (that is, give a verbal order that includes the required information on the CMN)?**

   It is acceptable for a **member of the prescribing provider's staff** to complete the beneficiary and provider information and diagnoses **only**. The prescribing provider must validate the accuracy of the information and complete the remainder of the form, including the specific order(s). The prescribing provider must sign and date the form. A verbal order is not acceptable.

6. **Does the CMN form have to be completed before the therapist conducts the initial evaluation?**

   Yes. Refer to Sections 47.10, 48.10, and 49.10 of the DOM Provider Policy Manual.

Evaluation/Reevaluation

1. **Who performs the evaluation and completes the evaluation form?**

   The evaluation must be completed by a state licensed therapist of the same discipline as the requested therapy (example: physical therapist must perform the evaluation for physical therapy). Refer to Sections 47.11, 48.11, and 49.11 of the DOM Provider Policy Manual.

2. **The Division of Medicaid provides coverage for re-evaluations based on medical necessity. Please clarify this policy.**

   It is expected that re-evaluations happen frequently throughout the process of providing the therapy. These routine re-evaluations are part of providing therapy services and are not eligible for separate reimbursement. Re-evaluations which may be considered for medical necessity include instances where there is significant change in the beneficiary's condition or functional status. Refer to Sections 47.11, 48.11, and 49.11 of the DOM Provider Policy Manual.

   DOM has also provided HSM with authorization to consider re-evaluations in instances where the beneficiary is being followed by a physician specializing in rehabilitation and the physician requests further evaluation by another therapist to assist in evaluating further therapy needs for the beneficiary. In this type instance, it is expected that the beneficiary is receiving therapy in his/her local community, and it is recognized that the therapist providing the therapy will also be doing re-evaluations.

3. **Can the therapist evaluate and initiate treatment on the same day?**

   The initial evaluation and the first therapy session should not be done on the same day. The provider should allow time to develop a plan of care and to obtain certification from the UM/QIO. Refer to Sections 47.11, 48.11, and 49.11 of the DOM Provider Policy Manual.

   Policy does include a provision for handling **urgent** cases. Refer to Sections 47.09, 48.09, and 49.09 of the DOM Provider Policy Manual.

Plan of Care (POC)

1. **Does the Plan of Care (POC) have to be developed for a specific period of time?**

   The POC may be developed to cover a period of treatment up to six months. The projected period of treatment must be indicated on the initial POC and must be updated with each subsequent revised POC. A POC for a projected period of treatment beyond six (6) months is not acceptable.

   The projected period of treatment indicated on the POC does not guarantee approval by the UM/QIO. Based on medical necessity, the UM/QIO may approve certification periods for less than **OR** up to six (6) months. Approved certification periods will not exceed the period of treatment indicated on the POC. Refer to Sections 47.12, 48.12, and 49.12 of the DOM Provider Policy Manual.

2. **Is the prescribing provider required to complete the plan of care form? When does it have to be signed?**

   Therapy services must be furnished according to a written plan of care (POC). The plan of care must be **approved** by the prescribing provider **before** treatment is begun. "Approved" means that the prescribing provider has reviewed and agreed with the therapy plan. The review can be done in person, by telephone, or facsimile. An approved plan does not mean that the prescribing provider has signed the plan prior to implementation, only that he/she has agreed to it. The plan of care must be developed by a therapist in the discipline. The prescribing provider must sign the POC before the initiation of treatment **OR** within thirty (30) calendar days of the verbal order approving the treatment plan. Policy does include a provision for handling urgent cases. Refer to DOM Provider Policy Manual Sections 47.12, 48.12, and 49.12.

3. When does DOM require a revised POC?

A revised POC is necessary any time one of the following occurs:

- The projected period of treatment is complete and additional services are required.
- A significant change in the beneficiary's condition and the proposed treatment plan requires that (1) a therapy provider propose a revised POC to the prescribing provider, or (2) the prescribing provider requests a revision to the POC. In either

  case, the therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.
- Information/documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates. In this situation, the UM/QIO is authorized by DOM to request that the therapy provider submit a revised POC. The therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services.

All therapy plans of care (initial and revised) must be authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign the POC before initiation of treatment **OR** within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.

DOM accepts the signature on the revised plan of care as a new order.

Refer to DOM Provider Policy Manual Sections 47.12, 48.12, and 49.12.

Review Process

1. Who reviews the pre-certification requests?

The review process is handled through the Utilization Management and Quality Improvement Organization, HealthSystems of Mississippi, based on information provided by the prescribing providers and therapists, medical necessity criteria, and

Division of Medicaid policies.

2. What criteria are used for medical necessity?

DOM has authorized use of the Milliman *Care Guidelines* as a tool to be used in review of the medical necessity. The *Care Guidelines* are evidence-based tools that reflect current best practices for the actual working environment of today's healthcare organizations.

3. Are the Milliman *Care Guidelines* applicable to only adults?

No. The *Care Guidelines* are not specific to adults only. Each review for children is carefully and individually evaluated in accordance with standards and the growth and development process for children. Both DOM and HSM are focused on ensuring children do receive medically necessary services.

4. Are Milliman *Care Guidelines* available to providers?

DOM and HSM do not provide copies of the Milliman *Care Guidelines* to providers. The guidelines are a commercially available product through www.milliman.com.

5. Is HSM authorized to reduce frequency and length of services without getting the prescribing provider's approval?

Yes. This is consistent with the role of utilization management companies who are contracted to approve services based on documented medical necessity and application of criteria and policies for the payor source.

6. What are the timelines for HSM providing a response to a request?

For pre-certification and concurrent requests, HSM will complete the review within 3 business days of receipt of all necessary information. For example, if a pre-cert/concurrent request is received on Monday, the provider will have a response by close of business Wednesday.

For retrospective requests, HSM will complete the review within 20 business days of receipt of all necessary information. For example, if a retrospective request is received on April 3, 2006, the provider will have a response by close of business May 3, 2006.

If a pre-certification request is pended for additional administrative information (clerical level) or additional clinical information (nurse level), the provider has three (3) business days to submit the information. The receipt date of the request is updated when the information is received.

If a concurrent request is pended for additional administrative information (clerical level), the provider has three (3) business days to submit the information. If a concurrent request is pended for additional clinical information (nurse level), the provider has one (1) business day to submit the information. The receipt date of the request is updated when the information is received.

If a pre-certification /concurrent request is pended by the physician review team, the provider has one (1) business day to submit the information. The receipt date of the request is updated when the information is received.

If a retrospective request is pended for additional information (nurse level), the provider has ten (10) business days to submit the information. The receipt date of the request is updated when the information is received. If a review is pended at multiple levels, such as clerical, nurse, physician, the timeframe is extended accordingly.

1. **How does HSM determine the start date for therapy services?**

   The start date for **initial** certification of therapy services (excluding the evaluation) is three (3) days from the receipt of all necessary information for a review request. The start date for certification of a **concurrent** review request is the date following the last certified day if the request is received in a timely manner (example: If the first certification period is 7/1/06 through 7/31/06, the concurrent certification period will begin 8/1/06 if the concurrent review request is submitted on or before the last day certified).

2. **Does HSM certify therapy services for beneficiaries who have <u>private</u> insurance as primary?**

   If the beneficiary has both Medicaid and private insurance and the provider plans to bill Medicaid, the therapy treatment must be pre-certified by HSM.

3. **Can I appeal HSM's decision?**

   DOM has contracted with HSM to handle reconsideration requests based on denial of services. All appeals other than those based on denials must be appealed directly to DOM.

<u>Electronic Documentation / Electronic Signatures</u>

1. **Will DOM allow hospitals to submit electronic documentation/signatures in lieu of the standardized forms?**

   Some hospital providers have expressed interest in adapting the standardized therapy forms into their own electronic documentation. If a hospital provider wants to explore this option, the hospital provider must submit a proposal in writing to HSM. DOM and HSM will review the proposal and determine if electronic documentation is acceptable in lieu of the standardized forms. DOM will expect the electronic formats to duplicate the standardized forms.

<u>Home Exercise Program (HEP)</u>

1. **What does HSM expect the provider to document for HEP?**

   The provider should describe the home program and the frequency that it is performed. The responsible caregiver should be identified and his/her response documented (example: ability to perform return demonstration and verbalization of understanding of the HEP). Frequency that the HEP is performed by the caregiver should be documented on concurrent requests. If applicable, the reason(s) that a caregiver is unable to participate in the HEP should be documented.

2. **Will HSM accept 'not applicable" for the HEP (example: beneficiary with autism-family needs keys for management, not HEP)?**

   No, HSM will not accept "NA" for the HEP. For HSM's purposes, HEP is defined as anything that the caregiver or beneficiary is doing on a daily basis to reinforce the goals and skills learned in therapy.

3. **What is expected of families or caregivers?**

   A home program is included in a successful therapy plan of care. DOM expects prescribing providers and therapists to include home programs for families and caregivers. It is further expected that the families and caregivers be available for instruction/ training by the therapist and participate in and be compliant with the home programs to ensure that the beneficiary is able to achieve and maintain the maximum level of function.

<u>Maintenance Policy</u>

1. **Does DOM policy provide coverage for therapy for maintenance?**

   No. Refer to DOM Policy Provider Manual Sections 47.13, 48.13, and 49.13.

<u>Services in Multiple Settings</u>

1. **Does the DOM policy allow coverage if the beneficiary is being seen for the same therapy service in multiple settings? An example is a child receiving speech therapy services at school and at a therapy clinic.**

   No.

Hospitals Off-Site Therapy Services

1. **Can a hospital provide a therapy service by salaried/contracted therapists at an off –site location and bill DOM for the service?**

   Hospitals are expected to bill only for services provided in a hospital outpatient therapy facility. Providing services outside of the facility is not considered an outpatient hospital service (example: beneficiary home, daycare, or school).

   Facilities may be on or off the hospital's main campus but within the service area of the hospital. A broad example is that DOM does not accept a hospital in North Mississippi setting up an outpatient hospital facility in central or south Mississippi.

Contact for Beneficiary Inquiries

1. **Who can adult beneficiaries or parents/legal guardians for children contact if they have questions or complaints?**

   Providers must direct adult beneficiaries or parents/legal guardians for children to the DOM's Beneficiary Relations Division at telephone (601) 359 – 6133. HSM is only authorized by DOM to handle provider inquiries.

   The DOM's Beneficiary Relations Division will only communicate with adult beneficiaries or parents/legal guardians of children due to the privacy regulations.

   In addition, parents/legal guardians may submit written inquiries to the Beneficiary Relations Division, Division of Medicaid, Robert E. Lee Bldg. / Suite 801, 239 North Lamar Street, Jackson, MS 39201-1399.

Claims Filing / Payment Issues

1. **Why are hospitals having difficulty getting claims paid for approved therapy services?**

   Systems issues that originally caused outpatient hospital claims to deny have been corrected. If hospital claims are not paying correctly, please contact your provider representative or the Division of Medicaid, Bureau of Medical Services.

   Some common reasons that outpatient therapy claims deny include the following:

   - Procedure codes billed do not match the procedure codes listed on the prior authorization
   - Dates of service on the claim do not match the dates listed on the prior authorization
   - Units billed exceed the units approved on the prior authorization
   - No prior authorization number (TAN) was listed on the claim
   - The prior authorization number (TAN) listed on the claim was not valid

2. **Who does a provider contact about questions on coverage of codes that do not require pre-certification?**

   The provider may contact the ACS Call Center at 1-800-884-3222 or their respective provider representative.

3. **Do the outpatient therapy visits apply toward the service limits?**

   No, except when the beneficiary has an emergency room visit on the same day.

Resources

1. **How does a prescribing provider or a therapy provider access the DOM policies?**

   DOM policies may be accessed at www.dom.state.ms.us. The therapy policies are in Sections 47 (physical therapy), 48 (occupational therapy), and 49 (speech therapy) of the DOM Provider Policy Manual.

2. **How does a provider access the HSM provider manuals and standardized forms?**

   A provider may access the HSM provider manuals at www.hsom.org. Click on the HSM Provider Manual and Certification Forms link, and then select "Outpatient Physical, Occupational, and Speech Therapy Provider Manual and Certification Forms".

3. **How does HSM provide training to the therapy providers in the pre-certification process?**

   Educational training sessions were offered to therapy providers during the past year. Providers who were unable to attend previous sessions and/or who desire further training may call the HSM Education Department at (601) 360-4961.

4. **How does a provider contact the HSM Help Line?**

   The toll free number is (866) 740-2221. The number for the Jackson area is (601) 360-4949.

Billing Tip For Hospice Providers

Election Forms Required for Dually Eligible Beneficiaries

Whenever Medicare and Medicaid are involved, you must send a copy of the election form to the fiscal agent for the Mississippi Division of Medicaid, ACS, at the time of election. You must also notify this same agency when the patient is no longer receiving hospice care and has been disenrolled. Dually eligible beneficiaries must elect the benefit under both programs at once per CMS guidelines, Section 204.2 of the CMS hospice manual.

Pharmacy News

Effective, November 1, 2006 Palvizumab (Synagis®) Prior Authorization criteria has been updated to the following:

RSV Risk Factors:
One of the following are considered sufficient:

- Chronic lung disease requiring medical treatment within the past six months (e.g. diuretics, systemic steroids, oxygen on a continuous basis, bronchodilators or ventilation-dependent.
- Hemodynamically significant Congenital Heart Disease (simple, small Atrial Septal Defects's (ASD), Ventricular Septal Defects's (VSD), and Patent Ductus Arteriosus (PDA) are not eligible).
- Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Deficiency Syndrome (AIDS)

OR

Must have **two** of the following:

- Exposure to tobacco smoke in the home
- School age Siblings
- Multiple Birth
- Day Care
- Severe neuromuscular disease*
- Congenital airway abnormality*

**new additions to criteria*

Health Information Designs (HID) handles Pharmacy Prior Authorization (PA) Requests. Synagis Prior Authorizations will be updated on a monthly basis due to weight and dose adjustments. PA requests are not required to be resubmitted every month. Prescribers are requested to include current weight and date of last injection with pharmacy reorder request. It is the responsibility of pharmacy vendor to submit a copy of the original PA approval letter with the current weight and date of last injection to HID for an updated prior authorization. By including the date of administration, you are confirming that the drug billed to Medicaid was administered and is not being recycled and/or double billed. Injections administered in a hospital setting, such as in NICU, are to be included on prior authorization form so as to avoid duplicate administration to the beneficiary. Pharmacy Prior authorization forms may be found at DOM's website at www.dom.state.ms.us, select Pharmacy Services, and Forms. Forms are also available through HID's website at www.hidmsmedicaid.com. Any dispensed Syngais vials that are returned unused, sealed, or unopened must be credited to Medicaid as it is expected that the vials have been properly stored and handled by professionals.

Billing Influenza and Pneumonia Immunizations for Adults (Beneficiaries Age 19 and Over)

The Division of Medicaid (DOM) is continuing efforts to educate Medicaid providers and beneficiaries on the benefits of receiving influenza and pneumonia immunizations prior to the influenza season. DOM encourages providers to assist in the effort to increase influenza and pneumonia protection in the State.

Physicians, nurse practitioners and physician assistants will be reimbursed for flu and pneumonia vaccines administered to beneficiaries age 19 and over as indicated below:

- For beneficiaries receiving immunizations only, the physician, nurse practitioner, or physician assistant may be reimbursed for CPT code 99211, the vaccine code(s), and the appropriate CPT vaccine administration code (CPT 90471 or 90472). CPT code 99211 does not count toward the limit of 12 physician office visits per fiscal year.

- For beneficiaries who are seen by the physician, nurse practitioner, or physician assistant for evaluation or treatment in addition to receiving these immunizations, the provider may be reimbursed for the appropriate CPT Evaluation and Management (E/M) procedure code, the vaccine code(s), and the CPT vaccine administration code(CPT 90471 or 90472). The CPT Evaluation and Management (E/M) procedure code billed in this instance will count toward the limit of 12 physician office visits per fiscal year.

- Effective October 1, 2003, HCPCS Codes G0008 and G0009 are no longer valid for billing administration fees for flu and pneumonia vaccines 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 for each additional vaccine administered.

- Rural Health Clinic (RHC) and Federally Qualified Health Centers (FQHC) providers will be reimbursed according to their encounter payment method. If an encounter visit is provided, one encounter payment is made regardless of other procedures included on the claim. If no encounter visit is provided, the CPT vaccine administration code (CPT 90471 or 90472) and the vaccine code(s) may be paid at the lower of the provider's charge or fee on file.

Reimbursement rates effective July 1, 2006 for vaccines and administration for beneficiaries age 19 and older are as follows:

Influenza Vaccines		Pneumonia Vaccine		Administration Fee	
CPT Code	**Fee**	**CPT Code**	**Fee**	**CPT Code**	**Fee**
90656	$15.82	90732	$27.03	90471	$14.91
90658	$12.06			90472	$9.08
90660	$21.18				

All immunizations for children age 18 and younger must be handled through the Vaccines for Children Program (VFC) and are subject to Medicaid policies in the Provider Manual, Section 77.

- Effective for dates of service on and after October 1, 2004, Mississippi Medicaid will reimburse physicians, nurse practitioners, and physician assistants for the FluMist influenza vaccine when given to beneficiaries ages 19 through 49. There will be no separate administration fee paid for the FluMist vaccine. Rural Health Clinics and Federally Qualified Health Centers will be reimbursed in accordance with the methodology applicable to their provider type.

Nursing Facility Civil Money Penalty Grant Application Notice

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 2007 is January 15, 2007. 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, Case Mix, at 601-359-6750.

Enhancement Grant: 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 project should be self sustaining once implemented. The grant awards range is $5000 -$50,000. Deadline for completion and receipt of application by DOM is ***January 15, 2007***.

Educational Program Grant: 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. The grant awards range is $5000 - $20,000. Deadline for completion and receipt of application by DOM is ***January 15, 2007***.

Contact: Evelyn H. Silas, Division Director
Bureau of LTC, Division of Case Mix
Division of Medicaid, Office of the Governor
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399
601-359-6750; Fax 601-359-1383
e-mail: lmehs@medicaid.state.ms.us

Allowable Board of Directors Fees for Nursing Facilities, ICF-MR's and PRTF's 2006 Cost Reports

The allowable Board of Directors fees that will be used in the desk reviews and audits of 2006 cost reports filed by nursing facilities (NF's), intermediate care facilities for the mentally retarded (ICF-MR's), and psychiatric residential treatment facilities (PRTF's) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for All Urban Consumers - All Items. The amounts listed below are the per meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2006 are as follows:

Category	Maximum Allowable Cost for 2006
0 - 99 Beds	$ 3,413
100 - 199 Beds	$ 5,120
200 - 299 Beds	$ 6,827
300 - 499 Beds	$ 8,534
500 Beds or More	$10,240

2006 Owner Salary Limits for Long-Term Care Facilities

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for the mentally retarded and psychiatric residential treatment facilities as owner's salaries for 2006 are based on 150% of the average salaries paid to non-owner administrators in 2005 in accordance with the Medicaid State Plan. These limits apply to all owners and owner/administrators that receive payment for services related to patient care. The limits apply to salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2006 are as follows:

- Intermediate Care Facilities for the Mentally Retarded (ICF-MR) $162,908
- Small Nursing Facilities (1-60 Beds) $ 94,957
- Large Nursing Facilities (61 + Beds) $124,398
- Psychiatric Residential Treatment Facilities (PRTF) $100,897

"Web Wise"

In an effort to better serve the provider community, several websites are available with current and pertinent information. Please take a moment and visit the following websites:

www.dom.state.ms.us
Provider manuals may be accessed or printed from this site.

http://mississippimedicaid.acs-inc.com
Remittance advices may be accessed and downloaded from this site.

http://msmedicaid.acs-inc.com
This site is often referred to as the "Web Portal". You may check eligibility, claim status, and view the latest updates on Late Breaking News.

www.hidmsmedicaid.com
Drug Prior Authorization forms are available at this site.

www.hsom.org
Plan of Care forms can be downloaded from this site.

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**
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**

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.

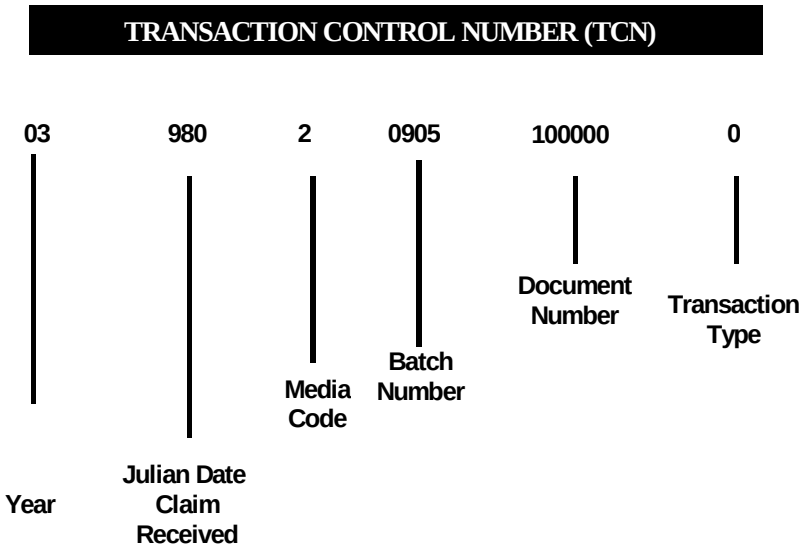
Manual Section	Policy Section	New	Revised	Effective Date
10.0 Durable Medical Equipment	10.02 Reimbursement		X	10/01/06
66.0 HCBS/ Independent Living Waiver	All (66.01-66.12)	X		10/01/06
69.0 HCBS/ Traumatic Brain Injury/ Spinal Cord Injury Waiver	All (69.0-69.12)	X		10/01/06
77.0 Immunization	77.05 Vaccines for Adults		X	10/01/06
10.0 Durable Medical Equipment	10.10 Apnea Monitors 10.27 Continuous Positive Airway Pressure (CPAP) with or without an In-Line Heated Humidifier 10.73 Suction Pump (Respiratory/ Gastric) 10.101 Hip Abductor Pillow/ Wedge		X X X X	11/01/06
29.0 Vision	29.01 Introduction 29.04 Exclusions 29.05 Eye Examinations/ Refractions		X X X	11/01/06
31.0 Pharmacy	31.12 Prior Authorization 31.13 Over the Counter (OTC) Drugs 31.15 Tobacco Cessation 31.24 Preferred Drug List		X X X X	11/01/06
38.0 Maternity	38.07 Post Operative Pain Management	X		11/01/06
51.0 Anesthesia	51.08 Post Operative Pain Management	X		11/01/06
52.0 Surgery	52.12 Post Operative Pain Management	X		11/01/06
53.0 General Medical Policy	53.06 Reduction Mammoplasty 53.13 Tobacco Cessation 53.23 Male Gynecomastia 53.24 Post Operative Pain Management 53.26 Hyaluronate Joint Injection	 X X X	X X	11/01/06
55.0 Physician	55.08 Post Operative Pain Management 55.09 Locum Tenens/ Reciprocal Billing Arrangement	X X		11/01/06
56.0 Injectables/ Physician Office	56.02 Hyaluronate Joint Injection	X		11/01/06

The Importance of the TCN in Filing Medicaid Claims

The transaction control number is often referred to as the TCN, a 17-digit number that appears on the weekly remittance advice. When paper or electronic claims are received by ACS for processing, they are assigned a unique TCN. It is the date stamp of how and when the claim was received and processed by ACS.

The 17-digit transaction control number has meaning as follows:

EXAMPLE 17-Digit TCN – 03980209051000000



Year The last two digits of the year for which the claim was received
Julian Date The month and day in Julian date format when the claim was received
Media Code The format of the claim.

Media Codes

2=Electronic Crossover claim
3=Electronic Claims claim
4=System Generated claim
6=Special Batch claim
8=Paper claim
9=Paper claim with Attachment

Transaction Type Tells the transaction type.

Transaction Type

7=Original
8=Void/Credit
9=Debit

Mississippi Medicaid Bulletin

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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

October

October 2006

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2 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 Checkwrite	31				

Checkwrites and Remittance Advices are dated every Monday. The Remittance Advice is available for download each Monday morning at http://msmedicaid.acs-inc.com while funds are not transferred until the following Thursday.