Mississippi Medicaid Bulletin

Volume 12, Issue 11

November 2006

Inside this Issue

Hardcopy Retro-Letters Are A Thing Of The Past	1
Third Party Payment and PPOs	1
ICD-CM Code Update	2
Late Breaking News	2
Unlisted Procedure Codes	2
NPI Deadline—6 Months and Counting!	3
IUDs and RhoGam	4
Billing Influenza and Pneumonia Immunizations for Adults	5
Additional Immunizations for the Vaccines for Children Program	6
ACS Customer Service	6
A New Inpatient Hospital Payment Method for Mississippi Medicaid	7
Medicaid Identification Card	16
Nursing Facility Civil Money Penalty Grant Application Notice	17
Policy Manual Additions/ Revisions	18
Internet Access is a Must!	19
Acquiring Additional Bulletins	19

Hardcopy Retro-Letters Are A Thing Of The Past

An implementation went into effect on August 7, 2006 that automated the processing of retro-letters as we have known it in the past. What this means is that there will be no need to send a copy of the retro-letter with a hardcopy claim for processing. Effective immediately, the system has been modified to allow claims to by-pass timely filing edits when billed within one year of the date of retroactive eligibility determination. The eligibility Add Date may be used as the determination.

If you have any claims outstanding or have attempted to get a letter from the beneficiary or local office, please submit the claims electronically and the system will process them accordingly.

Third Party Payment and PPOs

When a Medicaid provider is part of a preferred provider organization (PPO), you must report the contractual agreement (discount) plus the money received as the third party payment.

Section 6.03 of the Mississippi Medicaid Provider Policy Manual indicates when a Medicaid beneficiary is covered by a private insurance policy whose administrator has a PPO in which the Medicaid provider participates, the following applies:

> Medicaid is to make no payment when billed for the difference between the third party payment and the provider's charges. The provider agreed as a member to accept payment of less than his charges. This agreement and acceptance constitute receipt of full payment for services, and the Medicaid beneficiary who is insured has no further responsibility. Medicaid's intent is to make payment only when the beneficiary has a legal obligation to pay.

To comply with this policy, you must enter the total of the contractual adjustment and the third party payment as the third party amount in fields 54 of the UB92, and in field 29 of the CMS 1500. If no payment is received, enter zero in the third party field. An explanation of benefits must be attached if the insurance company denies the claim or the amount in the third party field is less than 20% of charges.

ICD9-CM Code Update

As a result of the Health Insurance Portability and Accountability Act (HIPPA), providers are required to bill with current codes 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.

Late Breaking News

Mississippi Medicaid Providers are encouraged to visit the "Late Breaking News" feature daily located within the Envision web-portal at http://msmedicaid.acs-inc.com for the latest on new and revised Medicaid policy, other Mississippi Medicaid 'hot topics', claims processing issues and forthcoming claims reprocessing.

The Mississippi Division of Medicaid and ACS have made concerted efforts to ensure that the information is provided expediently. Please tune in to what's new with Medicaid.

Unlisted Procedure Codes

In order to expedite the processing of claims submitted with unlisted procedure codes, providers should submit these claims in hard copy form with a description of the unlisted service included. The supporting medical documentation and corresponding description must be attached to the claim. Any claims submitted with unlisted procedure codes must be manually priced by the Medical Review Department at ACS and in order for them to accurately complete their review, appropriate supporting documentation and descriptions must be attached to the hard copy claim. Claims with unlisted procedure codes that are submitted electronically will be subsequently denied. If you have questions about the procedures surrounding unlisted procedure codes, please contact the ACS Provider/Beneficiary Services Call Center at 1-800-884-3222, or locally at 601-206-3000.

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.

NPI Deadline – 6 Months and Counting!

Getting an NPI is free - not having one can be costly.

> ***"When reporting your NPI to MS Medicaid, the certification form must be one of four Division of Medicaid approved formats."***

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, it is time to do so. If you have already obtained your NPI, please report it to MS Medicaid immediately. This month's NPI article will focus on obtaining and reporting your NPI to MS Medicaid. Please review your September 2006 and October 2006 MS Medicaid provider bulletins for more detailed information on NPI.

NPI Facts

- The NPI is the 10-digit standard unique numeric identifier for health care providers.
- 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.
- Providers are required to use their NPI as of May 23, 2007.
- Providers should continue to use their 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

IMPORTANT NOTE: The NPI certification form must be **one** of four Division of Medicaid approved formats. The four approved formats are described as follows:

1. Email from customerservice@npienumerator.com which includes the NPI for an individual healthcare provider
2. Email from customerservice@npienumerator.com which includes the NPI for an organizational healthcare provider
3. Official notice from CMS (Centers for Medicare and Medicaid Services) and Fox Systems, Inc. (the NPI Enumerator) which includes the NPI assigned to the healthcare provider. The CMS logo will be in the top left-hand corner and the Fox Systems, Inc. logo will be in the top right-hand corner of the notice.
4. Official notice from NCPDP (National Council for Prescription Drug Programs) which includes the NPI assigned to a pharmacy provider. The NCPDP logo will be in the top left-hand corner of the notice.

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.

If facsimile transmission and email are not viable options for you, the information requested above may be mailed to: *ACS Provider Enrollment, P.O. Box 23078, Jackson, MS 39225.*

In the event one of the nine 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 MS Medicaid Provider 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.

IUDs and RhoGAM

Claims submitted for services rendered relative to IUDs and RhoGAM must have the invoice attached in order for the claim to be processed appropriately. The invoice submitted with the hard copy claim must have a date that is before the date of service on the claim. Also, the invoice can only be submitted for the actual number of units purchased. Claims submitted electronically with services for IUDs or RhoGAM will be subsequently denied.

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:

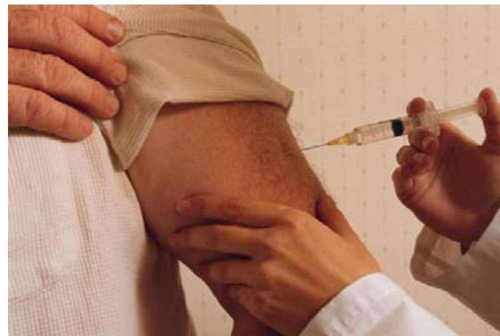
Influenza Vaccines		Pneumonia Vaccine		Administration Fee	
CPT Code	**Fee**	**CPT Code**	**Fee**	**CPT Code**	**Fee**
90656	$15.82	90732	$27.03	90471	$14.91
90658	$12.06			90472	$9.08
90660	$21.18				

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.

(continued from page 5)

- 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.

Additional Immunizations for the Vaccines for Children Program



The Vaccines for Children Program (VFC) has added six new vaccine codes (90660 EP –FluMist; 90680 EP-Rotavirus; 90734 EP-Menactra; 90733 EP-Menomune; 90710 EP-MMR/V(ProQuad) and 90715 EP-Tdap) effective July 1, 2006.

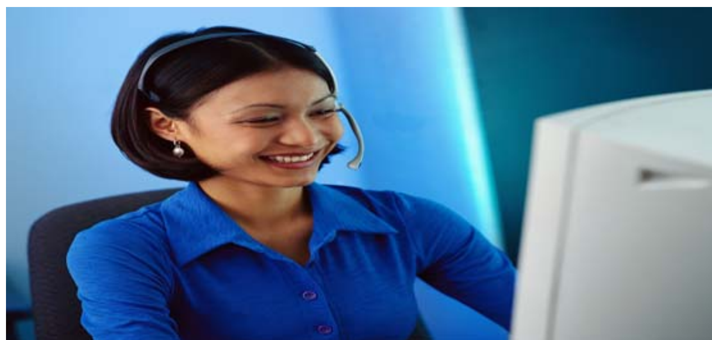
VFC providers must document the correct CPT vaccine code(s) and administrative code(s) on the CMS-1500 claim form in order to receive reimbursement for the administration of the immunizations given to Medicaid-eligible children and youth.

Immunization administration codes 90471 through 90473 with an "EP" modifier must be billed separately in addition to the above new vaccine codes indicating the appropriate number of units. Mississippi Medicaid allows $10 for each vaccine administered.

Questions relating these billing requirements should be directed to the Bureau of Maternal and Child Health at 601-359-6150.

ACS Customer Service

For quicker, more efficient service, please have all pertinent information ready when contacting Provider and Beneficiary Services at 1-800-884-3222.



You will need your:

- Provider ID Number
- Beneficiary ID Number
- Dates of Services
- Billed Amount

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

A New Inpatient Hospital Payment Method for Mississippi Medicaid

On January 1, 2007, the Mississippi Division of Medicaid will move to a new method of paying for hospital inpatient services. Our goals are to improve access to care, increase fairness to hospitals, reward efficiency, improve purchasing clarity, and reduce administrative burden for both the Division and the hospitals.

This document provides questions and answers about the new method. We invite additional questions and we welcome suggestions. The Division is working with a hospital technical advisory group convened by the Mississippi Hospital Association on questions of payment policy, implementation and provider education.

October 25 Update

This version of Frequently Asked Questions supersedes all previous versions. It includes the final values for the cost and day outlier threshold and other key features of the new payment method.

The New Inpatient Hospital Payment Method

1. What change is being made?

The Mississippi Division of Medicaid will change the method it uses to pay hospitals for inpatient care. Under the new method, hospitals will be paid per stay based on All Patient Refined Diagnosis Related Groups (APR-DRGs).

2. What providers and services will be affected?

The new method will apply to inpatient care in all acute care hospitals, including general hospitals, freestanding mental health hospitals and freestanding rehabilitation hospitals. The following services provided by acute care hospitals are not affected: outpatient care, Medicare crossover claims, and swing bed services. Psychiatric residential treatment facilities and nursing facilities are among the provider types not affected by the new method.

3. How much money is affected?

In the fiscal year that ended June 30, 2006, the Division of Medicaid paid acute care hospitals $502 million for inpatient care. This figure excludes "DSH" payments to hospitals and payments for care received by Medicaid patients for whom Medicare was the primary payer, which are made using a separate crossover payment policy.

4. How did the previous payment method work?

Until October 1, 2005, each hospital received an interim payment per day of care. The amount was specific to each hospital and ranged from about $500 a day to about $1,500 a day. The interim payment was based on cost reports filed by hospitals two to three years earlier and was subject to caps by hospital

class. (There were five general hospital classes, depending on number of beds.) For example, for care provided in June 2005, the hospital would receive an interim payment based on its cost report for 2003. After the hospital submitted its 2003 cost report, the report would be audited by a federal contractor and reviewed by Division staff. After cost settlement, final payment for a service provided in June 2005 would typically be made in 2007 or 2008.

Inpatient Payment Method Dates		
Method	**Dates**	**Description**
Previous	Before 10/1/05	Hospital-specific payment per diem made on interim basis, with cost settlement 2-3 years afterward.
Interim	10/1/05-12/31/06	Hospital-specific payment per diem, without cost settlement
New	As of 1/1/07	DRG-based payment per stay, without cost settlement

5. What change did the Division make on October 1, 2005?

Effective October 1, 2005, the Division established an interim payment method until the new DRG-based method goes into effect. The interim method is essentially a simplified version of the previous method. Hospitals are still paid per diem, but there is no longer a cost-settlement process (unless ownership changed after September 30, 2005 or a new facility opened). The per-diem rate for each hospital is the hospital's interim rate in RY 2005 unless the hospital's interim RY 2004 rate was higher, in which case the rate is the average of RY 2004 and RY 2005. The rates are adjusted for inflation. Although the interim method is simpler than the previous method, it has many of the same drawbacks as the previous method.

6. Why change to the new payment method?

The Division has five reasons.

- ***Improve access to care.*** Under the new method, the Medicaid payment for a particular inpatient stay will be closely tied to the acuity, or casemix, of the inpatient stay. Hospitals that take sicker patients can expect higher payments, which should improve access to care.

- ***Increase fairness to hospitals.*** Under the previous method, two hospitals were often paid very different amounts for the care of very similar patients. Under the new method, all hospitals will be paid similarly for similar patients.

- ***Reward efficiency.*** Under the previous method, hospitals that became more efficient and decreased cost were penalized with lower payments. Under the new method, hospitals will receive a flat rate for each stay of a given casemix level. If they improve efficiency, they will keep the savings.

- ***Improve purchasing clarity.*** The new method will allow the Division clearer insight into the services being covered. Each stay is assigned to a single DRG with a single payment. DRGs are organized so that each DRG contains stays that are similar both clinically and in terms of hospital resources used.

- ***Reduce administrative burden.*** Under the previous method, delays and adjustments to cost reports and payment rates bedeviled financial planning for both the hospitals and the Division. After a patient was discharged, hospital and Division financial managers had to wait several years before payment for that stay was finalized. Under the new method, a hospital will receive final payment for a stay shortly after it submits a claim. As well, the previous method depended on the Division receiving audited hospital cost reports from Medicare contractors. The future accuracy and timeliness of these audits is in question because hardly any Medicare payment now depends on these audits.

7. When will the new method go into effect?

The new method will be used for stays with admission dates on or after January 1, 2007. Claims received after January 1 for stays with admission dates before January 1 will be paid as they are now.

Components of the New Payment Method

8. Overall, how will the new payment method work?

The operation of the new method will be very similar to DRG-based payment methods currently in use by Medicare, BlueCross BlueShield of Mississippi and 34 other state Medicaid programs. Every inpatient stay will be assigned to a single DRG that reflects the difficulty of that case. For example, a patient with pneumonia will be assigned to one DRG and a patient with pneumonia and heart failure will be assigned to a different DRG. For each stay, the DRG base payment equals:

Relative weight for that DRG x base price = DRG base payment

For example, if DRG 1 has a relative weight of 0.75, DRG 2 has a relative weight of 1.5 and the base price is $3,500, then payment is as follows:

DRG 1: 0.75 x $3,500 = $2,625
DRG 2: 1.50 x $3,500 = $5,250

Hospitals are therefore paid more for more difficult cases and less for less difficult cases. At the same time, payment does not depend on the hospital's charges or costs, so the hospital has an incentive to improve efficiency.

9. How will hospitals be protected against the cost of exceptionally expensive cases?

About 5% of payments will be made as "outlier" payments. There will be two types of outlier payments.

- For mental health cases, where exceptionally expensive cases tend to be associated with long lengths of stay, hospitals will be paid $375 for each day that exceeds the "DRG long-stay threshold," which will be 19 days. This per-diem amount is called the DRG day outlier amount.

- For all other cases, hospitals will receive "DRG cost outlier payments" for stays where the gap between the hospital's estimated cost and the DRG base payment exceeds $50,000. The hospital's estimated cost equals the charges for that stay times the hospital-specific cost-to-charge ratio. The cost outlier payment policy is patterned after Medicare's cost outlier policy.

10. What changes, if any, will be made to disproportionate-share hospital (DSH) payments, medical education payments and payments for capital?

The DRG-based payment method will have no effect on DSH payment policy. Payments for medical education and payments to "low-DSH" hospitals, which are currently included in the per diem claim payment, will be made outside the claims processing system in the future. Under DRG-based payment, there will be no separate payment for capital.

11. What other factors might affect payments for individual cases?

As is common in DRG payment methods, there will be special calculations for transfer cases and for situations in which the patient has Medicaid coverage for only part of the stay (e.g., exhausted days).

The Division will pay the same rates to all hospitals, without labor-market adjustments such as Medicare has. This decision will promote access to hospital care in rural areas, since the typical effect of labor-market adjustments is to reduce payments in rural areas.

Overall Payment Levels

12. How will the new payment method affect overall funding to hospitals?

At this time the Division intends to implement the new method on a budget-neutral basis. That may change, up or down, depending on changes in the availability of funding for hospital services. The funding calculation will include adjustments for expected coding improvement and for the three-day window (see Question 23).

13. How will payments to individual hospitals be affected?

For some hospitals, payments will rise while for other hospitals they will fall. When a simulation was done of the new payment method using six months of data from January-June 2006, payments rose by more than 10% for 52 hospitals, rose by less than 10% for 13 hospitals, declined by more than 10% for 22 hospitals and declined by less than 10% for 17 hospitals. (The numbers refer to Mississippi hospitals.) These changes reflect both the new payment method (where payment depends on a hospital's casemix) and the previous payment method (where payment depended on a hospital's cost and on the cost of similarly sized hospitals). In the future, an increase in a hospital's casemix index will lead directly to increases in payment. Moreover, if a hospital decreases its costs then those savings will flow directly to the hospital's bottom line, with no offsetting reduction in payment as there was under the previous payment method.

Claim-specific details of the simulation are available to each hospital that requests them. An authorized hospital representative (e.g., chief financial officer) should contact Tiffany Hollis at Tiffany.Hollis@acs-inc.com or 601-206-2986.

14. Will the new method apply even to small hospitals? Medicare exempts critical access hospitals from its DRG-based payment method.

The new method will apply to all hospitals. The simulation using January-June 2006 data showed that of 51 Mississippi hospitals with fewer than 50 beds, 43 would see an increase in payments, with 36 of those hospitals seeing an increase of more than 10%. Small hospitals will be protected against exceptionally expensive cases by the outlier features and by the fact that they often transfer complex cases to larger hospitals.

15. How will mental health stays be paid?

A mental health stay is one that groups to one of the 72 DRGs for treatment of psychiatric and substance abuse conditions. Both general and freestanding hospitals will be paid using the same set of 72 payment rates, with higher payments for more complex stays regardless of setting. The payment rates will equal the national relative weights for each DRG times a policy adjustor times the DRG base price. The policy

adjustor recognizes the importance of Medicaid funding in ensuring continued access to acute mental health care in Mississippi. Separate policy adjustors will be used for pediatric (under 21 years old) and adult stays. Under the new payment method, the payment-to-cost ratio for mental health cases will be higher than for any other care category. (Note: Separate pediatric and adult policy adjustors may not be in place by January 1, in which case a single MH policy adjustor will be used on an interim basis.)

Exceptionally long mental health stays—those that exceed 19 days—will be eligible for day outlier payments for each day that exceeds the threshold.

16. How will payments change in future years?

At least annually, the Division will review the base price to determine what change, if any, would be appropriate. The combination of the base price, the number of stays, the average casemix per stay, and the impact of the mental health policy adjustor determines the overall level of payments. We will also update the APR-DRG grouping algorithm to include new ICD-9-CM diagnosis and procedure codes.

All Patient Refined Diagnosis Related Groups

17. Why were APR-DRGs chosen? Why not Medicare DRGs?

Medicare DRGs were designed for the Medicare population and are a poor fit for conditions that are especially important in a Medicaid population, such as neonatal medicine, pediatrics, and obstetrics. In the past Medicare said it had plans to redesign its neonatal DRGs, but in 2004 it explicitly said it would not do so and recommended that Medicaid programs not use Medicare DRGs.

Another issue, even for Medicare itself, has been that Medicare DRGs are relatively unsophisticated in reflecting the complications and comorbidities that can have very significant effects on a hospital's costs. For many Medicare DRGs there is only one level of severity. For some, there are two. For APR-DRGs,

Example of How Medicare DRGs and APR-DRGs Handle Complications and Comorbidities

Primary Dx = 562.11 Diverticulitis

Primary Px = 45.71 Multiple resection of colon

	Patient 1	Patient 2	Patient 3	Patient 4	Dx Description
Secondary Dx	569.41	569.41	569.41	569.41	Anal ulcer
		560.9	560.9	560.9	Intestinal obstruction
			422.99	422.99	Acute myocarditis
			426.0	426.0	A-V block, complete
				584.9	Acute renal failure
Medicare DRG	149	148	148	148	
APR-DRG	221-1	221-2	221-3	221-4	

Explanation: A hospital has four patients, each with diverticulitis and each of whom undergoes a colon resection. Patient 1 has a single, minor secondary diagnosis. The case is assigned to Medicare DRG 149 and APR-DRG 221-1. Patient 2 has a significant complication, which results in a "higher" DRG and higher payment under both Medicare DRGs and APR-DRGs. Patient 3 has additional complications, resulting in no change to the Medicare DRG but assignment to APR-DRG 221-3. Patient 4 is gravely ill, but the Medicare DRG assignment is unchanged. The APR-DRG assignment is to 221-4, which has a higher weight and higher payment rate than 221-3.

by contrast, each DRG has four levels of severity. The table on the previous page shows an example. As a result, the DRG assignment—and therefore the payment—more closely reflects the difficulty and expense of the case to the hospital. In April 2006, Medicare proposed to replace its current grouping algorithm (in use since 1983) with a new grouper based on APR-DRGs. Medicare is expected to make a final decision in August 2007.

18. What was done and will be done to verify that APR-DRGs are appropriate for the Mississippi Medicaid population?

The Division hired ACS Government Healthcare Solutions to conduct a thorough assessment of the options. ACS analyzed Mississippi Medicaid claims data from January-June 2004 using three groupers: Medicare DRGs, All Patient DRGs, and All Patient Refined DRGs. Using the statistical tests that are standard in payment method development, the contractor found that APR-DRGs consistently fit the Mississippi data very well, and better than either of the other groupers. The results for the Mississippi Medicaid population were similar to those found in an evaluation of national data that focused on neonatal care. That evaluation, published in the journal *Pediatrics*, is available at no charge at http://pediatrics.aappublications.org/cgi/reprint/103/1/SE1/302.

In October 2006, a second simulation was done using January-June 2006 data to verify the validity of APR-DRGs, set the base price and other payment parameters, and simulate impacts on a hospital-specific basis.

19. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by 3M Health Information Systems and the National Association of Children's Hospitals and Related Institutions (NACHRI). According to 3M, APR-DRGs have been licensed by over 20 state and federal agencies and by 1,600 hospitals. To date, APR-DRGs have been used mostly to adjust for risk in analyzing hospital performance. Examples are the "America's Best Hospitals" list by *U.S. News & World Report*, state "report cards," and analysis done by organizations such as the Agency for Healthcare Research and Quality (AHRQ), the Medicare Payment Advisory Commission (MedPAC) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The State of Maryland uses APR-DRGs for risk adjustment in setting hospital-specific payment rates. Among the payers considering adoption of APR-DRGs for payment purposes are Medicare, Pennsylvania Medicaid, Montana Medicaid and Wellmark, the BlueCross BlueShield plan in Iowa.

20. Does my hospital need to buy APR-DRG software to be paid by Medicaid?

No. The Medicaid claims processing system will assign the DRG and calculate payment without any need for the hospital to put the DRG on the claim. (This was how the simulations were done using existing data.)

At their option, hospitals can buy APR-DRG software for use in calculating expected payments and managing their own operations. In a letter to the Division dated January 6, 2006, 3M Health Information Systems listed the prices that it would charge Mississippi hospitals for basic APR-DRG software.

- Hospitals with fewer than 1,000 admissions a year: $3,500
- Hospitals with 1,001 to 5,000 admissions a year: $5,800
- Hospitals with 5,001 to 10,000 admissions a year: $8,700
- Hospitals with more than 10,000 admissions a year: Variable scale depending on bed size

Price increases would be limited to an inflation adjustment. 3M also makes the APR-DRG software available to other vendors (e.g., Premier, HBOC) so that APR-DRGs can be integrated into their systems.

Hospitals interested in using APR-DRG should contact their information systems vendor. If the vendor is not familiar with APR-DRGs, more information is available at www.3m.com/us/healthcare/his/products/coding/refined_drg.jhtml.

Such decisions are up to the hospital; the Division does not require that hospitals install APR-DRGs nor does the Division or ACS have any financial interest in whether hospitals buy this software.

21. What version of APR-DRGs will be implemented?

Medicaid will implement APR-DRG Version 20 including the ICD-9-CM mapper that reflects new procedure and diagnosis codes effective October 1, 2006.

Impacts on Coding, Billing and Other Hospital Operations

22. How will the new payment method affect medical coding requirements?

Assignment of the APR-DRG and calculation of payment use the standard information already on the hospital claim. APR-DRG assignment depends chiefly on the diagnosis fields and the ICD-9-CM procedure fields, so hospitals are advised to ensure that these fields are coded completely, accurately and defensibly. Hospitals may want to review their inpatient coding and make any necessary improvements as soon as possible. As do other DRG payers, the Division will review claims from hospitals whose claims show a marked increase in average casemix following implementation of DRGs.

23. Will Medicaid use a "three-day window" like Medicare does?

Yes. If a patient is admitted on a Thursday, the hospital should not submit separate outpatient claims for diagnostic or related services provided on Monday, Tuesday or Wednesday. Payment for the inpatient stay is intended to cover all services provided during the stay and during the three-day window before the admission date. The DRG base price has been set so that it reflects payments previously made for both the stay and any outpatient services within the three-day window.

To reduce administrative burden on hospitals, the Division's intention is to apply the three-day window in the same way that Medicare does. Services in revenue codes 254, 255, 30X, 31X, 32X, 341, 35X, 371, 372, 40X, 46X, 471, 48X (certain procedure codes only), 53X, 61X, 62X, 73X, 74X and 92X are always considered related. Services in revenue codes 54X, 82X, 83X, 84X, and 85X are never considered related. For all other revenue codes, the outpatient service is considered related to the inpatient service if the two claims have the same principal diagnosis.

24. What will the policy be for interim claims?

Hospitals will not be required to submit interim claims under any circumstances. Unlike many DRG payers, the Division will make interim payments if a hospital chooses to submit an interim claim during an exceptionally long stay. This policy is intended to encourage hospitals to treat patients who may need weeks or months of acute care.

If a stay exceeds 30 days then the hospital can submit an interim claim and will be paid an interim per diem amount of $375 times the number of days. When the patient is discharged, the hospital would submit a replacement claim (type of bill 117) covering the entire admit-thru-discharge time period. If more than one interim claim had been submitted, the hospital would void the additional interim claims. The net result is that the claims processing system would recover the interim payments and then make a single DRG-based payment for the entire stay.

Claims for “interim—last claim” (type of bill 114) and late charges (type of bill 115) will be denied. Hospitals should use the other bill types as applicable.

25. How will hospitals be paid for newborns?

Starting with dates of admission on January 1, 2007, hospitals should bill each newborn on his or her own claim. (Currently, most newborns are billed on their mother’s claim.) As do other DRG payers, Medicaid will make separate payments for the mother and the baby depending on the DRG that is assigned to each stay.

26. What if the patient is not Medicaid-eligible during the entire length of stay?

Medicaid beneficiaries over the age of 20 are subject to a service limit of 30 days of acute hospital inpatient care per state fiscal year (July-June). Other circumstances can cause a patient to be eligible for Medicaid for less than the entire length of stay. Currently, the claims-processing system denies any claim that includes non-covered days.

Under the new payment method, if a patient is eligible for Medicaid and has at least one day left under the service limit, the hospital should submit an admit-thru-discharge claim as it would for any other beneficiary. The claims processing system will price the entire stay using DRG-based logic (including outlier provisions as appropriate) and then prorate the payment. The prorated payment will be the DRG payment divided by the nationwide average length of stay for that DRG times the Medicaid covered days, with double payment for the first day to reflect increased hospital costs on the first day.

27. How will claims be paid when a dually eligible Medicare/Medicaid beneficiary exhausts his or her Medicare days?

If Medicare days are exhausted prior to the admission currently being billed, the entire stay should be billed to Medicaid with the Medicare exhausted days reflected as an occurrence code and date. If Medicare days are exhausted during the stay, then two claims should be submitted to Medicaid. For the days where Medicare is the primary payer, Medicaid will pay the coinsurance and deductible. For the days where Medicaid is the primary payer, Medicaid will price the claim by DRG like any other claim. On the second claim, the fact that Medicare days have been exhausted must be shown as an occurrence code and date.

28. When a Medicaid beneficiary exhausts his or her Medicaid days, how will that fact be shown on the remittance advice?

A Remark Code stating “Plan Limitation Exceeded” will appear on the remittance advice.

29. How many diagnosis and procedure codes will Medicaid use to assign the APR-DRG?

The Envision claims processing system and the APR-DRG grouper can accept as many as 24 secondary diagnosis codes and 24 secondary procedure codes in addition to the principal diagnosis and principal

procedure. However, it should be noted that when billing claims on paper, the maximum number of code fields on the claim form (UB 92 or UB 04) will determine the maximum diagnosis and procedure code numbers sent to the grouper.

30. How will prior authorization be affected?

Changes in prior authorization processes are being finalized. Future versions of this Q&A document will provide final details. At this time, the policy under consideration is as follows:

- Authorization of admission
  - In general, all admissions not listed here as exceptions will continue to need prior authorization from the quality improvement organization (HealthSystems of Mississippi).
  - An admission for delivery need not be authorized by HSM if the length of stay is less than three days (vaginal delivery) or less than five days (Cesarean). These deliveries, however, must be reported to HSM in order to receive a Treatment Authorization Number (TAN). If the length of stay exceeds these numbers, the hospital must contact HSM for authorization of the stay and issuance of a TAN.
  - Another exception concerns normal newborns. These admissions do not need to be authorized or reported to HSM when the following apply:
    - Admission type = 4 (newborn born within the facility), and
    - Length of stay is less than five days.

    All other newborn stays require authorization.

  When Medicare is the primary payer, authorization is never required.

- Authorization of length of stay
  - In general, prior approval for the length of stay is not required.
  - If a stay exceeds the DRG Long Stay Threshold of 19 days then the hospital must call the QIO for authorization of additional days. (This is an update to the existing authorization – not a new authorization.) This requirement will affect less than 5% of all stays but is appropriate because long stays may result in cost or day outlier payments.

Other Questions and Next Steps

31. Will hospitals still have to submit cost reports?

Yes. This is a requirement under federal law. The Division will use cost reports as a data source in the annual review of the base price.

32. Will payments be subject to adjustment after cost reports have been submitted?

No. Payment based on DRG will be final. A major benefit of the new payment method is that payments will not be subject to adjustment two to three years after the date of service.

33. What testing will be done to ensure a smooth implementation?

The new payment method is a major change to the Envision claims processing system and extensive testing is being undertaken. ACS provides updates to the hospital technical advisory group at monthly meetings. Key testing steps include structured tests of approximately 100 unusual situations, a volume test of 42,000 claims, and parallel testing of production claims submitted by a dozen beta test hospitals.

34. What will Medicaid do to educate and train hospitals about the new payment method?

Workshops for hospitals occurred in Grenada, Jackson and Hattiesburg on July 12, 14 and 18 respectively. Additional workshops are scheduled for Jackson on November 6 and 15; for Greenville on November 9; for Oxford on November 10; for Hattiesburg on November 13; and for Biloxi on November 14. Sign-up information is available on the web sites referenced in the next paragraph and in the monthly provider newsletter.

Training materials from the workshops are available on the Division's Provider Relations website, http://msmedicaid.acs-inc.com. The website also includes this FAQ document, examples of how claims will be priced under a wide range of scenarios, and a list of payment rates for each DRG. The link is under "Provider Information" and is listed under "Publications". Information is also found on the DOM website at http://www.dom.state.ms.us. The link is under "Medicaid Provider Information" and is listed as "Hospital Inpatient APR-DRG Payment."

Hospitals may also request claim-specific detail on the simulation results for their hospital. See Question 13. For each hospital, the Medicaid field representative assigned to that area will be the primary source of information.

35. Who can I contact for more information?

- ***Questions about provider education.*** The Medicaid field representative assigned to your hospital. If you don't have the contact information, contact Suzanne Danilson, Provider and Beneficiary Services Manager, ACS Government Healthcare Solutions, suzanne.danilson@acs-inc.com, 601-206-2936.
- ***Technical questions about APR-DRGs, outliers, etc.*** Kevin Quinn, Director, Payment Method Development, ACS Government Healthcare Solutions, kevin.quinn@acs-inc.com, 406-457-9550.
- ***Questions about Division policy.*** Margaret King, Director, Bureau of Reimbursement, Division of Medicaid, rbmck@medicaid.state.ms.us, 601-359-6155.
- ***Questions about the hospital technical advisory group.*** Mary Patterson, Vice President, Mississippi Hospital Association, mpatterson@mhanet.org, 800-289-8884.

Medicaid Identification Card

It is the responsibility of the Medicaid provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service. The provider is also responsible for confirming that the person presenting the card is the person to whom the card is issued. This can be done by requesting a picture ID, such as a driver's license, school ID card, or verifying the Social Security number and/or birth date. It is preferred that providers verify the identity of the person presenting for service with a picture ID when possible. If it is found that the person presenting for services is not the Medicaid beneficiary to whom the card was issued, the provider is responsible for refunding any monies paid by Medicaid to the provider for those services provided.

Additional information regarding the Division of Medicaid's policy regarding the Medicaid identification card is in Section 3.05 of the Provider Policy Manual. Providers are reminded that they should review this policy periodically with their office staff.

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***.

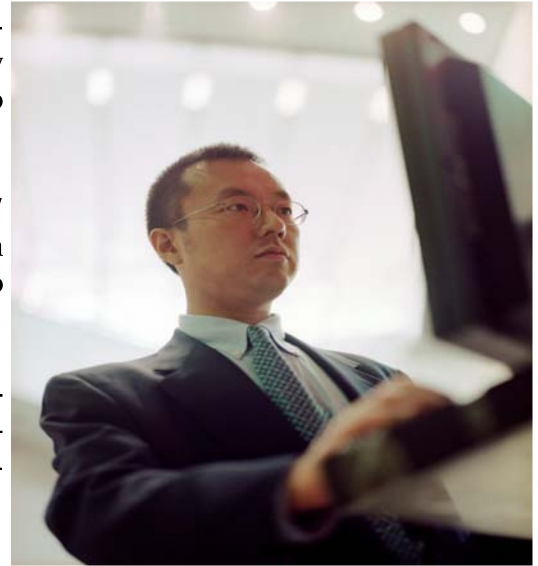
Contact: Evelyn H. Silas, Division Director
Bureau of LTC, Division of Case Mix
Division of Medicaid, Office of the Governor
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399
601-359-6750; Fax 601-359-1383
e-mail: lmehs@medicaid.state.ms.us

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	10.10 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
12.0 Non-Emergency Transportation (NET)	All (12.01 – 12.16)		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	31.02 Pharmacy Participation 31.12 Prior Authorization		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 52.13 Modifier -54, -55, -56	X 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 53.27 Modifier -54, -55, -56	 X 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
31.0 Pharmacy	31.13 Over the Counter (OTC) Drugs 31.15 Tobacco Cessation 31.24 Preferred Drug List	X X X		12/01/06
43.0 Federally Qualified Health Centers (FQHC)	All (43.01- 43.15)	X		12/01/06
77.0 Immunization	77.04 Vaccines for Children		X	12/01/06

Internet Access Is A Must!



In keeping up with the rapidly growing pace of business technology, Internet access is a must. Convenience is one of the many benefits the Internet provides. ACS encourages all providers to take advantage of the Mississippi Medicaid website.

The Mississippi Medicaid website is available 24 hours a day, 7 days a week. Over a period of time, using the website will result in tremendous cost and staff savings by the quick and easy access to Medicaid information.

The Mississippi Medicaid site was designed to assist the Mississippi Medicaid Provider with the ability to search and retrieve information immediately. The website is divided into two main areas: the public site and the data exchange site.

The public site contains provider support information such as:

- Manuals, provider enrollment applications, and enrollment forms
- Medicaid information, such as EDI service information
- Frequently asked questions
- Electronic claims submission software

The Data Exchange site is a secured site that contains Electronic Remittance Advices (ERAs) and Claim Rejection Reports. Providers are assigned a logon and password that will allow secure access to only that particular provider's Remittance Advice and/or Claim Rejection Report.

Providers can gain access to all of the above information by simply visiting the Division of Medicaid's website at www.dom.state.ms.us or ACS's EDI website at www.acs-gcro.com.

We encourage providers without Internet access in their offices to obtain it now. The Mississippi Medicaid site can save staff resources and money with instant information at no cost to the provider. The Internet is the avenue of choice for receiving current and immediate information.

Acquiring Additional Bulletins

One copy of the monthly Medicaid Bulletin is sent to every provider with an active provider number. If additional copies are needed, the bulletins may be downloaded from the publications page of the web portal at the following address: **http://msmedicaid.acs-inc.com**. Or, providers may call the ACS Provider and Beneficiary Services call center at 1-800-884-3222 to request additional copies.

Mississippi Medicaid Bulletin

ACS
P.O. Box 23078
Jackson, MS 39225

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

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

November

November 2006

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			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	15	16 EDI Cut Off 5:00 p.m.	17	18
19	20 Checkwrite	21	22	23 EDI Cut Off 5:00 p.m.	24	25
26	27 Checkwrite	28	29	30 EDI Cut Off 5:00 p.m.		

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.