Mississippi Medicaid Bulletin

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Inside this Issue

Billing Tip For WINASAP2003 Users

When using WINASAP2003 please be sure to check your rejection reports after submitting claims electronically. Review the Claims List to verify the status of your claims whether changed from BILLED to ACCEPTED. Providers can check two hours after the initial transmission by simply clicking {Tools}, {Receive Response}. This connects to the EDI host, then review the Claims List is displayed for review. If the status is REJECTED, the claims were not sent to the Envision claims processing system for processing. If the claims are rejected, please call 1-800-884-3222 and choose the EDI prompt. Additionally, please be prepared to provide the batch file number.

Procedural Changes for Claims Involving Beneficiary Retro-eligibility

Recent policy changes have simplified the process of filing claims involving beneficiary retroactive eligibility. When Medicaid is the primary insurance the claims can be filed electronically as they no longer require proof of the retroactive determination. The claims must be submitted within 12 months of the retroactive determination date otherwise the claims will deny for untimely filing. If the beneficiary is a dual eligible the claims must be filed and processed within 6 months of the retroactive determination date.

Please refer to the Mississippi Division of Medicaid Policy Manual, Section 3.03 Beneficiary Retroactive Eligibility at website www.dom.state.ms.us.

Modifier 54 and 55

Effective November 1, 2006 modifier 54 and 55 should be billed with surgery codes. Surgical codes billed with modifier 54 will pay 85% of allowed charges for the surgical procedure. Surgical codes billed with modifier 55 will pay 15% of allowed charges for post-op care.

Please refer to the Mississippi Division of Medicaid Policy Manual, Section 52.13 Modifier– 54,-55, and –56, and Section 53.27 at website www.dom.state.ms.us.

Needed: NPI Pilot Testers!

The Division of Medicaid (DOM) and ACS Government Healthcare Solutions are seeking providers to participate as National Provider Identifier (NPI) pilot testers prior to the May 23, 2007 implementation of NPI. Pilot testing helps both providers and DOM/ACS prepare for a successful implementation and transition to the use of the NPI.

If you are interested in becoming an NPI pilot tester, please contact ACS Provider Support at 800-884-3222 and be prepared to provide the following information to the customer service associate:

- Provider Number
- Provider Name
- Contact person – *Note:* the contact person should be able to answer claims and billing questions, as well as validate test results.
- Contact telephone number
- Contact email address

The deadline for expressing your interest in NPI pilot testing and providing the requested information above is December 29, 2006.

All providers who request to participate in NPI pilot testing may not be selected. Final selection of participants will be made by the Division of Medicaid and ACS Government Healthcare Solutions. Those providers selected as pilot testers will receive notification and additional information in January 2007.

If the providers have not already done so, it is strongly suggested that they obtain their NPI now. If you have not obtained and submitted your NPI to the Mississippi Medicaid program, please review your September 2006, October 2006, and November 2006 Mississippi Medicaid provider bulletins for more detailed information on NPI.

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
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
52.0 Surgery	52.14 Enterra Therapy	X		12/01/06
53.0 General Medical Policy	53.28 Enterra Therapy	X		12/01/06
77.0 Immunization	77.04 Vaccines for Children		X	12/01/06
68.0 HCBS/ Assisted Living Waiver	68.02 Eligibility 68.06 Covered Services		X X	01/01/07

New Additions to DOM's Preferred Drug List*

Effective January 1, 2007, the Division of Medicaid's Preferred Drug List, or PDL, will be updated. The following agents are added to Preferred Status:

(1) Anticonvulsant Drugs: Carbatrol®, Depakote®/Depakote ER®, Dilantin®, Equetro®, Gabitril®, Keppra®, Lamictal®, Lyrica®, Trileptal®, Topamax®, and Tegretol XR®
(2) Antipsychotic Agents: Geodon®, Risperdal®, Symbyax®, and Zyprexa®
(3) Disease-specific Immunosuppressant Agents: Enbrel ®, Humira®, and Raptiva®.
(4) Injectable Deep Vein Thrombosis Agents: Arixtra ® and Lovenox ®.
(5) Acne Preparations (drug coverage is limited to beneficiaries less than 21 years of age only): Benzaclin®, BenzamycinPak®, Duac®, Evoclin®, Klaron®, Nuox®, Suphera®, Tazorac®, and Zaclir®.
(6) Otic Antibiotics: Ciprodex® and Floxin® Otic.
(7) Growth Hormones: Genotropin®, Nutropin®/Nutropin AQ®, Norditropin®, Saizen®, Serostim®, and Tev-Tropin®.

**for comprehensive PDL list, refer to DOM's website at www.dom.state.ms.us, select Pharmacy Services, and go to Preferred Drug List*

Clarification: Albuterol inhalers and DOM's PDL

The Pharmacy Bureau has received questions regarding limited availability of Albuterol CFC in regards to MS Medicaid's Preferred Drug List. Preferred drugs have been selected for their efficaciousness, clinical significance, cost effectiveness and safety. Many preferred drugs have supplemental rebates and the retail cost and Medicaid costs are not the same. Since April 1, 2006, Albuterol CFC has been a preferred drug and Albuterol HFA has been a non-preferred drug. Albuterol CFC is being phased out and complete withdrawal from the marketplace is to be no later than December 31, 2008. For more information about the timeline and withdrawal of Albuterol CFC from the marketplace, go to the FDA's website at http://www.fda.gov/cder/, select drug shortages, and go to Albuterol.

Inhaled respiratory agents, such as albuterol, will be reviewed by the P & T Committee in early 2007 and subsequent changes to the PDL will become effective on July 1, 2007. For the complete PDL, refer to our website at www.dom.state.ms.us, select Pharmacy Services, and click on PDL. A chart listing preferred and non-preferred sympathomimetic respiratory agents as of April 1, 2006 is included for your easy reference:

Preferred Drugs Override/PA not required	Non-Preferred Drugs Override/ PA IS required
Sympathomimetics	
Albuterol (soln.for inhal., syrup, tabs)	albuterol HFA (generic**, Ventolin HFA, Proventil HFA**)
Albuterol CFC (*until completely withdrawn*	albuterol (**AccuNeb, Vospire ER**)
from the market by 12-31-08)	formoterol (**Foradil**)
levalbuterol (**Xopenex Inhalation Sol**)	pirbuterol (**Maxair**)
levalbuterol (**Xopenex HFA**)	
metaproterenol	
salmeterol (**Serevent Diskus**)	
terbutaline	

Changes to the Non-Emergency Medical Transportation Program

Effective November 1, 2006, LogistiCare Solutions, LLC will be managing the Non-Emergency Medical Transportation Program for the Division of Medicaid. LogistiCare will arrange transportation for eligible Medicaid beneficiaries to services covered by Medicaid, if they have no other means of transportation. Beneficiaries in a Family Planning, QMB, SLMB or QI-1 category of eligibility are not eligible for transportation services. Transportation arrangements to routine medical appointments must be made 72 hours (3 business days) in advance. Transportation may be arranged by the beneficiary, a caregiver or a medical facility by calling 1-866-331-6004. Before you call, please have the following information ready:

- current Medicaid ID number;
- time and date of the medical appointment;
- address and phone number of the medical facility; and
- reason for the appointment.

LogistiCare has provided a brochure which provides additional details regarding the transportation program. You may access this information on our website at www.dom.state.ms.us.

MISSISSIPPI MEDICAL ASSISTANCE PROGRAM PLAN OF CARE UPDATE

Effective January 01, 2007, all PLAN OF CARE AUTHORIZATION REQUESTS **for Expanded Service Office Visits/Physician Services**, as referenced in Division of Medicaid Policy Section 73.09, will be provider specific. Please include your billing provider number on all prior authorization request forms. This information is located in Section 1 of the Plan of Care form. If you do not give us an appropriate provider number in this section your authorization request form will be returned to you for this information.

COMPLETING A PLAN OF CARE FORM FOR FASTER RESULTS

Tips from the Bureau of Maternal and Child Health – Expanded EPSDT units to increase the timely processing of your Plan of Care form.

- ❖ Be sure that all 4 copies are attached.
- ❖ List full mailing address of Provider and list Provider billing number. If a stamp is used for provider address, make sure it is on all copies.
- ❖ Be sure that A, B, C, and D in the Medical Data section are completed.
- ❖ Be sure that Patient Information is filled out completely, most importantly the Medicaid ID# and Date of Birth (DOB).
- ❖ Be sure that Services Requested are listed.
- ❖ Do not write in Sections 5 or 6; these sections are for MEDICAID USE ONLY.
- ❖ Be sure that the Plan of Care is signed and dated by the PHYSICIAN, NURSE PRACTITIONER. If signed by anyone else, it will be returned. If you use a Rubber stamp signature, please be sure that all copies are appropriately stamped.
- ❖ Always use ink or type the Plan of Care .
- ❖ PLEASE BE SURE THAT WRITING IS LEGIBLE ON ALL 4 COPIES.
- ❖ Please do not mark through an Original PA number. If you have an original PA number, it should be submitted on our new Addendum form. All extensions and updated services within that fiscal year should be requested on the Addendum form. These forms may be ordered by calling ACS at (601) 206-2900 or 1 800 884 3222.
- ❖ Medical Review is done once a week, please allow at least two weeks for a response.

REMEMBER! THE PLAN OF CARE FORM IS LIMITED TO CHILDREN FROM BIRTH TO 21 YEARS OF AGE

If you have any questions regarding the Plan of Care form, please call 601-359-6138 (Jeanette Williams), 601-359-6143 (Rose Mary Beason) or 1-800-421-2408.

Attention EPSDT Providers – No More Period Limits for Allowable EPSDT Screenings!

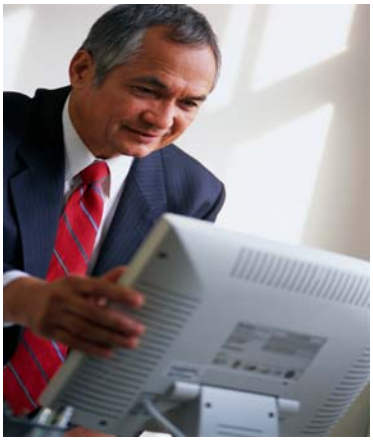
The Medicaid Claims processing system has been corrected to now look specifically at the age of the beneficiary as of the actual first date of services, eligible Medicaid children must be screened within the age parameter. A 12-month screening cannot be paid when it occurs before the child's 1st birth date. Please abide by the Mississippi Medicaid Periodicity schedule as shown below. When a beneficiary's age falls outside of the specified range, then the system will edit accordingly with exception code 0434 or 3234.

Only EPSDT Providers can be reimbursed for the above screening services. Due to the system change, allowable days can no longer be paid.

Screening Code		Modifier	Age of Child	Unit
New Patient	Established Patient			
99381	99391	EP	0 – 1 Months	1
99381	99391	EP	2 Months	1
99381	99391	EP	4 Months	1
99381	99391	EP	6 Months	1
99381	99391	EP	9 Months	1
99382	99392	EP	12 Months	1
99382	99392	EP	15 Months	1
99382	99392	EP	18 Months	1
99382	99392	EP	2 – 4 years*	1
99383	99393	EP	5 - 11 years*	1
99384	99394	EP	12 – 17 years*	1
99385	99395	EP	18 - 21 years*	1

* Beginning at 2 years of age EPSDT Screenings can be done annually*

Nursing Facilities: Electronic Reports for Case Mix



Case Mix Reports will now be available through the Division of Medicaid internet website: www.dom.state.ms.us. Once the authorized representative for the nursing facility has logged onto the website, the interim and closed quarter Case Mix Nursing Facility(NF) Reports can be retrieved by following the steps once the authorized representative for the nursing facility has logged on to the website. Instructions to access the electronic reports were mailed to each nursing facility administrator in November, 2006. If the NF did not receive these instructions, please call the telephone numbers noted below. The electronic copies will be in a PDF format with the ability to print out by the facility. Passwords to access the website and your reports will be unique to your facility only. You will only be able to access your nursing facility's reports.

Interim rosters and bedhold reports will continue to be mailed for the fourth quarter due on December 15, 2006 and January 15, 2007. Paper copies will no longer be mailed to the facility after January 15, 2007. If you have any questions or problems accessing the website, please contact the Case Mix Hotline at 601-359-5191; or Evelyn H. Silas at 601-359-6750.

IMPLANON

Effective for dates of service beginning August 1, 2006, the Division of Medicaid will cover the contraceptive implant IMPLANON. IMPLANON is indicated for women for the prevention of pregnancy for up to three years. When billing, please use the following codes:

CPT Codes – use these codes for the insertion and removal procedures
11981: Insertion, non biodegradable drug delivery implant
11982: Removal, non-biodegradable drug delivery implant
11983: Removal, with reinsertion, non-biodegradable drug delivery implant

HCPCS Code – use this code for the IMPLANON implant
J3490: Unclassified Drugs. NOTE – Claims for the IMPLANON implant must be submitted on a paper claim with the name of the drug (implant), strength, dosage and method of administration being indicated. Only (1) unit can be billed. Claims will be reviewed by the fiscal agent's Medical Services Unit and priced according to the dosage administered to the patient.

Implanon is NOT covered for Medicaid beneficiaries in the Family Planning Waiver (category of eligibility 029).

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 Services Call Center 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.

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.

November 20 Update

This version of Frequently Asked Questions supersedes all previous versions. Compared with the October 25 version, it includes new information on DRG weights and rates (questions 8-9), post-acute transfers (question 13), future changes in the base price (question 18), interim claims (question 26), pro-rated claims (question 28), the 30-day service limit (question 30), authorization of services (questions 33-41), preparation for implementation (questions 44-45) and provider education (question 46).

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's cost report was audited by a federal contractor and reviewed by Division staff, 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 an uncomplicated heart attack will be assigned to one DRG and a heart attack patient with a complication 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, DRG 190-1 has a relative weight of 1.281 and DRG 190-2 has a relative weight of 1.540 and the base price is $3,897.78, then payment is as follows:

DRG 190-1: 1.281 x $3,897.78 = $4,993.06
DRG 190-2: 1.540 x $3,897.78 = $6,002.58

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. Where I can find a list of weights and rates?

The list of relative weights and payment rates is available on the Provider Relations website at http://msmedicaid.acs-inc.com and the Division of Medicaid website at http://www.dom.state.ms.us. There are weights and rates for 1,256 DRGs. In addition, there are two error DRGs, for a total of 1,258 groups.

10. 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.

11. 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.

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

As is common in DRG payment methods, there will be special calculations for patients that are transferred to other acute care settings and for situations in which the patient has Medicaid coverage for only part of the stay (e.g., exhausted days). Details are shown in the Pricing Examples document on the Provider Relations and Division of Medicaid websites.

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.

13. Will Medicaid have a post-acute transfer policy like Medicare does?

In some circumstances Medicare will reduce payment to a hospital when the patient is transferred to a skilled nursing facility or other post-acute setting. Medicaid will not have a similar policy.

Overall Payment Levels

14. 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 future 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 25).

15. 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.

16. 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.

17. 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 relative weight 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.

18. How will payments change in the future?

At least annually, the Division will review the base price to determine what change, if any, would be appropriate. Changes would be made with an effective date of July 1. 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.

As the Division and the hospital industry gain experience with the new payment method, it is also possible that the Division will change the base price if it becomes clear that the initial value was set too low or too high. Any changes would be made on a go-forward basis; we do not intend to make retroactive adjustments.

<u>All Patient Refined Diagnosis Related Groups</u>

19. 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, by contrast, each DRG has four levels of severity. The table on this 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.

20. 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. The second simulation confirmed the appropriateness of APR-DRGs for the Mississippi Medicaid population.

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

APR-DRGs were developed by 3M Health Information Systems and the National Association of

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.

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 planning or considering adoption of APR-DRGs for payment purposes are Medicare, Pennsylvania Medicaid, Montana Medicaid and Wellmark, the BlueCross BlueShield plan in Iowa.

22. 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.

23. 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

24. 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.

25. 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 exactly the same principal diagnosis.

26. 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 access for 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. After the patient is discharged, the interim claims would be voided or adjusted and a single payment would be made covering the entire stay. If the hospital had submitted one interim claim, it would adjust that claim. If the hospital had submitted more than one interim claim, it would adjust one of the interim claims and void the others. The procedures for submitting adjustments and voids to Mississippi Medicaid have not changed. Although an example in our November 2006 trainings referred to bill types 117 (adjustment) and 118 (void), these bill types should not be used. Instead, please continue to submit the adjustment/void request form, which is available at https://msmedicaid.acs-inc.com/PDFs/AdjustmentVoidRequestForm.pdf.

Bill types 114 (interim claim—final bill) and 115 (late charges) are currently accepted but will be denied after January 1. Instead, submit a single claim (either bill type 111 or an adjustment) covering all services provided during the stay.

27. 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.

28. 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.

The Medicaid payment will be considered payment in full only for those days that were covered by Medicaid. For non-covered days, hospitals may seek payment from patients in the same way that they do now.

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

A remark code stating that the number of days exceeds the maximum will appear on the remittance advice.

30. Will there be a change to the 30-day limit?

The 30-day limit is in statute and any change would have to be made by the Mississippi legislature. If the legislature makes such a change during its 2007 session, it is possible that it would be made on a budget-neutral basis. In that case, the DRG base price would be slightly reduced to offset the increased utilization.

31. 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.

32. 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.

Authorization of Services

33. Under what circumstances will stays require prior authorization of the admission?

With two exceptions, all admissions will continue to need prior authorization from the quality improvement organization (HealthSystems of Mississippi).

The first exception is that 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 two and four days respectively, the hospital must contact HSM for authorization of the stay and issuance of a TAN.

The second exception is that normal newborn stays do not need to be authorized or reported to HSM. A normal newborn is defined as having admission type 4 (newborn born within the facility) and length of stay less than five days. All other newborn stays require authorization.

34. Under what circumstances will stays require prior authorization of the length of stay?

In general, prior approval for the length of stay is not required.

The only exception is that if a stay exceeds the DRG long say threshold of 19 days then the hospital must contact HSM for authorization of additional days. (This would be an update to the existing authorization of the admission. It would not be a new authorization.) This requirement will affect only about 2% of all stays but is appropriate because long stays may result in cost or day outlier payments.

35. When should the first continued stay (concurrent) review request be submitted?

The first continued stay review request should be submitted on the 19th day, when the patient reaches the DRG long stay threshold. If the 19th day falls on a weekend or holiday, then the request should be submitted on HSM's next business day. The day of admission will be counted as the first day.

36. When should subsequent continued stay (concurrent) reviews requests be submitted?

After the first continued stay request has been submitted and HSM has certified additional days, subsequent continued stay review requests should be submitted the day following the last day certified, or HSM's next business day.

37. What date of admission should be used if the patient has been in observation or other outpatient status prior to admission?

Currently, when a patient has been in outpatient observation status and is then admitted to inpatient status, the Division instructs the hospital to use the first day of outpatient observation status as the inpatient admission date. Under the new payment method, this instruction will change. The date of the inpatient admission should be the date the patient enters inpatient status as indicated by the physician's order. We believe this will reduce administrative burden on hospitals.

See question 25 about billing and payment of observation and other outpatient services provided in the three days before the inpatient admission.

38. Will providers still receive the 48-hour list after implementation of APR-DRGs?

No, after implementation of APR-DRGs, the 48-hour list will be eliminated. Currently, HSM faxes a list to providers notifying them of beneficiaries whose certifications expire within 48 hours. As over 95% of beneficiaries will not reach the 19-day length of stay threshold, the 48-hour list will not be as applicable, and, thus, will be discontinued.

39. How is length of stay calculated?

The length of stay equals the last day of service minus the first day of service, with two exceptions. First, if the patient is admitted and discharged on the same day, then the length of stay is one day. Second, if the patient is still a patient (discharge status 30) on the last day of service, then the last day also counts in the length of stay. For example:

Monday → Wednesday with discharge status 30 = 3 days
Monday → Wednesday with any other discharge status = 2 days
Monday → Tuesday = 1 day
Monday → Monday = 1 day

40. In some cases, a hospital will move a patient from a medical/surgical unit to a rehabilitation unit or psychiatric unit within the same hospital. Will this count as one stay or two for purposes of calculating DRG payment?

If HSM authorizes both stays as having met the criteria for medical necessity, then the hospital can discharge the patient from the medical/surgical unit and admit him or her to the rehabilitation or psychiatric unit. Two claims would be submitted, each with its own treatment authorization number (TAN), and two DRG payments would be made.

41. Is Medicaid authorization required for dually eligible beneficiaries when Medicare is the primary payer?

No.

Other Questions and Next Steps

42. 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 DRG base price.

43. 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.

44. What testing has been done to ensure a smooth implementation?

The new payment method is a major change to the Envision claims processing system and extensive testing has been undertaken. ACS provides updates to the hospital technical advisory group at monthly

meetings. Key testing steps included 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.

45. Is there a contingency plan?

Yes. All the claims processing logic currently used to price and pay claims will remain in place and is separate from the new logic. If there is any problem with the new payment method, it would be straightforward to revert to the pricing and payment logic.

46. What has Medicaid done to educate hospitals about the new payment method?

- A total of about 700 hospital staff have attended Division of Medicaid training sessions and presentations on the new payment method. These took place in July in Grenada, Jackson and Hattiesburg; in August in Philadelphia at the Healthcare Financial Management Association meeting; and in November in Jackson (two sessions), Greenville, Oxford, Hattiesburg and Biloxi. Another presentation will take place at the Mississippi Health Information Management Association meeting in Tupelo in February.

- Articles on the new method have appeared in each monthly provider bulletin since July 2006.

- The design and implementation of the new method has been discussed in detail with the hospital technical advisory group every month since January 2006.

- Medicaid field representatives proactively contacted many hospitals in and out of Mississippi to make them aware of the new payment method and answer any questions.

- Each hospital can request results from the financial simulation for that hospital at the claim-specific level. About 75 hospitals have requested and received these data.

- Training materials are available on both the Provider Relations website at http://msmedicaid.acs-inc.com and the Division of Medicaid website at http://www.dom.state.ms.us. These materials include this FAQ document, a complete list of DRG weights and rates, a set of pricing examples, and the presentations from the November trainings.

47. 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.

Application for Newborn Health Benefits Identification Number

The Division of Medicaid is pleased to announce the latest release of the "Application for Newborn Health Benefits Identification Number" form. This form is commonly referred to as the "K-baby or Newborn" form. The revised form can be located on the Division of Medicaid internet website at:

http://www.dom.state.ms.us/Provider/Newborns/newborns.html.

When the page is accessed, there will be a link titled, "Request for Newborn Health Benefits ID number form." Click on that link and the updated application form will display. The form can be saved and printed as a blank form and/or completed interactively by tabbing to each text field.

The "Application for Newborn Health Benefits Identification Number" form must be signed by the mother and completed prior to the mother's discharge. All information on the form must be completed correctly including the baby's name, date of birth and hospital fax number. The completed and signed form should be faxed immediately to the Medicaid Regional Office in the county where mother and baby will reside. The form will be faxed back to the hospital within 7-10 days showing the baby's permanent Medicaid ID number.

Private Duty Nursing (PDN) Providers

For dates of service beginning on November 1, 2006, HCPC Code S9123 billed with the "TG" modifier will be reimbursed at a higher rate. The new rate is $35.00 per unit. This new rate only applies to Private Duty Nursing RN's servicing Mississippi Medicaid beneficiaries on home ventilators. The Division of Medicaid will monitor all claims submitted for payment to ensure that this rate is only requested and paid for the beneficiaries receiving home ventilator management services.

Billing Tip - DME and Medical Supplies

Durable Medical Equipment is reusable medical equipment and should be billed using the modifiers NU, UE, RR, KR, RP, or MS including any miscellaneous codes that meet this definition. Medical supplies are disposable and these codes should be billed using the SC modifier.

Sterilization Consent Forms

Sterilization consent forms are scanned into the Envision system when sent to ACS for processing. To ensure that the forms are processed correctly, please verify that all of the appropriate form fields are completed and the signature and dates are clear and legible. The consent form consists of several copies. Please use a ballpoint pen and apply sufficient pressure when completing the forms to create legible documents.

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

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

December

December 2006

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4 Checkwrite	5	6	7 EDI Cut Off 5:00 p.m.	8	9
10	11 Checkwrite	12	13	14 EDI Cut Off 5:00 p.m.	15	16
17	18 Checkwrite	19	20	21 EDI Cut Off 5:00 p.m.	22	23
24	25 Checkwrite DOM and ACS CLOSED	26 DOM and ACS CLOSED	27	28 EDI Cut Off 5:00 p.m.	29	30

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.