Mississippi Medicaid Bulletin

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Inside this Issue

Assistance for Providers

Provider and Beneficiary Support staff is available to assist providers in various ways and can be reached at 1-800-884-3222. Questions regarding claims status, explanations of denials, provider enrollment inquiries, and assistance from EDI can be addressed immediately Monday through Friday 8 a.m. to 5 p.m. Inquiries can also be sent 24 hours a day, 7 days a week, 365 days a year via the Envision Web portal at http://msmedicaid.acs-inc.com by logging on and selecting "Ask Provider Relations."

Provider Field Representatives are available to assist providers with large complex issues and are also available to conduct policy, program, and software training. Should you experience complex issues or need training, please call or email the appropriate representative. Provider Representatives work in the field two to three days each week and are not always available immediately, but they return calls and email within 24 to 48 hours.

In an effort to protect Protected Health Information (PHI), claims should not be mailed to provider representatives. All claims should be mailed to

ACS
P.O. Box 23076
Jackson, MS 39255

Fee Schedules Online

ACS would like to thank the providers for their inquiries regarding current fee schedules. As a service to you, we have provided a current fee schedule for providers on the Envision website.

The address is http://msmedicaid.acs-inc.com. On the left hand column of the screen, please refer to the Provider Information section, and click on Fee Schedule link. When prompted, the procedure code and corresponding date of service may be entered. The listed procedure code and fee(s) will then be listed along with the Factor Code description.

For any additional information, please call the ACS Provider Support Line at 1-800-844-3222.

NPI Deadline – 2 Months and Counting!

NPI: Get it. Share it. Use it.

The National Provider Identifier (NPI) compliance date is May 23, 2007. By now, providers should have already obtained their NPI and provided it to Mississippi Medicaid. For more information on how to provide Mississippi Medicaid with your NPI, please reference pages 3-4 of your November 2006 Mississippi Medicaid Provider Bulletin.

Providers should now be moving from the enumeration stage into the implementation stage to ensure NPI readiness by the compliance date. In order to ensure NPI readiness at your facility, the following information and steps will assist you in your preparation:

1. Individual healthcare providers will be assigned a Type 1 NPI.
2. Organizations and subparts will be assigned a Type 2 NPI.
3. Electronic submitters must update their software application to address HIPAA transactions and CMS1500, UB04, and Dental claim form changes.
4. Contact/collaborate with your trading partners (health plans, TPAs, clearinghouses, etc.) to ensure their readiness.
5. Test the NPI, both internally and externally.
6. Educate your staff on the NPI and the use of it.
7. Implement the NPI into your business practices.

Important Facts:

- **Individuals or organizations with subparts (ER department, EKG department, Radiology department, or other facilities) which send electronic transactions must obtain separate NPIs.**

- **Effective May 23, 2007, Medicaid providers who have the same NPI for multiple Medicaid provider numbers MUST report a taxonomy code on all claims submitted to ACS Government Healthcare Solutions.**

- **Taxonomy codes are important for distinction and cross-reference to the appropriate NPI and legacy provider numbers.**

For additional Information:
Please note the following website address for the Centers for Medicare and Medicaid Services (CMS): http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp#TopOfPage

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 need additional information.

What Is Late Breaking News And Where Can I Find It?

Late Breaking News has become a place for providers to see the most current issues concerning Medicaid claim processing issues. Providers are encouraged to visit this website on a daily basis for an up-to-date list of issues and recommended resolutions. This will assist them with understanding the situation, and what is being done to correct it, and let them know if a mass reprocessing will occur.

The Late Breaking News is not updated daily, but as issues arise, providers need to be kept informed about any billing problems they may be experiencing. The update is approved by DOM and put online with a date/time stamp for providers to read when they visit the website. It is imperative that providers visit this link frequently.

The Late Breaking News link can be found at:

http://msmedicaid.acs-inc.com/ - located on the upper right hand corner under What's New? section

Message for All Providers of EPSDT Screenings

The Division's EPSDT program is now the "Mississippi Medicaid Cool Kids" program. EPSDT is the acronym for Early and Periodic Screening, Diagnostic and Treatment. The EPSDT program is a federally mandated program that was designed for Mississippi children ages birth to 21 years who are eligible to participate in the Medicaid program.

The Cool Kids program is free to qualified Medicaid youngsters and provides a way for them to receive medical examinations, check-up treatment, and special care they need to ensure they enjoy the benefits of good health. The Cool Kids examination provides a complete physical examination; hearing and vision examinations; any shots that are needed; necessary blood and urine tests; blood lead levels; an examination of the child's development including how he or she behaves, walks, talks, dresses, climbs and eats; an evaluation of the family's nutritional habits including what foods the child and his or her family eats; and medical referral or referral to another health care provider if special problems are discovered during the exam.

For more information about the Mississippi Medicaid Cool Kids program call statewide 1-800-421-2408, or in Jackson 601-359-6050.

Expanded EPSDT Services

Expanded EPSDT Services are health-care services that fall outside of the regular services that are covered by Medicaid and are rendered to children up to the age of 21 years. These services must be deemed medically necessary. "Medical necessity is defined as the determination by the Medical Assistance Program that a service is reasonably necessary to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life or cause suffering or pain or result in illness or infirmity or threaten to cause or aggravate a handicap or cause physical deformity or malfunction. There must also be no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service." These health-care services are rendered to correct or alleviate illnesses and conditions that were identified during the EPSDT screening.

When claims have been denied because the physician office visit service limits have been exceeded, the beneficiary may get additional visits through the EPSDT program if the provider is a participant. The additional visits can be obtained through the Maternal and Child Health Bureau when the provider submits a Plan of Care form (MA-1148). The request for the forms and the submission of the prior approval requests should be forwarded to

Mississippi Division of Medicaid
Maternal and Child Health Services
Robert E. Lee Building
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399

The form contains a Prior Authorization (PA) number which is preprinted and located in the upper right corner. The MA-1148 has four copies. The white copy is retained for DOM's records, the yellow copy is for the fiscal agent, the pink copy is for the primary provider and the gold copy is for the "other" provider. DOM will return the "provider's copy" and the "other provider's copy" to the primary physician once the determination for approval or disapproval has been made. A copy of the decision will be sent to the fiscal agent to enter the information into the Prior Approval file and the fourth copy will be retained by DOM. It is the primary physician's responsibility to forward the "other provider's copy" to the servicing provider.

Medicaid claims that are filed for reimbursement must have the preprinted PA number on the CMS-1500 (field 23) and the UB-92 / UB-04 (field 63). The PA number is an eight character alpha/numeric number, and for the claim to process correctly, all eight characters must appear legibly on the claim.

"Always remember that a healthy child leads to a healthy adult."

Pharmacy News Update

The Division of Medicaid has received calls from parents/ legal guardians advising that pharmacies are billing them for non-covered services for beneficiaries under age 21. While there are many services not covered under the Division of Medicaid's pharmacy policy, there are circumstances that may allow coverage through EPSDT (refer to Policy Manual Section 73.09). Pharmacy providers are encouraged to contact the Bureau of Pharmacy at 601-359-5253 for information on cases on which the EPSDT Expanded Services provisions may apply.

Freedom of Choice in Selecting Providers

The Division of Medicaid has received complaints from beneficiaries regarding freedom of choice when selecting a Medicaid provider. The Medicaid policy regarding the right of freedom of choice of providers for the beneficiary may be located in the Division of Medicaid Provider Policy Manual, Section 3.07, page 1, or the website address:
http://www.dom.state.ms.us/Provider/Provider_Manuals/Section_3_Beneficiary_Information.pdf.

Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Section 1902(a) (23) of the Social Security Act provides that "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required."

Providers of Medicaid services agree to comply with this section of the Act in the Provider Agreement. This means that providers may not take any action to deny freedom of choice to individuals eligible for Medicaid by using systems, methods, or devices which would require persons eligible for Medicaid to obtain a service from a particular provider.

This also means that providers may not require any individuals eligible for Medicaid to sign a statement of waiver, if such statement would, in any manner, deny or restrict that individual's free choice of a provider of any services for which the individual may be eligible. Providers cannot use any method of inducement (including free transportation, refreshments, cash or gifts) to influence a beneficiary to select a certain provider.

Exception: Under a federal waiver or approved State Plan amendment, freedom of choice may be restricted for individuals enrolled in a managed care program. These individuals are required to receive primary care from a primary care provider (PCP) and have specialty care prior authorized by the PCP.

Violation of a beneficiary's right for freedom of choice for a provider may result in termination of your provider agreement.

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.

Hospice Enrollment/Disenrollment Forms

Hospice providers participating in the Medicaid program that execute a provider agreement with the Division of Medicaid may be reimbursed for services provided to qualified Medicaid beneficiaries. Providers must submit Enrollment and Disenrollment Forms on all beneficiaries requesting hospice services at their facility. Beneficiaries may revoke the election of hospice care for the following reasons: death, hospitalization unrelated to terminal illness, seeking treatment other than palliative in nature, client choice, or no longer meets program requirements. These forms cannot be faxed to the fiscal agent. Please allow 3 to 5 business days for these forms to be processed. All Enrollment/Disenrollment Forms can be mailed to

ACS
Attention: File Maintenance
P.O. Box 23076
Jackson, MS 39225

Enrollment/Disenrollment Forms can be found on the Division of Medicaid website (www.dom.state.ms.us). Please select the Provider Policy Manual, Section 14 for forms. This section also provides directions for completing these forms.

IMPORTANT NOTICE

Medicare Part D Fraud and Abuse Contact

As a part of the Medicare Modernization Act (MMA) of 2003, the Centers for Medicare & Medicaid Services (CMS) implemented the Medicare Part D benefit for eligible individuals throughout the United States. In order to safeguard this program CMS contracted with a group of organizations called Medicare Part D Drug Integrity Contractors (MEDICs) to detect and prevent Part D fraud and abuse.

Mississippi's Medicare Part D Drug Integrity Contractors or MEDICs' Fraud and/or Abuse contact is Science Applications International Corporation or SAIC. SAIC's duties include investigation of complaints, audits, fraud case development, support of law enforcement, MA PD and PDP education, and beneficiary training and outreach.

Complaints or allegations of fraud, waste or abuse in the Part D program in MS can be referred to

MEDIC West Program
Science Applications International Corporation
450 North Brand Boulevard
Suite 410
Glendale, CA 91203
Confidential Fax Number: (818) 543-7690
1-877-7SAFERX (877-772-3379)

Additional Information or questions regarding SAIC may be directed to:

Craig Swartz
Outreach Manager
MEDIC West
Science Applications International Corporation
7008 Security Boulevard, Suite 210
Baltimore, MD 21244
Office Telephone: (571) 241-4723
swartzcm@saic.com

New Web Portal on the Horizon

ACS and DOM are pleased to announce that effective April 30, 2007, the Envision Web Portal will be further enhanced with several new features as well as a new appearance. Some of the improved features are

1) Ability to obtain information such as policy, forms, billing tips, and FAQs according to provider type
2) Perform claim inquiry and receive the specific edit codes for the reason of denial
3) Search provider bulletins by keywords
4) View General Billing Tips
5) View top three Late Breaking News messages on the home page

Access to the Mississippi *Envision* Web Portal is available 24 hours a day, 7 days a week, 365 days a year via the Internet at **http://msmedicaid.acs-inc.com.** Don't forget to bookmark the DOM Web Portal in your browser *Favorites* the first time you visit the site so you can quickly return again and again. More information on the new Web Portal will be published in future Provider Bulletins.

Notice To All School Health-Related Service Providers

As a result of the web portal enhancements, the School Service Checklist will be available online beginning April 30, 2007. Providers will be able to submit requests for school-based therapy services via the web portal. This enhancement only applies to therapy provided by the school in accordance with the respective beneficiary Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). The Division of Medicaid strongly encourages the use of the new enhancements because the enhancements will allow providers to submit secure information in a timely fashion, thereby eliminating lost and/or misplaced paper transmittals. ACS will be conducting provider training workshops to educate all providers in response to the new enhancements. This is not applicable to therapy providers who submit requests for therapy services to HealthSystems of Mississippi.

Notice To All Providers Who Submit Prior Authorizations/Plans Of Care Requests To The Division Of Medicaid

The Prior Authorization/Plan of Care process will be available online beginning April 30, 2007 as well. Providers will be able to submit requests for many of the services that require prior authorization requests along with the appropriate attachments via the web portal. This enhancement does not apply to any prior authorizations currently serviced through HealthSystems of Mississippi (HSM) i.e., therapy services, hospitalization, and durable medical equipment (DME). The Division of Medicaid strongly encourages the use of the new enhancements because the enhancement will allow providers to submit secure information in a timely fashion, thereby eliminating lost and/or misplaced paper transmittals. This is not applicable to providers who submit requests to DOM contractors (ex: HealthSystems of MS, HID etc.).

UB92 Transition to UBO4

In May 2005, the National Uniform Billing Committee (NUBC) unveiled the Uniform Bill 2004 (UB04) form. This form will replace the CMS-1450 or Uniform Bill 1992 (UB92) form by May 23, 2007. UB92 is the claim form currently used by hospitals, home health, hospice, psychiatric residential treatment facilities, nursing facilities, and intermediate care facilities to bill services to the Medicaid Program. One of the major changes on the UB04 form is the inclusion of the National Provider Identifier (NPI).

As a result of this change, the Division of Medicaid will be requiring that all paper claims previously submitted on a UB92 form be submitted on a UB04 form. **ACS and DOM will accept both the UB92 and UB04 forms from March 1, 2007 through May 22, 2007. However, beginning May 23, 2007 only the UB04 from will be accepted from that date forward.**

To effectively assist you with completing and submitting the UBO4 form, the following information is provided as a guide.

Field Number	Field Name	Description	Requirement
1	Provider Name	Enter the provider's name exactly as it appears in the upper left hand corner of the remittance advice. Enter the provider's mailing address, city, state, zip code and telephone. Line 1 - Provider Name Line 2 – Provider Street Address Line 3 – Provider City, State, Zip Line 4 – Provider Telephone, FAX, Country	**Required**
2	Pay-to Name	Line 1 – Pay-to Name Line 2 – Pay-to Address Line 3 – Pay-to City, State Line 4 – Not used **Not capturing**	
3a	Patient Control Number	Enter the patient account number. The patient's account control number, when furnished, will be reflected on the remittance advice.	Optional
3b	**Medical Record Number**	**Enter the provider taxonomy of the billing provider if the provider is a subpart of the facility**	**Required, If Applicable**
4	Type of Bill	Enter the type of bill code. This code indicates the specific type of bill being submitted and is critical to ensure accurate payment.	**Required**
5	Federal Tax Number	Federal Tax Number	

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Field Number	Field Name	Description	Requirement
6	Statement Covers Period – From/Through	Enter the inclusive days being reported on the bill in mm/dd/yy format. When billing for **outpatient services**, enter the first visit in the 'from' block and the date of the last visit in the 'through' block. On **hospital claims** the 'from' date must always equal the date of admission with the following three exceptions: 1) the second half of a split bill, or 2) the patient's Medicaid eligibility begins after the admission date, or 3) the baby remains hospitalized after the mother is discharged. On **PRTF** claims the "from" date must always equal the date of admission with the following exceptions: 1) the second half of a split bill, or 2) the patient's Medicaid eligibility begins after the admission date.	**Required**
7	Unlabeled	**Reserved**	
8a	Patient Name ID	**Not capturing**	
8b	Patient Name	Enter beneficiary's name, as it appears on the Medicaid ID card, in last name, first name and middle initial format.	**Required**
9a	Patient Street	Patient Street	
9b	Patient City	Patient City	
9c	Patient State	Patient State	
9d	Patient Zip	Patient Zip Code	
9e	Patient Country Code	Patient Country Code	
10	Patient Birthdate	Enter patient's birthdate in MM/DD/YYYY format.	**Required**
11	Patient Sex	Enter the sex of the patient. M – male, F – female, U – unknown	**Required**
12	Admission Date	Enter the month, day, and year of the admission of the beneficiary, mm/dd/yy format. This field is not required for FDC claims.	**Required**
13	Admission Hour	Enter time of admission in military time (24 hour clock).	**Required**
14	Type of Admission/Visit	Enter the admission code. Not required for FDC and hospice claims.	**Required**
15	Source of Admission	Enter the appropriate source of admission code. Not required for FDC and hospice claims.	**Required**

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Field Number	Field Name	Description	Requirement
16	Discharge Hour	**Not capturing**	Not required
17	Patient Discharge Status	Enter patient status code as of Field 6 'through' date.	**Required**
18-28	Condition Codes	Enter the appropriate condition code taken from the code structure in the Uniform Billing Manual.	**Required, If Applicable**
29	Accident State	**Not capturing**	
30	Unlabeled	**Reserved to capture the CLIA NUMBER**	
31-34	Occurrence Code/Date	Enter the appropriate occurrence code and date (mm/dd/yy format). See the Uniform Billing Manual.	**Required, If Applicable**
35-36	Occurrence Span Code/From/Through	Span Code not captured; From/Through dates should be entered in mm/dd/yy format.	
37	Unlabeled		
38	Responsible Party Name/Address	**Not capturing**	
39-41	Value Codes and Amounts	Enter the appropriate value code and amount. See the Uniform Billing Manual for Value Code structure. For Non Amount related Value codes also please include decimals. For example Value Code 80 is for Covered days. if the covered days on the claims is for 5 days…need to enter it as 5 in amount field and 00 in decimal place Note: Covered Days, Non Covered Days, Coinsurances Days and Life time reserve days should be entered on the form using value codes.	**Required, If Applicable**
42	Revenue Code	Enter the revenue code that identifies a specific service or item. The specific revenue codes can be taken from the revenue code section of the Uniform Billing Manual. Note: For hospital claims, if the revenue code(s) indicate surgery, there must be a surgery ICD-9-CM code in fields 80-81 a-e.	**Required**
43	Revenue Code Description	Enter the standard abbreviation of the narrative description for revenue code. Revenue descriptions are listed in the Revenue code section of the Uniform Billing Manual.	**Required**

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Field Number	Field Name	Description	Requirement
44	HCPCS/Rates/HIPPS Rate Codes	Enter the appropriate CPT or HCPCS Code for the services, including but not limited to: lab and radiology procedures, diagnostic tests, injectable drugs, and accommodation rate information. Not required for hospice claims.	**Required**
45	Service Date	For FDC and hospital outpatient services only, enter the month, day and year, mm/dd/yy format. Not required for hospice claims or PRTF claims.	**Required**
46	Units of Service	For FDC and hospital outpatient services only, enter the month, day and year, mm/dd/yy format.	**Required**
47	Total Charges	Enter the total charges pertaining to the related revenue codes for the current billing period as entered in the statement covers period. Charges incurred after the "through" date in field 6 cannot be billed on the UB04. Enter the grand total charges at the bottom of this field to be associated with revenue code 001.	**Required**
48	Non-covered Charges	Enter the charge for any non-covered service such as take-home drugs or services by private duty nurses.	**Required, If Applicable**
49	Unlabeled		
50	Payer Name	Enter the name in A, B and C identifying each payer organization from which the provider might expect some payment for the bill. One entry must be Medicaid, if the payer is Mississippi Medicaid.	**Required**
51	Health Plan ID	**Not captured**	
52	Release of Information	**Not captured**	
53	Assignment of Benefits	**Not captured**	
54	Prior Payments	Enter the amount paid by any other insurance carrier; do not include Medicare payments or contractual adjustments when no prior payment from the third party source is made.	**Required, If Applicable**
55	Estimated Amount Due	**Not captured**	
56	**NPI**	**Enter the National Provider Identifier.**	**Required**
57	Other Provider ID	Enter the eight-digit MS Medicaid ID number, as it appears in the upper left hand corner of the remittance advice.	**Required**
58	Insured Name	Enter the insured's name in A, B and C that relates to the payers in Form fields 50 A, B and C.	**Required**

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Field Number	Field Name	Description	Requirement
59	Patient's Relationship	**Not captured**	
60	Insured's Unique ID	Enter the insured's ID number in 50 A, B and C that relates to the insured's name in 58 A, B and C. Enter the patient's nine-digit Medicaid beneficiary identification number as it appears on the Medicaid card omitting the last three digits found after the ID number. A claim cannot be processed without the proper 9-digit ID number assigned to the individual who is receiving services. Each eligible beneficiary will have a Medicaid ID number. If the beneficiary is exempt from co-payment, enter the applicable exception code immediately following the Medicaid ID number. In the case of an infant who does not have an ID number assigned, the mother's Medicaid ID number should be entered in this field followed by the infant exception code "K".	**Required**
61	Insurance Group Name	State the name of the group or plan through which the insurance is provided to the insured.	**Required, If Applicable**
62	Insurance Group Number	State the number assigned by the insurance company to identify the group under which the individual is covered.	**Required, If Applicable**
63	Treatment Authorization Code	Enter the TAN authorization number in this field. This field is not required for Freestanding Dialysis Centers (FDC) claims.	**Required, If Applicable**
64	Document Control Number	Enter the DCN which is assigned to the original bill. **Not captured**	**Required**
65	Employer Name	Enter the name of the employer that could provide a source of third party insurance payment.	**Required, If Applicable**
66	DX Version Qualifier	**Not captured**	
67	Principal Diagnosis Code	Enter the ICD-9-CM code for the principal diagnosis codes that relate to the billing period.	**Required**
67a-q	Other Diagnosis	Enter the ICD-9-CM code for any other diagnosis codes that relate to the billing period.	**Required, If Applicable**
68	Unlabeled		
69	Admitting Diagnosis Code	Enter the ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.	**Required**

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Field Number	Field Name	Description	Requirement
70	Patient's Reason for Visit Code	**Not captured**	
71	PPS Code	**Not captured**	
72	External Cause of Injury Code	**Not captured**	
73	Unlabeled		
74	Principal Procedure Code/Date	Enter the appropriate ICD-9-CM surgical procedure code, if the operating room was used. Record the date in the mm/dd/yy format. This field is not required for hospice claims.	**Required, If Applicable**
75	Unlabeled		
76	Attending – NPI/QUAL/ID	Enter the NPI and ID for the attending provider. Qual Code not captured.	**Required, If Applicable**
77	Operating – NPI/QUAL/ID	**Not capturing**	
78	Other ID – QUAL/NPI/QUAL/ID	Enter the NPI and ID for the other provider. Qual Codes not captured.	**Required, If Applicable**
79	Other ID – QUAL/NPI/QUAL/ID	**Not capturing**	
80	Remarks	Use this area for notations providing additional information necessary to adjudicate the claim.	**Required, If Applicable**
81	Code-Code – QUAL/CODE/VALUE	**Not capturing**	

Time Limit for Filing Claims

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

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

1. Claims filed within 12 months from the date of service, but denied can be resubmitted with the transaction control number (TCN) from the original denied claim recorded in the appropriate field on the resubmitted claim.
2. Claims over 12 months can be processed if the beneficiary's Medicaid eligibility has been approved retroactively by the Division of Medicaid or the Social Security Administration through their application processes. Proof of retroactive determination or the appropriate documentation from the determining agency should accompany the claim and be filed within 12 months from the date of the retroactive letter.
3. The 12-month filing limitation for newly enrolled providers begins with the date of issuance of the provider eligibility letter.
4. The 180-day filing limitation for Medicare/Medicaid crossover claims will be determined using the Medicare payment register date as the date of receipt of Medicaid. Claims filed after the 180-day timely filing limitation will be denied.

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

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
21.0 Community-Based Mental Health Services	21.01 Introduction 21.02 Provider Categories 21.03 Definitions 21.04 General Requirements 21.05 Exclusions 21.06 Therapeutic Services 21.07 Evaluative Services 21.08 Documentation Requirements 21.15 Limitations to Service Provision 21.16 Prior Authorization 21.18 Clinical Record Review Process 21.19 Therapeutic Services Record Review 21.20 Psychological Evaluation Record Review		X X X X X X X X X X X X X	03/01/07
42.0 Foot Care	All (42.01-42.26) except 42.11	X		03/01/07
7.0 General Policy	7.03 Maintenance of Records		X	04/01/07
10.0 Durable Medical Equipment	10.55 Oxygen and Oxygen Supplies		X	04/01/07
52.0 Surgery	52.16 Supplies/Surgical Trays	X		04/01/07
55.0 Physician	55.11 Supplies/Surgical Trays	X		04/01/07
77.0 Immunization	77.05 Vaccines for Adults		X	04/01/07

Sanctioned/Excluded Providers

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

2007 CPT/HCPCS Code Updates

The system has been updated with the 2007 Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding system (HCPCS) codes. Claims using the new 2007 CPT and HCPCS codes will now pay appropriately. Previously submitted claims that denied because the 2007 codes were not in the system will be reprocessed in the near future.

Assistance from ACS Provider Field Representatives
March 2007

ACS Provider Field Representatives will provide services to providers in all counties of Mississippi and out of state providers. They are available to assist you by telephone, email, or in person with complex billing questions, claims issues, and provider education. A provider visit may be scheduled at a time that is convenient for you. If your Provider Field Representative is in the field or not available, please leave a voice mail message. You should receive a response within two business days.

Prior to scheduled provider visits, you should submit a list of issues to your Provider Field Representative to be covered during the visit. This will allow the representative an opportunity to research the issues and be prepared to provide needed assistance to you.

ACS Provider Field Representatives may be reached by contacting them at the phone numbers listed on the chart below. Representatives are assigned by billing location and not service location.

County	Provider Representative	Telephone #
Adams	Chris Yount	601.206.2904
Alcorn	Michelle Keel	601.572.3271
Amite	Chris Yount	601.206.2904
Attala	Ekida Wheeler	601.572.3265
Benton	Michelle Keel	601.572.3271
Bolivar	Cynthia Morris	601.572.3237
Calhoun	Machelle Dorman	601.206.3025
Carroll	Cynthia Morris	601.572.3237
Chickasaw	Machelle Dorman	601.206.3025
Choctaw	Ekida Wheeler	601.572.3265
Claiborne	Chris Yount	601.206.2904
Clarke	Parren Clark	601.572.3275
Clay	Machelle Dorman	601.206.3025
Coahoma	Cynthia Morris	601.572.3237
Copiah	Chris Yount	601.206.2904
Covington	Randy Ponder	601.206.3026
Desoto	Michelle Keel	601.572.3271
Forrest	Randy Ponder	601.206.3026
Franklin	Chris Yount	601.206.2904
George	Randy Ponder	601.206.3026
Greene	Randy Ponder	601.206.3026
Grenada	Cynthia Morris	601.572.3237
Hancock	Randy Ponder	601.206.3026
Harrison	Randy Ponder	601.206.3026
Hinds	Alice Smith	601.206.2948

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County	Provider Representative	Telephone #
Holmes	Cynthia Morris	601.572.3237
Humphreys	Ekida Wheeler	601.572.3265
Issaquena	Ekida Wheeler	601.572.3265
Itawamba	Michelle Keel	601.572.3271
Jackson	Randy Ponder	601.206.3026
Jasper	Parren Clark	601.572.3275
Jefferson	Chris Yount	601.206.2904
Jefferson Davis	Chris Yount	601.206.2904
Jones	Parren Clark	601.572.3275
Kemper	Parren Clark	601.572.3275
Lafayette	Machelle Dorman	601.206.3025
Lamar	Randy Ponder	601.206.3026
Lauderdale	Parren Clark	601.572.3275
Lawrence	Chris Yount	601.206.2904
Leake	Ekida Wheeler	601.572.3265
Lee	Machelle Dorman	601.206.3025
Leflore	Cynthia Morris	601.572-3237
Lincoln	Chris Yount	601.206.2904
Lowndes	Machelle Dorman	601.206.3025
Madison	Ekida Wheeler	601.572.3265
Marion	Chris Yount	601.206.2904
Marshall	Michelle Keel	601.572.3271
Monroe	Machelle Dorman	601.206.3025
Montgomery	Cynthia Morris	601.572.3237
Neshoba	Ekida Wheeler	601.572.3265
Newton	Ekida Wheeler	601.572.3265
Noxubee	Parren Clark	601.572.3275
Oktibbeha	Ekida Wheeler	601.572.3265
Panola	Cynthia Morris	601.572.3237
Pearl River	Randy Ponder	601.206.3026
Perry	Randy Ponder	601.206.3026
Pike	Chris Yount	601.206.2904
Pontotoc	Michelle Keel	601.572.3271
Prentiss	Michelle Keel	601.572.3271
Quitman	Cynthia Morris	601.572.3237
Rankin	Randy Ponder	601.206.3026
Scott	Ekida Wheeler	601.572.3265
Sharkey	Ekida Wheeler	601.572.3265
Simpson	Randy Ponder	601.206.3026
Smith	Parren Clark	601.572.3275
Stone	Randy Ponder	601.206.3026
Sunflower	Cynthia Morris	601.572.3237
Tallahatchie	Cynthia Morris	601.206.3237

(Continued from page 15)

County	Provider Representative	Telephone #
Tate	Michelle Keel	601.572.3271
Tippah	Michelle Keel	601.572.3271
Tishomingo	Michelle Keel	601.572.3271
Tunica	Michelle Keel	601.572.3271
Union	Machelle Dorman	601.206.3025
University Medical Center	Randy Ponder	601.206.3026
Walthall	Chris Yount	601.206.2904
Warren	Chris Yount	601.206.2904
Washington	Ekida Wheeler	601.572.3265
Wayne	Parren Clark	601.572.3275
Webster	Machelle Dorman	601.206.3025
Wilkinson	Chris Yount	601.206.2904
Winston	Parren Clark	601.572.3275
Yalobusha	Cynthia Morris	601.572.3237
Yazoo	Ekida Wheeler	601.572.3265

Out of State Assignments		
Alabama	Randy Trammell	601.206.2987
Louisiana	Randy Trammell	601.206.2987
Tennessee	Randy Trammell	601.206.2987
Shelby Co, TN	Michelle Keel	601.572.3271
Other States	Randy Trammell	601.206.2987

Completing the Adjustment/Void Request Form

In order for provider requests for adjustments and voids of claims to be processed appropriately, it is extremely important that the Adjustment/Void Request Form is completed fully. The Adjustment/Void Request Form is a one-page document used by the provider community to give direction regarding requests to adjust or void claims already submitted and processed. There are several sections on the form that identify the type of request and additional fields which supply the necessary details required to adjust or void the indicated claim(s). All fields must be completed in order to process the request of the provider. Additionally, there is an "other explanation" field that is made available to allow for further details regarding the request.

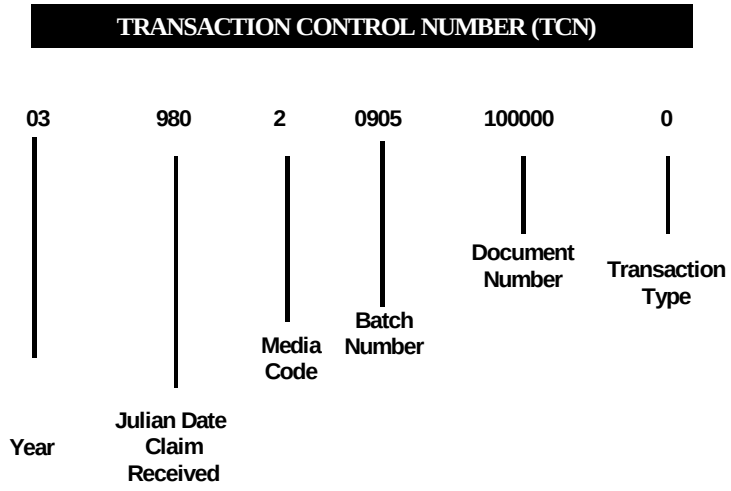
If an Adjustment/Void Request Form (AVR) is received by ACS and it is not completed fully, then it will be returned to the provider for clarification. If you need assistance completing the Adjustment/Void Request Form, please contact Provider Services at 800-884-3222 and ask a Service Associate for assistance, or contact your assigned Provider Field Representative.

The Importance of the TCN in Filing Medicaid Claims

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

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

EXAMPLE 17-Digit TCN – 03980209051000000



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

Media Codes

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

Transaction Type Tells the transaction type.

Transaction Type

7=Original
8=Void/Credit
9=Debit

"Web Wise"

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

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

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

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

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

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

Verifying Beneficiary Eligibility

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

When verifying eligibility through the call center, please obtain the call record number (CRN) from the Call Center Associate prior to ending the call. When verifying eligibility through the web portal, please print a copy of the documentation which contains the eligibility information. If verifying eligibility through the use of a swipe card verification device, please keep a copy of the receipt. If verifying eligibility though the use of the AVRS, please document the audit reference number. Please be advised that this is a tool for providers to identify eligibility prior to treatment; however, it is not a guarantee of payment.

The Division of Medicaid Website Reminder

The Division of Medicaid hosts a wealth of information on the website, www.dom.state.ms.us, from Provider Manuals to phone and fax contact numbers to fee schedules. Medicaid Eligibility Guidelines can also be found on this website. Under the link entitled, "Medicaid Provider Information," Billing tips, as well as, Provider Bulletins dating back to 1995, may be found in this linkage. The Division of Medicaid's website is proven to be a very useful tool for providers.

Provider Quick Contact List

There are several resources designed to address your questions concerning Medicaid claims processing, billing, mailing, policy procedures and more. To effectively assist you with these needs, the following information will serve as a guide to contacting the proper resource.

Contact Name	Contact Address/Phone Number/Website (if applicable)
ACS Medicaid Web Portal	http://msmedicaid.acs-inc.com
ACS Provider and Beneficiary Services	P.O. Box 23078 Jackson, MS 39225 **1-800-884-3222 or 601-206-3000**
• **Claims**	P.O. Box 23078 Jackson, MS 39225
• **Adjustment/Void Requests**	P.O. Box 23077 Jackson, MS 39225
• **Financial Correspondence (Mail with Checks)**	P.O. Box 6014 Ridgeland, MS 39158-6014
Automated Voice Response System (AVRS)	**1-866-597-2675 or 601-206-3090**
Health Information Designs (HID)- To obtain pharmacy prior authorization	**1-800-355-0486** **or** **601-709-0000**
HealthSystems Mississippi (HSM) (Peer Review Organization – conducts certification reviews of some Medicaid services.)	**1-888-204-0221** **or** **601-352-6353**
ACS EDI – For assistance with transmission of electronic claims	www.acs-gcro.com **1-866-225-2502**
Division of Medicaid – • Third Party Liability • EPSDT Services	801 Robert E. Lee Bldg. 239 N. Lamar St. Jackson, MS 39201 **601-359-6050** www.dom.state.ms.us
Division of Medicaid – • Provider and Beneficiary Services	801 Robert E. Lee Bldg. 239 N. Lamar St. Jackson, MS 39201 **601-359-6133**

Medicaid Identification Card

It is the responsibility of the Medicaid provider to verify eligibility of the Medicaid beneficiary 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 picture identification (ID), such as a driver's license, school identification (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 picture identification (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 about the policy of the Division of Medicaid 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.

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Jackson, MS
Permit No. 53

ACS
P.O. Box 23078
Jackson, MS 39225

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

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

March

March 2007

Sunday	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*
	CHECKWRITE			1 **EDI Cut Off 5:00 p.m.**	2	3
4	5 CHECKWRITE	6	7	8 **EDI Cut Off 5:00 p.m.**	9	10
11	12 CHECKWRITE	13	14	15 **EDI Cut Off 5:00 p.m.**	16	17
18	19 CHECKWRITE	20	21	22 **EDI Cut Off 5:00 p.m.**	23	24
25	26 CHECKWRITE	27	28	29 **EDI Cut Off 5:00 p.m.**	30	31

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