Mississippi Medicaid

Volume 13, Issue 7

July 2007

Bulletin

Inside this Issue

WINASAP 2003 Version 5.12

Version 5.12 of WINASAP 2003 was released Monday, May 21, 2007, and can be downloaded from the MS Medicaid web portal http://msmedicaid.acs-inc.com. There are three changes in version 5.12:

- A search/lookup function was added to the Patient List to allow the user to find a specific patient data record.
- Modification was made to allow the keyboard to be used for choosing the correct selection for the "Signature on file" yes/no.
- WINASAP 2003 is able to support internet connectivity in addition to the current asynchronous dial-up.

Please call ACS Provider and Beneficiary Services at 1-800-884-3222 for questions regarding WINASAP 2003.

Correction

The article, *Mississippi Medicaid Roads to Good Health* on page six in the June Provider Bulletin, mistakenly directed readers to Mississippi Medicaid Provider Policy Manual section 53.30 for the Physical Exam policy. The correct section is 53.18.

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.

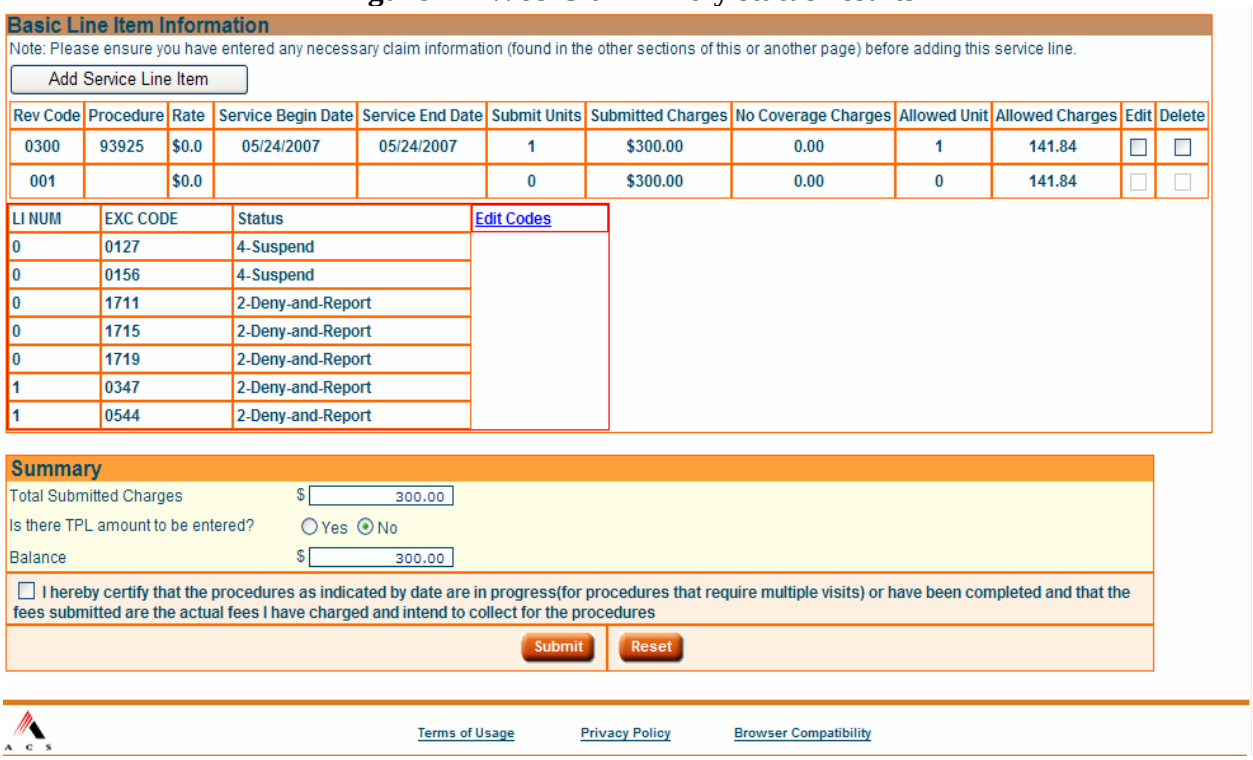
Understanding Edit Code Settings On the Web Portal

With the latest enhancements to the Mississippi Medicaid Envision Web Portal, providers now have a new resource to further understand the status of their claims with regard to edit codes which post against a claim. Most providers are already accustomed to seeing these codes on their remittance advices (RAs). If the claim status is reviewed on the web, additional information is available which will aid the provider in determining the necessary action, if any, for getting the claim paid.

When the claim is entered online, as seen in Figure 1, this supplementary information is contained in the **LI NUM** (Line Number) and **STATUS** columns on the Web Portal Claims Entry screen under the Provider Tab. Similar information is available through the Claims Inquiry screen of the Web Portal, as seen in Figure 2, for all claims (regardless of whether it was entered via the Web Portal Claim Entry.) When the line number is listed as 0 (zero), this means that it is a "Header Level" edit. If the edit posts at the "Header Level," it means that edit status applies to the entire claim. In other words, if a claim denies or suspends at the "Header Level", then the entire claim denies or suspends. No "denied" claim at the Header Level can have individual paid claim lines. It is possible, however, for a claim to have a "paid" status where some individual claim lines have paid, while some of the other individual claim lines denied.

Other edits can post at the "Line Level." A "Line Level" edit means it only applies to that particular line number of the claim that is referenced. At the conclusion of this article is a chart (Figure 3) showing the various edit status dispositions. It is possible for a claim to pay some individual lines while denying or suspending others. If there are no suspended claim lines, then the claim has completed its final adjudication. If the claim has denied lines, then you now know specifically which claim lines were the reason for the denial and can work to resolve those items if necessary.

Figure 1 – Web Claim Entry status results



Basic Line Item Information

Note: Please ensure you have entered any necessary claim information (found in the other sections of this or another page) before adding this service line.

Add Service Line Item

Rev Code	Procedure	Rate	Service Begin Date	Service End Date	Submit Units	Submitted Charges	No Coverage Charges	Allowed Unit	Allowed Charges	Edit	Delete
0300	93925	$0.0	05/24/2007	05/24/2007	1	$300.00	0.00	1	141.84	☐	☐
001		$0.0			0	$300.00	0.00	0	141.84	☐	☐

LI NUM	EXC CODE	Status	Edit Codes
0	0127	4-Suspend	
0	0156	4-Suspend	
0	1711	2-Deny-and-Report	
0	1715	2-Deny-and-Report	
0	1719	2-Deny-and-Report	
1	0347	2-Deny-and-Report	
1	0544	2-Deny-and-Report	

Summary

Total Submitted Charges $ 300.00

Is there TPL amount to be entered? ○ Yes ◉ No

Balance $ 300.00

☐ I hereby certify that the procedures as indicated by date are in progress(for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures

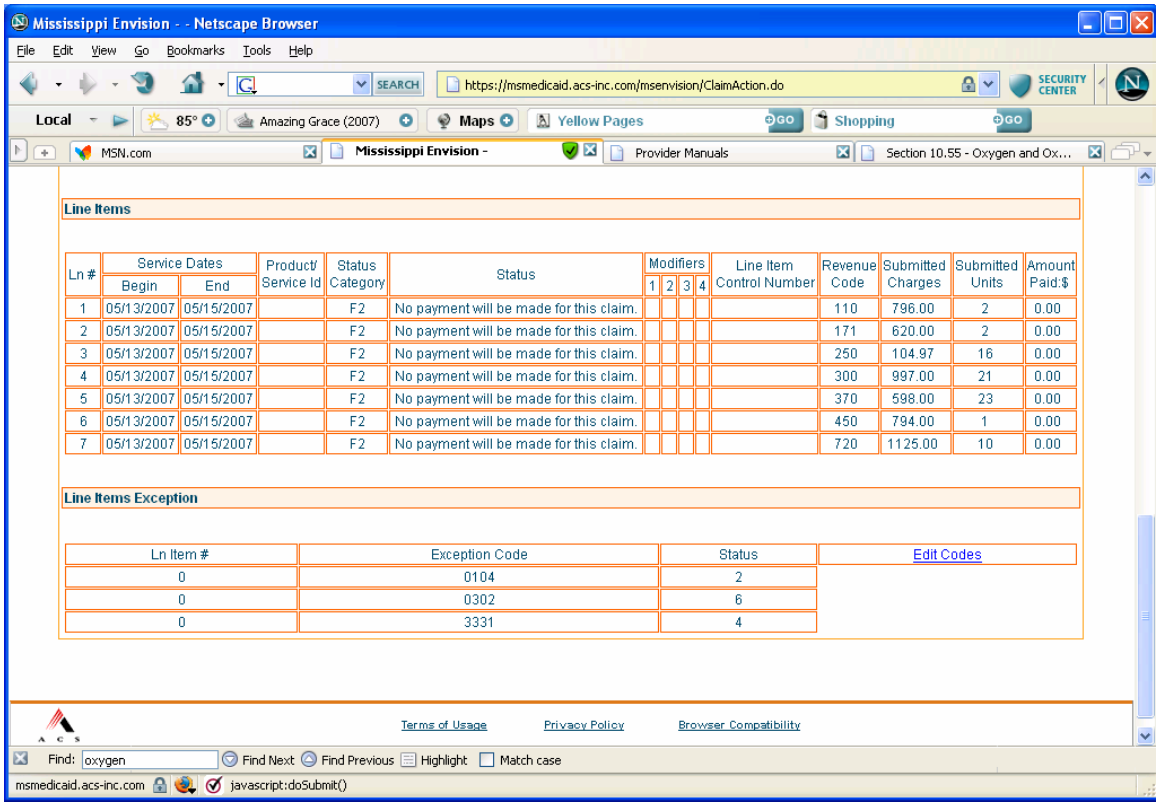
Submit Reset

Terms of Usage Privacy Policy Browser Compatibility

(Continued on the next page)

(Continued from page 2)

Figure 2 – Claims Inquiry via the Web Portal (claim example unrelated to Figure 1 on previous page)



Ln #	Service Dates Begin	Service Dates End	Product/ Service Id	Status Category	Status	Modifiers 1	2	3	4	Line Item Control Number	Revenue Code	Submitted Charges	Submitted Units	Amount Paid:$
1	05/13/2007	05/15/2007		F2	No payment will be made for this claim.						110	796.00	2	0.00
2	05/13/2007	05/15/2007		F2	No payment will be made for this claim.						171	620.00	2	0.00
3	05/13/2007	05/15/2007		F2	No payment will be made for this claim.						250	104.97	16	0.00
4	05/13/2007	05/15/2007		F2	No payment will be made for this claim.						300	997.00	21	0.00
5	05/13/2007	05/15/2007		F2	No payment will be made for this claim.						370	598.00	23	0.00
6	05/13/2007	05/15/2007		F2	No payment will be made for this claim.						450	794.00	1	0.00
7	05/13/2007	05/15/2007		F2	No payment will be made for this claim.						720	1125.00	10	0.00

Ln Item #	Exception Code	Status	Edit Codes
0	0104	2	
0	0302	6	
0	3331	4	

Figure 3 – Edit Dispositions

Status Code	Edit Disposition Status
1	Super Suspend
2	Deny & Report
3	Deny
4	Suspend
5	Pay & Report
6	Pay
F	Force Pay
D	Force Deny

Charges Not the Responsibility of the Beneficiary

Providers who have agreed to become Medicaid providers are expected to bill for covered services and accept Medicaid payment as reimbursement in full. Some charges are not the beneficiary's responsibility and must not be billed. Examples of such charges are as follows. Please note that the following list is not all-inclusive.

1. The beneficiary may not be billed for telephone calls and missed or cancelled appointments.
2. The beneficiary may not be held liable for billed charges above what is maximally allowed by Medicaid.
3. The beneficiary may not be charged for the cost of copying medical records.
4. The beneficiary may not be billed for claims denied due to provider errors. It is the responsibility of the provider to file claims in a timely manner, to correct errors, and to provide essential information to support the processing of the Medicaid claim.
5. The beneficiary may not be billed for claims denied due to errors made by the DOM, the fiscal agent, or due to changes in federal or state mandates.

For more information, please refer to Section 3.09 of the Mississippi Medicaid Provider Policy Manual.

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 allowing 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. When Medicaid is the primary insurance the claims can be filed hardcopy or electronically as they no longer require proof of the retroactive determination. The claims must be submitted within 12 months of the retroactive determination date

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 by 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. If the beneficiary is a dual eligible, the claims must be filed and processed within 6 months of the retroactive determination date.

License Expiration

In accordance with Section 4.02 of the Medicaid Provider Policy Manual, it is the responsibility of a provider to maintain current and accurate information with the Division of Medicaid and the ACS, the fiscal agent. If at any time the license, permit, or certification of the provider is suspended, revoked, surrendered, or expired, that provider is ineligible to provide services to Medicaid beneficiaries and file claims for services.

If the provider's license has expired and the Medicaid provider number has been inactive for less than one year, the provider must submit a copy of his/her current license as well as update any other information that may have changed in order for his/her Medicaid provider number to be reopened.

If the Medicaid provider's number has been inactive for more than one year, the provider must re-enroll as a Medicaid provider. In this case, the provider must call ACS at 1-800-884-3222 to request a provider enrollment packet, which includes both the provider application and enrollment agreement. The provider also may download the provider enrollment packet on the Envision Web Portal at http://msmedicaid.acs-inc.com.

For further information regarding requirements for specific providers and services, please consult Medicaid Division policy via the internet at http://www.dom.state.ms.us or the Envision Web Portal at http://msmedicaid.acs-inc.com.

Tetanus Toxoid Injections

Immunizations are covered by Mississippi Medicaid according to the policies detailed in the Medicaid Provider Manual Section 77. Vaccines for children under age 19 are covered as described in Section 77.04 through the Vaccines for Children (VFC) program. Because the vaccines are provided free of charge, Mississippi Medicaid pays $0.00 when the vaccine code is billed, while the administration is reimbursed at $10.00 per injection when the provider bills CPT codes 90471 and 90472 appropriately. For this reason, when CPT code 90718 "Tetanus and diphtheria toxoids (Td) adsorbed when administered to 7 years or older, for intramuscular use" is billed for a beneficiary ages 7 through 18, the code is paid at $0.00.

Immunizations for adults (beneficiaries age 19 and older) are covered as described in Section 77.05. For tetanus toxoid vaccine, providers were instructed in the March 2005 Provider Bulletin to bill CPT code 90703 "Tetanus toxoid adsorbed, for intramuscular use." This code will be paid at the lower of the provider's charge or the maximum allowable fee, which is currently $19.26. If CPT code 90718 is billed for beneficiaries age 19 and older, ACS Medical Review returns the claim with a letter advising the provider to use CPT code 90703.

Third Party Liability (TPL) on Maternity Claims

Providers have requested clarification of their responsibility for maternity claims for Medicaid patients who have third party coverage and obtain Medicaid secondary, midway or after delivery. For example, a patient notifies the attending provider one month after the delivery that she now has Medicaid as secondary coverage – retroactive to the beginning of her pregnancy. The patient has Blue Cross Blue Shield (BCBS) as primary coverage, and the provider has already filed her prenatal care and delivery to BCBS.

The provider has two options but must bill Medicaid in regards to the above situation.

1. The provider may void the TPL claim thereby refunding the TPL payment, and bill Medicaid as the primary. Medicaid will pay the claim and seek reimbursement from the third party source.
2. The provider may bill Medicaid and provide the amount of the third party payment on the claim.

Section 6.3 of the Mississippi Medicaid Provider Manual address the above situation and is directly quoted below for reference.

Billing Medicaid after Receiving a Third Party Payment or Denial

> After receiving payment or denial from all third party sources, the provider is required to file a claim with the Medicaid fiscal agent. The amount of third party payment must be indicated in the appropriate claim field. The claim is processed and Medicaid either pays the balance due on the claim (the total Medicaidpayment amount less the third party payment amount) or makes no additional payment if the third party payment is equal to or greater than the total amount due from Medicaid. In either situation, the beneficiary's history of services is updated.

PA No Longer Required for Duoneb®, Flovent®, Maxair®, ProAir HFA®, Proventil HFA®, Pulmicort Flexhaler®, and Ventolin HFA®

Changes in the Preferred Drug List, or PDL, enacted during the January 9, 2007, and April 10, 2007, Pharmacy & Therapeutics Committee Meetings, become effective July 1, 2007. Among these changes is the addition of several respiratory agents to the PDL list. Added to the list are Duoneb(r), Flovent(r) HFA, Maxair(r), ProAir HFA(r), Proventil HFA(r), Pulmicort Flexhaler(r), and Ventolin HFA(r). Previously, these agents were nonpreferred agents and required prior authorization to be covered by MS Medicaid. Albuterol CFC products will continue to have preferred status.

The FDA has mandated that more ozone-friendly inhalers be produced. A new safe and effective alternative propellant, hydroflouroalkane (HFA), has been created to replace CFCs. Recognizing the decline in supplies of generic CFC-containing metered dose inhalers due to their anticipated replacement with safer hydroflouroalkane (HFA) inhalers, DOM has added several rescue inhalers to the PDL list including ProAir HFA(r), Proventil HFA(r), and Ventolin HFA(r). These agents will no longer require prior authorization.

The standard for all inhalers starting in 2009 will be the new HFA inhalers phasing out MDIs containing CFCs.

Mississippi Division of Medicaid
Preferred Drug List

The agents listed below are preferred products on the Mississippi Medicaid Preferred Drug List (PDL). The preferred drug list is a medication list recommended to the Division of Medicaid by the Pharmacy and Therapeutics Committee and approved by the Executive Director of the Division of Medicaid. These drugs have been selected for their efficaciousness, clinical significance, cost effectiveness and safety for Medicaid beneficiaries.

Most generic agents are preferred, do not require prior authorization, and are not individually listed below.
Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug.
For more information concerning the PDL including non-preferred agents, the OTC formulary and other specifics please visit our website at www.dom.state.ms.us.

List Effective 7-1-2007

ANALGESICS

Cox- 2
None

NSAIDS
Generics only

Narcotics
Avinza®
Kadian®

ANTI-INFECTIVE AGENTS

ANTIFUNGALS
Grifulvin V ®
Gris-PEG®
Lamisil®

ANTI--PROTOZOAL
Alinia®

ANTI-VIRAL
Copegus®Tabs
Hepsera®
Rebetol® Syrup
Valcyte®
Valtrex®

CEPHALOSPORINS
Ceftin® Suspension
Omnicef®
Suprax® Suspension

FLUOROQUINOLONES
Avelox®

MACROLIDES
Biaxin XL®

PENICILLINS
Augmentin®
AugmentinXR®

SULFONAMIDES
Gantrisin® Susp

TETRACYCLINES
Generics only

Miscellaneous
Cleocin Ped.Soln®

OTIC ANTI-INFECTIVES
Ciprodex®
Floxin®

CARDIOVASCULAR

ACE Inhibitors
Altace®

ACE Inhibitor/Diuretics
Generics Only

ACEI/CCB Combinations
Lotrel®

ARBs&Combinations
Avapro®, Avalide®
Benicar®, Benicar HCT®
Diovan®, Diovan HCT®

ANTIHYPERLIPIDEMICS
Advicor®
Lipitor®
Lovaza®
Niaspan®
Tricor®
Vytorin®
Zetia®

Beta-Blockers
Coreg®, Coreg CR®
Toprol XL®

Beta-Blocker/Diuretics
Generics Only

Calcium Channel Blockers
Generics Only

CCB/Antihyperlipidemic
Caduet®

Diuretics& Aldosterone Receptor Antagonists
Generics Only

RENIN INHIBITORS
None

CENTRAL NERVOUS SYSTEM AGENTS

ADHD AGENTS
Adderall®-XR
Concerta®
Daytrana®
Focalin®
Focalin® XR
Metadate® CD
Strattera®

ALZHEIMER'S AGENTS
Aricept®
Exelon®
Namenda®

ANTICONVULSANTS
Carbatrol®
Depakote®/Depakote®ER
Dilantin®
Equetro™
Gabitril®
Keppra®
Lamictal®
Lyrica®
Trileptal®
Topamax®
Tegretol® XR

ANTIDEPRESSANTS
Effexor XR®
Wellbutrin XL®

ANTIEMETICS
Zofran®

ANTIPSYCHOTICS
Geodon®
Risperdal®

ANXIOLYTICS
Generics only

MIGRAINE AGENTS
Imitrex®
Maxalt®

SEDATIVE/HYPNOTICS
Ambien® CR
Lunesta™
Rozerem™

SKELETAL MUSCLE RELAXANTS
Generics only

ENDOCRINE AND METABOLIC AGENTS

ANTIDIABETICS
Actos®
ACTOplus Met™
Avandamet®
Avandaryl™
Avandia®
Byetta®
Duetact™
Januvia™/Janumet™
Starlix®

INSULINS
Apidra®
Lantus®
Levemir®
Novolin® N
Novolin® R
Novolin® 70/30
NovoLog®
NovoLog® Mix 70/30

ESTROGENS-PROGESTINS
Premarin®
Premphase®
Prempro®

GROWTH HORMONES
Genotropin®
Norditropin®
Nutropin®/Nutropin®AQ
Saizen®
Serostim®
Tev-Tropin®

OSTEOPOROSIS
Boniva®
Evista®
Fosamax®
Miacalcin®

THYROID/ANTI-THYROID AGENTS
All Brands & Generics

GASTROINTESTINAL AGENTS

H-2 ANTAGONISTS
Generics Only

INFLAMMATORY BOWEL DISEASE
Asacol®
Canasa®
Dipentum®
Lialda®
Pentasa®

LAXATIVES(Rx)
Amitiza®

PPIs
Prevacid®
Zegerid®

HEMATOLOGICAL AGENTS

ANTICOAGULANTS-INJECTABLE
Arixtra®
Lovenox®

HEMATOPOIETIC
Aranesp®
Procrit®

PLATELET AGGREGATION INHIBITORS
Aggrenox®
clopidogrel

IMMUNOLOGIC AGENTS

Enbrel®
Humira®
Raptiva®

NEPHROLOGIC AGENTS

Fosrenol®
Magnebind® Rx
PhosLo®
Renagel®

RESPIRATORY AGENTS

ALLERGY-ANTIHISTAMINES
Astelin® Nasal Spray
Clarinex®
loratadine
Palgic®
Vazol™/ Vazol™ D
Zyrtec®

ALLERGY-NASAL Corticosteroids
Flonase®
Nasonex®

RESPIRATORY AGENTS-cont.-
ANTIASTHMATICS
Advair®
Asmanex®
Combivent®
Duoneb®
Flovent® HFA/Diskus
Intal ® Aerosol Inhaler
Maxair®
ProAir® HFA
Proventil® HFA
Pulmicort® Flexhaler
Pulmicort Respules®
Pulmicort Turbuhaler®
Singulair®
Spiriva®
Ventolin® HFA
Xopenex HFA®
Xopenex® Inhalation Soln
TOPICAL AGENTS
Acne Preparations (Under Age 21 only)
BenzaClin®
Benzamycin® Pak
Duac™
Evoclin™
Klaron®
NuOx
Suphera™
Tazorac®
Zaclir
Anti-inflammatory Agents
Generics only
Antibacterial Agents
Clindesse®
Antifungals
Naftin®
Vusion®
Antipruritic
None
Antiviral
None
Miscellaneous-Skin and Mucous Membrane Agents
Aldara®
Elidel ®
Scabicides and Pediculicides
Eurax®
Ovide®
permethrin
UROLOGICAL AGENTS
ANTICHOLINERGIC/ ANTISPASMODICS
Detrol®/Detrol LA®
Enablex®
BPH AGENTS
Flomax®
Uroxatral®

Effective
07/01/07 through 12/31/07

Albuterol HFA PDL Changes

The FDA has mandated that more ozone-friendly inhalers be produced. A new safe and effective alternative propellant, hydroflouroalkane or HFA, has been created to replace chlorofluorocarbons or CFC propellants. Starting in 2009, the standard for all inhalers will be the new HFA inhalers phasing out metered dose inhalers containing CFC. Recognizing the decline in supplies of generic CFC-containing metered dose inhalers, the DOM has added several HFA rescue inhalers to the PDL list including ProAir® HFA, Proventil® HFA, and Ventolin® HFA. Previously, these agents were non-preferred agents and required prior authorization to be covered by MS Medicaid. These agents will no longer require prior authorization. Albuterol CFC products will continue to have preferred status.

PDL Corrections and Clarifications

The following is a correction to the list published in the June bulletin:

Preferred Drug List Changes, Effective July 1, 2007

Drug class	PDL Additions	PDL Removals
Antipsychotics		***Zyprexa®, Symbyax®***

The following are clarifications to the list published in the June bulletin:

Preferred Drug List Changes, Effective July 1, 2007

Drug class	PDL Additions	PDL Removals
Antihyperlipidemics	***Lovaza®***[1]	
Respiratory Agents	***Flovent® Diskus, Flovent® HFA***[2]***, Pulmicort® Flexhaler, Pulmicort® Turbuhaler***[3]	

[1]FDA mandated product name change from Omacor®, omega-3-acid ethyl esters, to Lovaza®.
[2]Formulation descriptions Diskus and HFA inadvertently omitted from original list.
[3] Formulation description Turbuhaler inadvertently omitted from original list.

How to Locate the Mississippi Medicaid Prescribing Provider List on the New Enhanced Web Portal

The Medicaid Prescribing Provider Listing has been moved. No login is required. You may use the Provider Tab from the Homepage, select Provider Type Specific Information, choose Pharmacy, then select Prescribing Provider List. The list, which is in the Adobe Acrobat format, consists of prescribing providers in the following states: Mississippi, Tennessee, Alabama, Louisiana, and Arkansas. The "Search" feature of Adobe is available to assist in locating providers in the document.

The list has been revised to include the prescribing provider's NPI numbers that are currently on file with Medicaid. This list is routinely updated every Monday morning to include any NPI numbers that ACS has input during the previous week. Prescribing providers can verify that their NPI is correctly loaded into the ACS system and pharmacists can gather the NPI numbers without contacting the physician.

ATTENTION: Dental Providers!!!

Provider Workshops – July & August 2007

ACS Government Healthcare Solutions, in conjunction with the Mississippi Division of Medicaid, will conduct provider workshops for dental providers in July and August 2007. The specific dates and locations of the workshops are listed below:

Date/Time	Location
July 17, 2007 9:30 am – 3:00 pm	Sam's Town Casino 1477 Casino Strip Resorts Blvd. Robinsonville, MS 38664
July 18, 2007 9:30 am – 3:00 pm	BancorpSouth Conference Center 387 East Main Street Tupelo, MS 38804
July 24, 2007 9:30 am – 3:00 pm	Beau Rivage Conference Center 875 Beach Blvd. Biloxi, MS 39530
August 3, 2007 9:30 am – 3:00 pm	MS TelCom Center 105 Pascagoula Street Jackson, MS 39205

The same information will be presented at each workshop. Workshop registration will be from 8:30 to 9:30 a.m. A light lunch will be provided in Tunica, Tupelo, and Jackson. Topics covered in the morning session include

- Enhanced Web Portal Functionality
- Using the Web Portal for Prior Authorizations

The following three breakout sessions will be offered in the afternoon from 1:00 pm to 3:00 p.m.

Claims Resolution: Provider Relations representatives will be available to assist providers with individual claims issues. Providers attending this session should bring specific claims examples with beneficiary numbers and dates of service or specific TCN examples.

WINASAP 2003: This session is a comprehensive WINASAP demonstration that will include creating databases, claims, and adjustment/voids. The session will also incorporate submitting claims, the process of receiving a response file, and how to identify claim status. The session is for new billers but can serve as a refresher course for trained individuals.

Policy/Billing Tips: This session will include a presentation on Medicaid dental policy, instructions on completing the new 2006 dental claim form, top dental denial edits, and tips on how to resolve denied claims.

The workshops are free of charge. Seating is limited. Please RSVP by **July 6, 2007**. Mail the RSVP to ACS Government Healthcare Solutions, ATTN: Provider/Beneficiary Services, P.O. Box 23078, Jackson, MS 39225 or fax it to ACS, Attn: Provider/Beneficiary Services at **601-572-3200**. You may contact Tamara Cry at 601-206-3028 or email her at tamara.cry@acs-inc.com to RSVP or if you have questions about the workshops.

We look forward to meeting with you in July and August and working with you in the coming years.

Sincerely,

ACS Government Healthcare Solutions

Please complete the RSVP Section and mail or fax by July 6, 2007 to

ACS Government Healthcare Solutions
ATTN: Provider/Beneficiary Services
P.O. Box 23078
Jackson, MS 39225

Provider Name	***Provider Number***
Provider Telephone Number	***Contact Name***
Name(s) of Attendees	
Date of Workshop Location Attending	

Dental Fees and Limits - Changes Effective July 1, 2007

In accordance with House Bill 528, authorized during the 2007 Legislative Session, dental procedure code fees have been changed for dates of service beginning July 1, 2007. These changes may be accessed by visiting our website at www.dom.state.ms.us. It is the intent of the Legislature to encourage more dentists to participate in the Medicaid Program.

In addition, the legislation established a maximum annual benefit limit of $2500 per beneficiary per fiscal year (July 1 – June 30). This benefit limit will be applied toward **ALL** dental services and procedure codes (excluding Orthodontia) for **ALL** beneficiaries. Exceptions to the $2500 limit may be made if a prior authorization (PA) is requested and approved by DOM prior to rendering services. This change is effective for dates of service beginning July 1, 2007.

The Division of Medicaid is increasing the maximum lifetime benefit limit for orthodontia to $4200 per beneficiary. Orthodontia-related services are covered only for beneficiaries under age twenty-one (21) and must be prior authorized. This change is effective for dates of service beginning July 1, 2007.

Ambulance Rate Update

Effective July 1, 2007, reimbursement rates for covered ground ambulance services will be updated as follows:

ALS Emergency Services		Rate
A0427	ALS Emergency	$229.80
A0390	ALS Mileage (Per Mile)	$4.38
BLS Emergency Services		
A0429	BLS Emergency	$193.52
A0380	BLS Mileage (Per Mile)	$4.38
Non-Emergency Ambulance Transport		
A0428	BLS Non-Emergency	$120.95
A0380	BLS Mileage (Per Mile)	$4.38
Neonatal Transport		
A0225	Neonatal Transport	$229.80
A0390	ALS Mileage (Per Mile)	$4.38

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
2.0 Benefits	2.02 Benefits and Limitations		X	07/01/07
11.0 Dental	11.02 Dental Programs 11.21 Lifetime Maximum Benefits		X X	07/01/07
18.0 MH/ Psychiatric Residential Treatment Facility	18.14 Reimbursement		X	07/01/07
19.0 Intermediate Care Facility/Mentally Retarded	19.09 Reimbursement		X	07/01/07
36.0 Nursing Facility	36.06 Reimbursement		X	07/01/07
46.0 Radiology	46.06 Teleradiology	X		07/01/07
67.0 HCBS/Mentally Retarded/Developmentally Disabled Waiver	All sections (67.01-67.11)	X		07/01/07
7.03 General Policy	6.03 Maintenance of Records		X	08/01/07
28.0 Transplants	All sections (28.01-28.18) except 28.08 and 28.15		X	08/01/07
47.0 Outpatient Physical Therapy	47.03 Exclusions 47.12 Plan of Care		X	08/01/07
48.0 Outpatient Occupational Therapy	48.03 Exclusions 48.12 Plan of Care		X	08/01/07
49.0 Outpatient Speech-Language Pathology (Speech Therapy)	49.03 Exclusions 49.12 Plan of Care		X X	08/01/07
52.0 Surgery	52.18 Skin Tag Removal	X		08/01/07
53.0 General Medical Policy	53.32 Botulinum Toxins A and B	X		08/01/07
77.0 Immunizations	77.05 Vaccines for Adults		X	08/01/07

Division of Medicaid Pre-Admission Screening (PAS) Application For Long Term Care Programs

The effective implementation date for the Pre-Admission Screening (PAS) process and application for Long Term Care has been postponed. Watch "Late Breaking News" for the new implementation date. The new PAS process and physician certification forms replace admission to a **Nursing Facility and the Home and Community Based Services waiver programs as follows: Elderly and Disabled Waiver, Independent Living Waiver, Traumatic Brain Injury/Spinal Cord Injury Waiver, and Assisted Living Waiver**. The current Nursing Facility 260 or Level I (PASRR Determination) is included in the new PAS process and must be generated as required for nursing facility admission. Training for this new process was held in April, May, and June in several locations across the state with good attendance. The PAS application should not be completed for persons being admitted to a nursing facility that is not a Medicaid-certified Nursing Facility. This includes short stay admissions covered under Medicare Part A. A PAS will be required only if and when the resident applies to a Medicaid-certified Nursing Facility.

The threshold for each applicant to be eligible for a DOM Long Term Care program is 50 points. If an applicant receives a score range from 45-49, a secondary review is conducted by DOM staff. A score of less than 45 is an automatic denial with the option of appeal through the DOM's appeal process. Scoring for the hard copy version must be submitted to Long Term Care as noted below.

If you have questions, please refer to your training materials, the PAS Policy, and Frequently Asked Questions (FAQs) located on the DOM website at www.dom.state.ms.us under Long Term Care.

The PAS is available electronically and in hard copy for your convenience. The electronic version is available on the ACS web portal at Long Term Care, Pre-Admission Screening Application. The electronic version is user friendly and provides on-line prompts for each section. This version will automatically score the application and generate the summary pages for the physician certification for each program's application.

The hard copy version of the PAS is available by contacting ACS at 1-800-884-3222 or Long Term Care at 601-359-9547. Upon completion of the hard copy version PAS, the screener(s) will transfer the information recorded in Sections I through IX to Section X (PAS Summary & Physician Certification), and will forward Section X to the applicant's/recipient's physician for the necessary certification. Once the physician's certification has been received, Section X of the PAS must be faxed to 601-359-1383 for nursing facility determinations or 601-359-9532 for waiver program admission determinations or mailed to the appropriate parties.

If you experience any problems for the electronic version, please contact ACS at 1-800-884-3222.; or you may contact the Long Term Care office for any other questions at 601-359-9547.

DME, Medical Supplies, Orthotics, Prosthetics - 2007 Fee Update

The Division of Medicaid has updated the maximum allowable fees for DME, medical supply, orthotic, and prosthetic procedure codes according to the Mississippi State Plan based on the 2007 Centers for Medicare & Medicaid Services (CMS) rates. The DME Fee Schedule is available on the Division of Medicaid website at www.dom.state.ms.us under the heading of Medicaid Fee Schedules. The new fees will be available and effective for dates of service on and after July 1, 2007.

The following procedure codes will change from manual pricing to fee pricing effective for dates of service beginning July 1, 2007:

Code	Fee
A4463	$10.65
A4565	$5.75
L2232	$65.25
L3806	$279.21
L3808	$173.46
L3915	$326.74

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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

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July

July 2007

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

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