Mississippi Medicaid Bulletin

Volume 13, Issue 10

October 2007

Inside this Issue

Employee Education about False Claims Recovery

The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicaid and Medicare programs. This Act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowingly" is defined to mean that a person, with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The Deficit Reduction Act of 2005 was designed to improve federal and state oversight and enforcement actions against fraud and abuse in the Medicaid program. It requires any entity receiving more than 5 million dollars in Medicaid funds per year to instruct their workforce on the following issues:

- The federal False Claims Act
- Any state civil or criminal penalties for false claims
- Whistleblower protections

A false claims violation is any conduct that leads to the submission of fraudulent claims to the government such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills or services never performed or items never furnished, or otherwise causing a false claim to be submitted.

The Mississippi Medicaid program is tasked with the responsibility to ensure the integrity of the activities conducted within the Medicaid programs. Therefore, the Division of Medicaid is required to audit any entity receiving more than 5 million dollars in Medicaid funds per year. Providers who meet this requirement will be required to submit to the Division the policies/procedures on employee education regarding false claim recovery. It is imperative that Medicaid providers have policies and procedures in place to protect the rights of the employee as a "whistleblower". Sanctions will be imposed by DOM due to non-compliance with policies and procedures required as a result of the employee false claims recovery process.

Do You Have Your NPI?

The Mississippi Division of Medicaid must have your NPI number. Beginning on November 23, 2007, claims submitted to the Division without the NPI **will deny.**

ICD-9-CM Code Update

As a result of the Health Insurance Portability and Accountability Act (HIPAA), providers are required to bill with current code sets. The Division of Medicaid has updated its system to accept new and deny invalid ICD-9-CM codes effective October 1, 2007.

Remember that ICD9-CM is composed of codes with either 3, 4, or 5 digit numbers. A code is invalid if it has not been coded to the full number of digits required for that code. You must, therefore, use a current version of ICD-9-CM which is updated October 1 of each year. Be sure to keep your previous books as they may be needed when reconciling older claims.

Help Slow Rising Prescription Costs

To address rising drug costs, the Division of Medicaid's (DOM's) Pharmacy Program works to help improve quality and manage costs. Prescribers can help slow rising costs in DOM's Pharmacy program by prescribing

Drugs from the Preferred Drug List (PDL):

- From 2005 through June 2007, the utilization of preferred drugs rather than non-preferred drugs has resulted in savings of ***$93M*** for the DOM and the State of Mississippi**.**
- Supplemental rebates associated with the PDL and in effect since April 2006, have resulted in an additional savings of ***$10M***.[1]

DOM's PDL is a comprehensive preferred drug list including branded and generic agents in more than 60 therapeutic classes or categories. Drugs are recommended for placement on the PDL by the P&T committee, a team of Medicaid prescribers and pharmacists who work in collaboration with the DOM. The Committee conducts quarterly reviews of the most current medical studies and makes updates to the PDL.

The PDL may be found at www.dom.state.ms.us; go to Pharmacy Services, and select PDL. The DOM's PDL is updated two times annually, on January 1st and on July 1st.

Generic Drugs:

Generic drugs are FDA-approved and are as safe and effective as brand name drugs.[2] Most of the time generic drugs are less expensive than their branded counterparts. Between 2002 and 2005, 87 brand name drugs became available generically. For every 1 percent increase in generic drug use, the State of Mississippi can reduce its total cost by 1 percent.[3] In other words, for every 1 percent increase in generic utilization per year, the state saves $4 million. During August 2007, DOM paid an average reimbursement of $28.69 per pharmacy claim for generic drugs. Of the total pharmacy claims reimbursed by DOM in August 2007, 62.3 percent were for generic drugs.

[1] Statistics supplied by Health Information Designs (HID).
[2] Refer to FDA's letter to healthcare providers at http://www.fda.gov/cder/news/nightgenlett.htm.
[3] *Drug Topics*, PBMs are driving up generic utilization, Aug. 8, 2005.

Pharmacy Drug Changes

Effective November 1, 2007, the following addition will be made to DOM's PDL:

Exforge® will be added as a preferred ARB/CCB combination product

Effective November 1, 2007, the following changes will be made to DOM's optional coverage:

Chantix ® will become a covered drug.
Prescription prenatal vitamins will be covered for women up to age 45.
Promethazine with codeine is removed from covered status as a cough suppressant.
Benzonatate will become a covered cough suppressant.[4]

Effective November 1, 2007, the following changes will be made to DOM's OTC formulary:

Additions to the formulary are a) Bulk laxatives[5]; b) Docusate[5]; c) Multivitamin and mineral supplements[5]; and d) Zinc oxide 40 % (compares to Desitin)[5].
Deletions from the formulary are a) Naphazoline/pheniramine ophthalmic drops; b) phenoazopyridine 95mg; c) Niacin 50 mg, 100mg, 125mg, 250mg, 400mg and 500mg; and d) prenatal vitamins.

[4] For beneficiaries 10 years of age and above.
[5] Limited to beneficiaries up to age 21 years of age.

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

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

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

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

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

- HCPCS Codes G0008 and G0009 are no longer valid for billing administration fees for flu and pneumonia vaccines to beneficiaries age 19 and over. Providers must bill 90471 if one vaccine is administered and 90472 for each additional vaccine administered.

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

Reimbursement rates effective July 1, 2007 for vaccines and administration for beneficiaries age 19 and older are as follows:

Influenza Vaccines		Pneumonia Vaccine		Administration Fee	
CPT Code	**Fee**	**CPT Code**	**Fee**	**CPT Code**	**Fee**
90656	$16.57	90732	$27.03	90471	$14.91
90658	$12.62			90472	$9.08
90660	$21.18				

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

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

Pre-Admission Screening (PAS) Process and Application for Long Term Care Programs

IMPORTANT NOTICE

The effective implementation date for the Pre-Admission Screening (PAS) is October 1, 2007.

Nursing Facilities and the Home and Community Based Services, including Elderly and Disabled Waiver, Independent Living Waiver, Traumatic Brain Injury/Spinal Cord Injury Waiver, and Assisted Living Waiver, will begin using the new PAS either in hard copy format or electronically.

The electronic version may be accessed through the ACS Web portal-- https//:www.msmedicaid.acs-inc.com. The electronic version of the PAS is located under the Provider tab, scroll to Long Term Care/PAS (Application for Potential Beneficiary).

The hard copy version may be requested via the ACS website, or at http://www.dom.state.ms.us. The PDF format will allow the hard copy to be downloaded to an individual computer or completed on line and printed for submission via facsimile.

If you have any questions, please contact Long Term Care at 601-359-9547; Nursing Facilities only, 601-359-6541; or HCBS only 601-359-6141.

Home Health Claims for the Elderly and Disabled Waiver Program

Home Health claims for Medicaid beneficiaries enrolled in the Elderly & Disabled Waiver Program must be "split-billed." Under regular Mississippi Medicaid State Plan benefits, beneficiaries are allowed up to 25 home health visits each year. Additional home health visits may be covered for beneficiaries on the Elderly & Disabled Waiver. Claims must be submitted on separate claim forms for State Plan visits and for waiver visits.

Example #1
Beneficiary 555-55-5555, M. Jones receives 30 home health visits in July 2008.
• A claim should be filed with 25 home health visits for dates of service in July 2008. • A separate claim should be filed with 5 home health visits for dates of service in July 2008.

Example #2
Beneficiary 555-55-5555, M. Jones receives 15 home health visits in July 2008 and 15 home health visits in August 2008.
• A claim should be filed with 15 home health visits for dates of service in July 2008. • A claim should be filed with 10 home health visits for dates of service in August 2008. • A separate claim should be filed with 5 home health visits for dates of services in August 2008.

Please contact your ACS provider representative if you have questions about this issue.

Family Planning Waiver Program

Any female between the ages of 13 – 44 is eligible to receive payment of services through the Family Planning Waiver program. Beneficiaries enrolled in the Family Planning Waiver program can only receive family planning services. This includes the annual visit, follow-up visits and medically necessary supplies related to birth control and oral contraceptives **only**.

Beneficiaries can **only** obtain oral contraceptives from a provider that is enrolled in the oral contraceptive program with the Mississippi State Department of Health (MSDH). Beneficiaries can not go to the local pharmacy to receive oral contraceptives. It is a requirement that the beneficiary receive a physical examination from a Medicaid participating provider in order to receive the birth control and oral contraceptives. If a provider would like to enroll in the pharmacy program, please call the MS State Department of Health at 601-576-7486; and if you have any questions regarding the MS Family Planning Waiver Program please contact the Division of Medicaid at 601-359-6150.

MS Cool Kids (EPSDT) Screenings – Quick Billing Tips

- Always bill age appropriate screening code and with the EP modifier.
- Annual age specific screenings should not be completed prior to the child's birthday.
  For example: Provide 12 month screening on or after the child's first birthday.
- Do not schedule annual screenings prior to the child's birthday.
  For example: Do not schedule at 11.5 months for the 12 month screening.
- Schedule future annual screenings one year from the anniversary date.
  Remember that only one screening is allowed per fiscal year for ages 2-21.
- Bill for all services rendered.

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.

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
7.0 General Policy	7.10 Limited English Proficiency Plan	X		10/01/07
8.0 Ambulance	8.13 Transport of Nursing Facility Residents 8.14 Transport of Dual Eligibles		X X	10/01/07
12.0 Non-Emergency Transportation (NET)	12.11 Monitoring/Quality Assurance		X	10/01/07
25.0 Hospital Inpatient	25.35 Trauma Team Activation/Response	X		10/01/07
36.0 Nursing Facility	36.08 Admission Requirements 36.10 Temporary Leave Payments 36.17 Out of State Placements		X X X	10/01/07
53.0 General Medical	53.35 Ventricular Assist Device	X		10/01/07
64.0 LTC/Pre-Admission Screening (PAS)	All sections (64.01- 64.17)	X		10/01/07
65.0 HCBS/ Elderly and Disabled Waiver	65.06 Prior Approval/ Physician Certification 65.07 Covered Services		X X	10/01/07
66.0 HCBS/ Independent Living Waiver	66.05 Prior Approval/ Physician Certification		X	10/01/07
68.0 HCBS/Assisted Living Waiver	68.05 Prior Approval/ Physician Certification		X	10/01/07
69.0 HCBS/Traumatic Brain Injury/Spinal Cord Injury Waiver	69.05 Prior Approval/Physician Certification		X	10/01/07
72.0 Family Planning Waiver	72.06 Standards of Care		X	10/01/07
10.0 Durable Medical Equipment	10.62 Pressure Reducing Support Surface		X	11/01/07
25.0 Hospital Inpatient	25.36 Sterilization and Deliveries in the Same Admission	X		11/01/07
55.0 Physician	55.13 Teaching Facilities Billing for Resident Services	X		11/01/07

PRSRT STD
U.S. Postage Paid
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

October

October 2007

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