Mississippi Medicaid Bulletin

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Inside this Issue



# Getting an NPI is Free – Not Having One Can Be Costly

The Mississippi Division of Medicaid must have your NPI number. Beginning on January 2, 2008, claims submitted to the Division without the NPI **will deny.**

***Need more Information?***

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page http://www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

## 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.

# 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.

# Provider Notice: Tamper-Resistant Delay

Congress has delayed the implementation of a law that will require prescribers to write prescriptions for Medicaid beneficiaries on tamper-resistant prescription pads. The new regulation has been postponed until April 1, 2008.

The Division of Medicaid urges all providers to use the next six months to prepare for this new requirement.

Please refer to the Division of Medicaid website at www.dom.state.ms.us under Pharmacy Services for further updates on this issue.

# DESI Drugs: *What are they?*

The term "DESI" comes from the Drug Efficacy Study and Implementation (DESI) program, a program established by the FDA to review the effectiveness of drugs approved between 1938 and 1962.[1] A DESI drug is a drug that was approved solely on the basis of its safety prior to 1962. Since that time, Congress has amended the laws to require a drug to be deemed effective as well as safe. Examples of DESI drugs are Donnatal® and Librax® and their generic counterparts.

The DESI program was initiated by the FDA to evaluate the effectiveness of those drugs that had been approved in the past on the basis of safety grounds alone. If the review indicates a lack of substantial evidence of a drug's effectiveness for all of its labeled indications the drug becomes referred to as a less-than-effective (LTE) drug and the FDA proposes a withdrawal of approval of the drug for marketing.[2] After administrative proceedings have been concluded, continued marketing is only permitted if an NDA (New Drug Application) is approved for that drug. Most DESI drugs proceedings have been concluded but there are still a few pending.

Mississippi Medicaid will not reimburse for those drugs deemed less than effective by the FDA as a result of the Drug Efficacy Study Implementation (DESI) program. In accordance with Section 1903(i)(5) of the Social Security Act, federal funds participation (FFP) is not available for DESI drugs for all labeled indications. This means that State Medicaid programs paying for DESI drugs must do so entirely with state funds.[3]

Beginning January 1, 2008, this regulation will also apply to drugs administered in physician's offices.

Each calendar quarter, the Centers for Medicare & Medicaid Services (CMS) publishes a list of DESI drugs which has been reviewed for accuracy by the FDA and which can be viewed at http://www.cms.hhs.gov/MedicaidDrugRebateProgram/downloads/desi.pdf.

## Why is it important to use the correct Prescriber's Identification Number?

(1) **Incorrect Prescriber numbers skew Drug Utilization Review data and data collection is flawed.** Inaccurate or erroneous prescriber identification numbers distort pharmacy claims information for the DOM and Health Information Designs (HID) who is DOM's DUR contractor. The Medicaid Drug Utilization Review (DUR) Program's main emphasis is to promote patient safety by an increased review and awareness of outpatient prescribed drugs. Additionally, States are required to submit an annual report to CMS regarding patient safety, provider prescribing habits and dollars saved by avoidance of problems such as drug-drug interactions, drug-disease interactions, therapeutic duplication, and over-prescribing by providers using the data collected from DUR reports.[4]

(2) **Incorrect prescriber numbers can be a typographical error and/or fraudulent entry**. Incorrect prescriber identification numbers can be typographical errors. Incorrect prescriber identification numbers can be fraudulent as in situations when a pharmacy is filling a prescription and the prescriber's identification number is not known or the number that pharmacy has does not work on the claim and pharmacy inserts a random provider/NPI number into the required field. The claim processes and they are paid. This pharmacy employee has just committed a fraudulent act against MS Medicaid which could lead to sanctions against them and the company. It is considered a fraudulent act to knowingly submit a prescriber identification number, such as a NPI, another prescriber's identification number, a pharmacy provider number or a random number, that does not belong to the provider who has written the prescription.

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[1] Center for Medicare & Medicaid Services, www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp.
[2] *Ibid.*
[3] CMS's Less Than Effective (LTE) and Identical, Related and Similar (IRS) Drugs, or go to http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp

[4] CMS Drug Utilization Review Overview, http://www.cms.hhs.gov/DrugUtilizationReview/

# Help Slow Rising Prescription Costs

To address rising drug costs, DOM's Pharmacy Program works to help improve quality and manage costs. Prescribers can help slow rising prescription costs in DOM's Pharmacy program by using Dose Optimization[5] when appropriate for their patients. Dose optimization refers to situations where a single dose of a higher strength medication taken once daily replaces the same medication when taken multiple times daily. Dose Optimization yields the same total daily dose, can offer substantial cost savings, and increases compliance with drug therapy. Some examples of dose optimization and costs savings are

## DOSE OPTIMIZATION[6]

| Drug Brand Name | Current dosing schedule | Monthly costs | Targeted dosing schedule | Monthly costs | Monthly Savings | Annual Savings |
|---|---|---|---|---|---|---|
| Zyprexa® | two Zyprexa® 5 mg daily | $446.68 | one Zyprexa® 10 mg daily | $334.48 | $113.20 | $1358.40 |
| Risperdal® | two Risperdal® 0.5 mg daily | $232.82 | one Risperdal® 1 mg daily | $123.90 | $108.92 | $1207.04 |
| Cenestin® | two Cenestin® 0.625mg daily | $90.66 | one Cenestin® 1.25mg daily | $47.29 | $43.37 | $520.44 |
| Coreg® CR | two Coreg® CR 20 mg daily | $222.11 | one Coreg® CR 40 mg daily | $113.01 | $109.10 | $1309.20 |
| Januvia® | two Januvia® 25 mg daily | $321.75 | one Januvia® 50 mg daily | $162.83 | $158.92 | $1907.04 |
| Lescol® | two Lescol® 20 mg daily | $139.88 | one Lescol® 40 mg daily | $71.89 | $67.99 | $815.88 |
| Norvasc® | two Norvasc® 2.5 mg daily | $112.13 | one Norvasc® 5 mg daily | $58.02 | $54.11 | $649.32 |
| Lexapro® | two Lexapro® 5 mg daily | $152.71 | one Lexapro® 10 mg daily | $81.61 | $71.10 | $853.20 |
| Prevacid® | two Prevacid® 15 mg daily | $300.31 | one Prevacid® 30 mg daily | $152.11 | $148.20 | $1,778.40 |
| Effexor ®XR | two Effexor® XR 75 mg daily | $216.91 | one Effexor® XR 150 mg daily | $120.01 | $96.90 | $1162.80 |
| fluoxetine | two fluoxetine 10 mg | $40.01 | one fluoxetine 20 mg | $12.47 | $27.54 | $330.48 |

***Being knowledgeable about drug costs can help prescribers determine the most cost effective therapy for their patients.***

[5]Dose optimization may not be appropriate for all beneficiaries. Only drugs approved by the Food and Drug Administration (FDA) for once daily dosing and have different strengths available at similar costs are options for Dose Optimization.
[6]Costs based on DOM's maximum allowable costs and do not include rebates, if applicable.

# NDC Codes to be Required for Physician-Administered Drugs: January 1, 2008

As required by the Deficit Reduction Act and federal regulations published by CMS on July 17, 2007, Mississippi Medicaid will implement important changes affecting payment of drugs administered incident to a physician service:

1. **The National Drug Code (NDC) will be required for all drugs administered incident to a physician service for claims with dates of service beginning January 1, 2008.**
    a. This affects all drugs (including injectable, intravenous, biologicals, oral, radiological contrast agents, and compounded drugs) in the following ranges: J0000 through J9999; S0000 through S9999; and Q0000 through Q9999.
    b. An NDC will be required in addition to the HCPCS code.
    c. Claims billed for these drugs without an NDC will be denied.
    d. An NDC is not required for vaccines or other drugs in the CPT code ranges 01000 through 99999.
    e. The NDC must be 11 digits in a 5-4-2 grouping, e.g., 00169706101. Providers may need to enter "leading zeros" in order to constitute an 11-digit NDC code.
    f. The NDC must be valid. The NDC will be matched against a database to ensure its validity.
2. **Mississippi Medicaid will only reimburse drugs that are subject to a drug manufacturer rebate and are not considered a DESI (Drug Efficacy Study Implementation) drug.**
    a. Drugs that are not under the federal rebate program will no longer be covered.
    b. Drugs that are considered DESI will no longer be covered. A list of DESI drugs is available from CMS at this link: http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp.
    c. It is important for the provider to begin checking all drugs currently being stocked and administered, and begin ordering only rebated, non-DESI drugs now in order to be prepared for the new requirement.
    d. Providers will soon be able to check the Web Portal to see which drugs are subject to federal rebate that will continue to be covered under this new requirement.
    e. Providers must not rely on the DOM fee schedules for HCPCS codes to determine whether a drug is covered. A single HCPCS code could map to several NDC's, some of which may not be covered.
3. **This new requirement will affect certain providers and claim types.**
    a. Providers that are reimbursed based on a fee must submit the NDC with the HCPCS code(s) when drugs are billed as described in #1. This would include providers such as physicians and nurse practitioners in private practice, dialysis facilities, ambulance providers, independent radiology facilities, and other providers that bill these drugs and are paid on a fee basis.
    b. Providers that are reimbursed based on a rate are not required to submit the NDC or the HCPCS code(s) for drugs. This would include providers such as inpatient and outpatient hospitals, FQHC's, rural health clinics, ambulatory surgical centers, home health agencies, nursing homes and other long-term care facilities, and other providers that are paid based on a per diem, encounter, or other type of rate.

IMPORTANT: Affected providers should begin now to develop procedures to record the NDC for drugs administered and billed to Medicaid, in addition to the HCPCS code(s), and to ensure that rebated, non-DESI drugs are billed to Medicaid in order to receive payment. Claims will be denied for dates of service beginning January 1, 2008, if drugs are billed that are1) not subject to rebate, or 2) DESI drugs, or 3) billed without an NDC.

Specific billing instructions will be published in the Provider Bulletin and posted to the Envision Web Portal site prior to January 1, 2008. Providers may need to work with their billing companies or clearinghouses to ensure that billing requirements will be met by January 1, 2008. This new requirement applies to all Medicaid programs, so billing companies and clearinghouses with experience in other states may already be prepared for this change.

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

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

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

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

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

- 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 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 | $13.22 | | | 90472 | $9.08 |
| 90660 | $21.18 | | | | |

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

- Mississippi Medicaid will reimburse physicians, nurse practitioners, and physician assistants for the FluMist influenza vaccine when given to beneficiaries age 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.

# New Claims Payment and Billing Instructions for FQHC's and Rural Health Clinics

New Mississippi Medicaid policy for Federally Qualified Health Centers (FQHC's) and Rural Health Clinics (RHC's) will be effective beginning December 1, 2007. With these policy changes, claims payment and billing instructions for FQHC's and RHC's are as follows:

1. All FQHC and RHC claims will be paid at the encounter rate set for the individual provider, except in certain situations as explained in this billing policy.

2. All claims for the same beneficiary, same date of service, same FQHC or RHC provider that are billed with at least one encounter code will be paid at one encounter rate. Other codes listed on the claim will zero pay.

3. No fee-for-service, non-encounter rate payments will be made to an FQHC or RHC provider for any reason.

4. Up to four separate encounters, i.e., medical, dental, vision/optical and mental health, may be paid on the same beneficiary for the same date of service to the same FQHC or RHC provider.

5. Services provided in the inpatient or outpatient hospital setting are not payable to the FQHC or RHC provider. These services must be billed by the physician on his/her Medicaid provider number. Claims billed by an FQHC or RHC provider with the following places of service will be denied:
   POS 21 Inpatient hospital
   POS 22 Outpatient hospital
   POS 23 Emergency room hospital

6. Certain procedures are not payable to an FQHC or RHC provider and claims/claim lines will deny.

7. All limitations and exclusions for all procedure codes apply, including but not limited to:
   - Service Limits (including dollar limits)
   - Non-covered or invalid procedure codes
   - Provider type restrictions
   - Prior authorization requirements

8. Medical Encounters:
   a. All medical services for the same beneficiary, same date of service, and same FQHC or RHC provider must be billed on one CMS-1500 or X12 Professional claim.
   b. Certain medical procedure codes will trigger an encounter payment (see Medical Encounter Code list).
   c. Additional medical encounter(s) may be paid for the same beneficiary, same date of service, and same FQHC or RHC provider only if the encounter requires an additional diagnosis or treatment that was not related to a previous encounter on that day. Claims for additional encounters must be billed on a paper claim with explanatory documentation attached. These claims will hit edit 3218:

- Electronic and paper claims with no attachments will deny – the provider may appeal by submitting documentation to support the reason for an additional encounter;
- Paper claims with an attachment will suspend for review and may be paid with documentation to support the need for an additional encounter.

9. Dental Encounters:
    a. All dental services for the same beneficiary, same date of service, and same FQHC or RHC provider must be billed on one American Dental Association or X12 Dental claim.
    b. Any covered dental procedure code in the HCPCS code range D0000 through D9999 will generate an encounter payment (see Dental Encounter Code list).
    c. Only one dental encounter payment can be made regardless of the number of dental procedures billed on that date of service.

10. Vision/Optical Encounters:
    a. All vision/optical services for the same beneficiary, same date of service, and same FQHC or RHC provider must be billed on one CMS-1500 or X12 Professional claim.
    b. Any covered eye examination procedure code in the CPT code range 92002 through 92014 will generate an encounter payment (see Vision/Optical Encounter Code list).
    c. Only one vision/optical encounter payment may be made regardless of the number of vision/optical procedures billed on that date of service.
    d. Eyewear (eyeglass frames, lenses, and contact lenses) codes V0000 through V9999 and other vision-related codes 92015 through 92499 will zero pay. No fee-for-service payments will be made for these codes.

11. Mental Health Encounters:
    a. All mental health services for the same beneficiary, same date of service, and same FQHC or RHC provider must be billed on one CMS-1500 or X12 Professional claim.
    b. Certain mental health procedure codes will trigger an encounter payment (see Mental Health Encounter Code list).

# ENCOUNTER CODES FOR FQHC'S AND RHC'S

(For dates of service beginning 12/1/07)

Medical Encounter Code List

| | |
|---|---|
| 99201 through 99215 | Physician Office Visits (including Antepartum) |
| 99241 through 99275 | Physician Office Consultations |
| 99304 through 99310 | Physician Nursing Facility Visits |
| 99315 | Physician Nursing Facility Visit |
| 99318 | Physician Nursing Facility Visit |
| 99324 through 99337 | Physician Domiciliary, Rest Home, or Custodial Care Visits |
| 99341 through 99350 | Physician Home Visits |
| 99381 through 99397 | Physician Preventive Medicine Visits (EPSDT Screening & Physical Exams) |
| 99401 | Physician Preventive Medicine Visits (EPSDT) |
| 59425 through 59426 | Physician Antepartum Visits |
| 59430 | Physician Postpartum Office Visit |
| H0023 | PHRM/ISS Service |
| H1002 | PHRM/ISS Service |
| S9127 | PHRM/ISS Service |
| S9445 | PHRM/ISS Service |
| T1017 | PHRM/ISS Service |
| T1023 | PHRM/ISS Service |

Dental Encounter Code List

| | |
|---|---|
| D0000 through D9999 | Dental Codes |

Vision/Optical Encounter Code List

| | |
|---|---|
| 92002 through 92014 | Physician/Optometrist Eye Exam Visits |

Mental Health Encounter Code List

| | |
|---|---|
| 90801 | Psychiatric Diagnostic Visit |
| 90804 through 90805 | Psychotherapy Visits |
| 90808 | Psychotherapy Visit |
| 90810 through 90815 | Psychotherapy Visits |
| 90845 through 90847 | Psychotherapy Visits |
| 90853 through 90857 | Psychotherapy Visits |
| 90865 | Psychiatric Service |
| 96110 through 96111 | Central Nervous System Assessments |

## Policy Manual Additions/ Revisions

The following policies and policy sections have been added and/or revised in the DOM Provider Policy Manual. Providers of these services may view these changes by accessing the DOM website at www.dom.state.ms.us and clicking on "Provider Manuals" in the left window.

| Manual Section | Policy Section | New | Revised | Effective Date |
|---|---|---|---|---|
| 10.0 Durable Medical Equipment | 10.62 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 |
| 3.0 Beneficiary Information | 3.01 Eligibility of Groups | | X | 12/01/07 |
| 50.0 Respiratory Therapy | 50.02 Respiratory Therapists | X | | 12/01/07 |
| 53.0 General Medical Policy | 53.38 Breast Reconstruction for Symmetry | X | | 12/01/07 |

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

# *November*

## *November 2007*

| *Sunday* | *Monday* | *Tuesday* | *Wednesday* | *Thursday* | *Friday* | *Saturday* |
|---|---|---|---|---|---|---|
| | | | | 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 **DOM and ACS CLOSED** | 23 | 24 |
| 25 | 26 CHECKWRITE | 27 | 28 | 29 **EDI Cut Off 5:00 p.m.** | 30 | |

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