Mississippi Medicaid Bulletin

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NO NPI ON FILE WITH MEDICAID….. NO PAYMENT AFTER JANUARY 1, 2008

Mississippi Medicaid will require the National Provider Identifier (NPI) on electronic and paper transactions effective January 1, 2008. **If your NPI is not on file with the Division of Medicaid, your claims will deny beginning January 2, 2008.**

- If you are a health care provider who renders care and bills Medicaid for services, you need an NPI.
- If you bill Medicare for services, you need an NPI!
- If you bill other health care plans, you need an NPI!

Getting an NPI is easy. Getting an NPI is free. If you delay applying for your NPI, you risk your cash flow and that of your health care partners as well.

Pharmacy point of sale (POS) claims must include NPI numbers for the primary/billing provider or the dispensing pharmacy and for the secondary provider or the prescriber. Claims without either pharmacy or secondary NPI will deny.

Fax your NPI to Division of Medicaid, Provider and Beneficiary Relations at 601-359-4185. If you need more information, contact Evelyn H. Silas or Mary Randazzo at 601-359-6133.

Medicare Advantage Plans
Part C

The Division of Medicaid will now accept Medicare Advantage Plans - Part C claims filed for dually eligible beneficiaries, individuals enrolled in Medicare and eligible for Medicaid coverage. DOM will not accept any electronic Part C claims. These claims must be paper submission only,

Instructions for Submission of Part C Claims

1. All claims should be submitted on the appropriate paper Medicaid Crossover Claim and attach the EOB to each claim. To access these forms, go to www.dom.state.ms.us, select Medicaid Provider Information/Forms for Providers. Instructions should be followed for completion as indicated.
2. Claims processed with the EOB payment date of December 1, 2007 and thereafter, will be subject to the 180 day timely filing limitation.
3. Providers should indicate across the bottom of the crossover claim form that this is for an **"Advantage Plan."**
4. Part C Claims should be sent to:

   ACS
   P.O. Box 23076
   Jackson, MS 39225

Submission of Part C Past 180 Day Filing Time Limit

1. All claims should be submitted on the appropriate paper Medicaid Crossover Claim and attach the EOB to each claim. To access these forms, go to www.dom.state.ms.us, select Medicaid Provider Information/Forms for Providers. Instructions should be followed for completion as indicated.
2. Claims to be processed for consideration of timely overrides must be received by April 1, 2008 and submitted to:

   Division of Medicaid
   Attention: Provider and Beneficiary Relations
   550 High Street, Suite 1000
   Jackson, Mississippi 39201

   NOTE: Claims that are not sent to the Bureau of Provider and Beneficiary Relations by the above required deadline **will not** be reimbursed by the Division of Medicaid.

For additional assistance, contact the ACS Call center at 1-800-884-3222.

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.

CPT Add-on Codes

The + sign in front of a code in the CPT book identifies an add-on code. These services are always performed with another service or procedure and should never be reported alone. They should always be reported with the appropriate primary service or procedure.

An example of this would be CPT add-on code 11732. This code should always be reported with 11730. When performing this procedure on multiple digits, you would need to report the first digit with the primary code of 11730 and each additional digit with 11732.

Not coding the primary and add-on procedures correctly could cause claim denials, incorrect payments, and possibly review of your claims for incorrect coding practices.

Guidelines for the billing of add-on codes are located in the Introduction section of the CPT book.

Third Party Liability

FREQUENTLY ASKED QUESTIONS

- Are you having problems getting your claims paid because of insurance information on Medicaid's file?
- Are you being prompted to bill the third party when the patient has no coverage?

Solutions to these common problems can be found in our FAQ section. The FAQs will be updated periodically. If you have additional questions please submit them through the web portal.

Question: What is TPL?
Response: TPL is an acronym for Third Party Liability. This means that a person or entity is responsible for medical expenses other than Medicaid.

Question: Who do I call to get the insurance information removed from a record?
Response: Contact Darlene Branson in the DOM, Bureau of Recovery at 601-359-6095.

Question: How long does it take to update a beneficiary's insurance record?
Response: It takes 2 to 3 business days.

Question: Is the Medicaid recipient responsible for their third party insurance co-pay or deductible?
Response: No. The Provider should bill the insurance plan, attach the explanation of benefits to the Medicaid claim, and Medicaid will pay up to its allowed amount.

Question: How will I know what patients have been included when a mass adjustment occurs?
Response: You should contact your Provider Beneficiary Relations Representative at 1-800-884-3222.

Question: When the third party pays the claim in full or pays more than Medicaid will allow, do I have to file the claim with Medicaid?
Response: Yes, this is considered an informational claim, and will be used to update the history of service for the patient.

Question: Can a beneficiary have Medicaid and private insurance together?
Response: Yes, having private insurance does not disqualify an individual from Medicaid participation. However, the beneficiary is responsible for reporting insurance changes. The private insurance is the primary payer and Medicaid is the secondary payer or payer of last resort.

Question: Do I need to report to Medicaid that a patient no longer has insurance?
Response: Yes, report the change in insurance by telephone at 601-359-6095, by fax at 601-359-6632, or through the web portal. Failure to report this change may delay the payment of claims.

Long Term Care (LTC) Pre-admission Screening (PAS) Training

In response to requests from providers, the Mississippi Division of Medicaid will offer on-going training opportunities for the LTC pre-admission screening (PAS) instrument which became effective October 1, 2007. The training will be offered at the Division offices in Jackson on December 17, 2007 from 2:00 - 4:30 p.m., and December 18, 2007 from 9:00 a.m. - 12:00 p.m. Seating is limited to 20 individuals per session, so pre-registration is required. A pre-registration form accompanies this article. Please complete the form and FAX it to Tremeka Minor at (601) 359-9532. Reservations will be made on a first come, first reserved basis. You will be notified of your acceptance by telephone. When one session is full, the next session will be filled with the next twenty names on the registration list. Please limit reservation requests to one or two persons per institution, facility, or provider so that as many providers as possible may benefit from this training.

NOTE: PAS Frequently Asked Questions (FAQs) located at https://msmedicaid.acs-inc.com/msenvision/questionanswer.do?CATEGORY_TYPE=Long%20Term%20Care

DIVISION OF MEDICAID, BUREAU OF LONG TERM CARE
Registration for December 2007 Pre-Admission Screening (PAS) Training

CIRCLE ONE
Registration for: December 17 (2-4:30 p.m.) December 18 (9:00 a.m.-Noon)

NAME OF FACILITY/PROVIDER	ADDRESS AND TELEPHONE NUMBER
PERSON ATTENDING TITLE:	PERSON ATTENDING TITLE:

FAX TO: TREMEKA MINOR AT 601-359-1383 OR E-MAIL TO LMTJM@MEDICAID.STATE.MS.US

Allowable Board of Directors Fees for Nursing Facilities, ICF/MR's and PRTF's 2007 Cost Reports

The allowable Board of Directors fees that will be used in the desk reviews and audits of 2007 cost reports filed by nursing facilities (NF's), intermediate care facilities for the mentally retarded (ICF/MR's), and psychiatric residential treatment facilities (PRTF's) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts using the Consumer Price Index for All Urban Consumers - All Items. The amounts listed below are the per meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2007 are as follows:

Category	Maximum Allowable Cost for 2007
0 - 99 Beds	$ 3,505
100 - 199 Beds	$ 5,258
200 - 299 Beds	$ 7,010
300 - 499 Beds	$ 8,763
500 Beds or More	$10,516

2007 Owner Salary Limits for Long-Term Care Facilities

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for the mentally retarded and psychiatric residential treatment facilities as owner's salaries for 2007 are based on 150% of the average salaries paid to non-owner administrators in 2006 in accordance with the Medicaid State Plan. These limits apply to all owners and owner/administrators that receive payment for services related to patient care. The limits apply to salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2007 are as follows:

- Small Nursing Facilities (1-60 Beds) $101,621
- Large Nursing Facilities (61 + Beds) $129,303
- Intermediate Care Facilities for the Mentally Retarded (ICF-MR) $110,772
- Psychiatric Residential Treatment Facilities (PRTF) $158,075

Frequently Asked Questions in the Pharmacy Bureau

Question: What smoking cessation drugs are covered by Medicaid?
Response: Effective November 1, 2007, varenicline (Chantix®) is added for coverage for DOM beneficiaries. Previously covered smoking cessation drugs, such bupropion (generic Zyban®)and nicotine replacement products, continue to be covered.

Question: What smoking cessation drugs are covered by Medicaid for dual eligibles?
Response: Only OTC smoking cessation products are Medicaid covered for the dual eligible. Legend smoking cessation products, such as varenicline (Chantix®), bupropion (generic Zyban®), and prescription tobacco replacement products, are covered by Medicare Part D.

Question: What provider numbers are to be used on pharmacy claims?
Response: Effective January 1, 2008, DOM requires that pharmacy claims use NPI for the billing/pharmacy provider number and NPI for the prescribing provider.

Question: What will happen if a pharmacy submits claims without the pharmacy and/or prescriber NPI numbers?
Response: Effective January 2, 2008, pharmacy claims without the billing (pharmacy) provider's NPI and/or the secondary (prescriber) provider's NPI will deny.

Question: How can I get prescribers' NPI numbers?
Response: Contact the prescriber's office, request their NPI number and load in your system. For providers who are Medicaid providers and have submitted their NPI to MS Medicaid, ACS/DOM has prepared a crosswalk of MS Medicaid provider numbers and NPI numbers. The shortcut to the crosswalk list is https://msmedicaid.acs-inc.com/msenvision/prescribingProviderList.do.

Question: What if the prescriber is not a MS Medicaid provider? Are there any other resources to get this NPI?
Response: CMS has prepared a NPI Registry. The shortcut to the Registry is https://nppes.cms.hhs.gov/NPPES/Welcome.do.

Question: Why do I need to have a MS Medicaid provider number if I have a NPI number?
Response: MS Medicaid Providers must have both a Medicaid provider number and a NPI number for

- ***HIPAA compliance:*** HIPAA mandates the use of NPI. All health care providers who choose to transmit any health information in electronic form are required to obtain and use an NPI.

- ***Reimbursement:*** MS Medicaid providers numbers are necessary for provider reimbursement of Medicaid services.

Question: What happens when and/or if a random NPI is used on a pharmacy claim?
Response: Using an incorrect or random NPI distorts Drug Utilization Review (DUR) data causing data collection to be flawed. Using a random NPI may be a fraudulent entry. It is considered a fraudulent act to knowingly submit a prescriber identification number, such as a NPI, another prescriber's identification number, or a pharmacy provider number, that does not belong to the provider who has written the prescription. ***Remember*** 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, then the pharmacy employee has just committed a fraudulent act against MS Medicaid which could lead to sanctions against them and the company.

Preferred Drug List Changes
Effective January 1, 2008

Drug class	PDL Additions	PDL Removals
Acne agents[1]		Klaron®, Benzymycin pak®
Ophthalmic antibiotics[2]	AzaSite®, Zymar®, Ocuflox®	
Ocular Allergy Agents[2]	Optivar®, Elestat®, Alocril®, Patanol®, Alamast®	
Antipsychotics	Abilify®	

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 the 90 Day Maintenance List[3].** DOM has a Maintenance list of drugs which may be prescribed in 90 day increments. Not all drugs are suitable for placement on the maintenance list. Factors determining placement on this list include standards of care, the safety issues related to the dispensing of a 90 day supply, the therapeutic cost effectiveness associated with the drug and the modality of how it is dispensed.

Advantages to using the 90 Day Maintenance List include

- beneficiaries who requires more than five drugs monthly can potentially fill more needed prescriptions during those months that the maintenance medication will not be refilled;
- beneficiary saves on co-payments and the State saves two dispensing fees; and
- Increased beneficiary compliance may result in fewer hospital visits and an overall decrease in medical expenditures per beneficiary.

DRUG COSTS COMPARISONS[4] BY USING 90 DAY MAINTENANCE LIST OF COMMONLY PRESCRIBED AGENTS

DRUG NAME	90 DAY MAINTENANCE COSTS [5]	COSTS FOR 3 THIRTY DAY SUPPLIES	ANNUAL SAVINGS/PER BENEFICIARY[6]
HCTZ 25 MG DAILY (#30)	$5.43	$15.25	$39.28
METFORMIN 500 MG TWO TIMES DAILY (#60)	$68.94	$78.76	$39.28
RANTIDINE 150 MG TWO TIMES DAILY (# 60)	$24.49	$34.31	$39.28
CITALOPRAM 20 MG DAILY (#30)	$32.72	$42.54	$39.28

[1] Drug use restricted to beneficiaries up to age of 21 years of age.
[2] New class to PDL.
[3] For the comprehensive 90 Day Maintenance List, go to DOM's website at www.dom.state.ms.us; go to pharmacy services; and select 90 Day Maintenance List.
[4] Drug costs are based on DOM reimbursement including dispensing fees
[5] Costs calculated by number of daily doses multiplied times 90 days plus dispensing fee.
[6] Annual savings is calculated by multiplying the difference (from costs of three 30 day supplies and 90 Day Maintenance Costs) times 4 (quarters in a year).

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.

Continued on the next page

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.

DME Providers – Using Miscellaneous HCPCS Codes

For durable medical equipment, medical supplies, prosthetics, and orthotics, DME providers must request prior authorization and bill using the appropriate HCPCS code(s) for the item(s) provided. In instances where a specific HCPCS code has not been assigned to a particular item, providers may request prior authorization and bill using miscellaneous HCPCS codes such as A9999 or E1399. When submitting a prior authorization request for one of the miscellaneous codes, the provider must attach an invoice or a copy of the manufacturer's suggested retail price (MSRP) as described in Section 10.02 of the Medicaid Provider Policy Manual.

It is not acceptable to request prior authorization or bill for items using miscellaneous HCPCS codes in order to receive a higher reimbursement than the maximum fee allowed by Medicaid for the appropriate specific HCPCS code for the item.

Maternal and Child Health Plan of Care Authorization Requests

When submitting paper Plan of Care Authorization Requests (MA-1148) for extended physician office and/or outpatient emergency visits, you **MUST** submit the multi-layered form (white, yellow and pink copies). The goldenrod copy may be retained by the provider for their record. The above multi-layered form should be sent to DOM at the address listed below.

DIVISION OF MEDICAID
Suite 1000
Walter Sillers Bldg.
550 High Street
Jackson, MS 39201
Attn: Bureau of Maternal and Child Health

NOTE: The ADDENDUM TO PLAN OF CARE (MA-1148A) has been revised. Effectively immediately please submit the new Addendum form. The new Addendum form may only be submitted when you have a ***nine (9) digit Prior Authorization number*** for that beneficiary. Follow the same instructions with the Addendum as stated above for the ***Original Plan of Care Form.*** You may obtain these forms from the fiscal agent, ACS, by calling 1-800-884-3222.

If you have questions, you may call the DOM, Bureau of Maternal and Child Health at (601) 359-6150 or 1-800-421-2408.

Procedures for Providers Requesting a Dental Prior Authorization

Web Portal Process

Provider submits the **dental** request by using the ACS web portal secure side. The provider logs into the secure side by using his userid and password. Once the provider has logged onto the secure side the provider should:

Select the provider link
Stroll down to prior authorization
Select the option "Enter PA Request"
Select the "Dental" Option
Enter the Beneficiary ID number and the Provider ID number
Select the "submit" option takes you to the form

Provider submits the **oral surgery** request by using the ACS web portal secure side. The provider logs into the secure side by using his userid and password. Once the provider has logged onto the secure side the provider should:

Select the provider link
Stroll down to prior authorization
Select the option "Enter PA Request"
Select the "Oral Surgery" Option
Enter the Beneficiary ID number and the Provider ID number
Select the "submit" option brings you to the form

How to Complete the Form via the web:

Note: Beneficiary and Provider information populates automatically

Any other insurance	Not Required
Covered by Workmans Comp?	Not Required
Complete as Required	Required
Child Screening Referral	Not Required
Name of Referring Physician	Not Required
Diagnosis, Primary	Not Required
Diagnosis, Secondary	Not Required
Date of Service	Required
Provider Comments	Required if requesting services which do not require a tooth number
Surface involved	Required as needed
Requested Treatment Plan	Required
Check box by "red" asterisk	Required

Check box if x-rays or pictures are to be uploaded
Select the "submit" option once all information is completed

Provider submits the **orthodontic** request by using the ACS web portal secure side. The provider logs into the secure side by using his userid and password. Once the provider has logged onto the secure side the provider should:

Select the provider link
Stroll down to prior authorization
Select the option "Enter PA Request"
Select the "Orthodontic" Option
Enter the Beneficiary ID number and the Provider ID number
Select the "submit" option

How to Complete the Form via the web:

Note: Beneficiary and Provider information populates automatically

Orthodontic Treatment Need Criteria	Required
Services Requested	Required
Procedure Code	Required
Services Description	Populates Automatically
Begin Date	Required
End Date	Required
Units/No Months	Required
Total Charge	Required

Note:

Additional information such as x-rays, pictures and models are still required with prior authorization (PA) request being submitted via the web portal. The PA will be denied if the information is not received in the DOM Bureau of Medical Services within 5 working days of the receipt of the PA request. Please refer to Section 11 of the Mississippi Medicaid Provider Policy Manual if you are unsure of which procedures require additional information.

Paper PA Process

Oral Surgery and Dental providers must request the Dental Services Authorization Request form, MA-1098, by contacting ACS, fiscal agent, at 1-800-884-3222, and asking for the mailroom. ACS will mail a package of 50 forms to the provider. The provider should insert the required information on the form, and return the form to the DOM Bureau of Medical Services at the address listed in the upper left hand corner of the form.

How to Complete the Form:

1. Patient's Name	Required
2. Medicaid ID Name	Required
3. Date of Birth	Required
4. Provider Name and Address	Required
5. Provider No.	Required
6. a. Any other INS?	Not Required
b. Covered by Workman Comp:	Not Required

7. Complete as Required — Not Required
8. Child Screening Referral — Not Required
9. Name of Referring physician etc. — Not Required
10. a. Diagnosis Primary — Not Required
    b. Diagnosis secondary — Not Required
    c. Surface involved — Not Required
11. Requested Treatment Plan — Required
12. Dentist's Signature and Date — Required

Orthodontic providers must request the Dental Services Orthodontics Authorization Request form, MA-1097, by contacting ACS, fiscal agent, at 1-800-884-3222, and asking for the mail room. ACS will mail a package of 50 forms to the provider. The provider should insert the required information on the form, and return the form to the DOM Bureau of Medical Services at the address listed in the upper left hand corner of the form.

How to Complete the Form:

Part I – Identification

1. Patient's Medicaid ID No: — Required
2. Date Of Birth — Required
3. Patient's Address — Not Required
4. Patient's Name — Required
5. Provider's Name and Address — Required
6. Provider No. — Required

Part II – Orthodontic Treatment Need Criteria

Required

Part III – Requested Treatment Plan

Service Description # of Months Total Charge Required

Provider's Signature: Required
Date: Not Required

Part IV Approved Services

Medicaid Use Only

Prior Authorization Process for Eyeglass and Hearing Aids

(Prior to submitting ANY prior authorization request, the provider of service must verify the beneficiary's eligibility.)

Vision and Hearing Prior Authorization Request Forms (Paper):

Providers are to complete the appropriate Eye Glass/Hearing Aid authorization request form using the appropriate procedure codes. The form number is (DOM-210). The completed request form should be submitted to: Division of Medicaid, Suite 1000, Walter Sillers Building, 550 High Street, Jackson, MS 39201.

Vision and Hearing Prior Authorization Request Forms (Web Portal):

The provider must access the Web Portal through Mississippi Envision and select Web Registration for first time users, or just Login (for existing users) using your Login ID and Password.

- Click on **Provider**
- Stroll down to **Prior Authorization**
- Select option to **Enter PA Request**
- Select the type of PA **Eye Glass/Hearing Aid**
- Enter **Beneficiary ID (Number)** and **Provider ID**
- Click **Submit**
- Provider and Patient information will automatically populate
- Under Medical Data - Select which type of authorization is needed
  - Type the Reason for Request/Justification
- Type the Procedure Code
- Tab to next box and the procedure description will automatically populate
- Tab to Requested Date and key in the date of service
- Tab to Unit/Number of Months and key in the number of units you are requesting
- Tab to Total Charges
- If you are requesting an additional procedure, click the Add New Line Item box. This will allow you to submit additional procedure codes as needed.
- Check the box with the red asterisk; this is to certify that all information is accurate and true.
- If you should need to submit additional documentation such as an invoice you should upload your information by clicking on the box next to the submit button.
- Additional information may also be submitted via fax to 601-359-5252.
- Once all necessary information has been completed, click the **Submit** button.
- Be sure to either print a copy of the PA or record the PA number for your record.

Policy for Vision and Hearing is located in the Division of Medicaid Policy Manual, Sections 29 (Vision) and 30 (Hearing Aid).

Prior Authorization Process
For Fixed Wing Air Ambulance

(Prior to submitting ANY prior authorization request, the provider of service must verify the beneficiary's eligibility.)

Fixed Wing Air Ambulance Prior Authorization Requests (Paper Only)

All air ambulance fixed wing transports must be prior authorized. The prior authorization (PA) must be requested by telephone or fax; there is no electronic process for these PA's. The prior authorization process is as follows:

- The referring physician/transferring hospital may call the Division of Medicaid (DOM) to request urgent air transportation.
- The physician/hospital must complete a Request for Urgent Air Ambulance Approval Packet, including a medical necessity letter from the physician. The packet is available to providers if requested from the DOM Bureau of Medical Services.
- All documents must be submitted to the DOM Bureau of Medical Services by fax.
- The referring physician/transferring hospital must also contact a DOM-approved air ambulance provider to arrange the transport with them.
- When all required PA documents have been received by the DOM Bureau of Medical Services, DOM staff will review the documentation for compliance with Medicaid policy and medical necessity.
- The air ambulance provider will be notified about the decision. If the transport is approved, the approval letter will be faxed to the air ambulance provider and the transport can be covered.
- A prior authorization number is not issued and is not needed on the air ambulance provider's claim. The authorization letter is sent to the fiscal agent, and the claim will be approved for payment if there is an authorization letter.

Coverage policies are detailed in the Division of Medicaid Provider Policy Manual Section 8.04.

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
3.0 Beneficiary Information	3.01 Eligibility of Groups		X	12/01/07
43.0 Federally Qualified Health Center	All (43.01- 43.15)	X		12/01/07
44.0 Rural Health Clinics	All (44.0- 44.16)	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
8.0 Ambulance	8.17 Unused Injectable Drugs *	X		01/01/08
11.0 Dental	11.09 Restorative Services 11.10 Endodontics 11.21 Dental Benefit Limits 11.24 Occlusal Guard 11.26 Unused Injectable Drugs *	 X X	X X X	01/01/08
25.0 Hospital Inpatient	25.36 Sterilization and Deliveries in the Same Admission		X	01/01/08
41.0 Dialysis	41.09 Unused Injectable Drugs*	X		01/01/08
43.0 Federally Qualified Heath Centers	43.16 Unused Injectable Drugs*	X		01/01/08
44.0 Rural Health Clinics	44.17 Unused Injectable Drugs*	X		01/01/08
53.0 General Medical Policy	53.31 Sleep Disorder Studies 53.39 Unused Injectable Drugs *(Cross-references to section 53.39)	X X		01/01/08
55.0 Physician	55.15 Unused Injectable Drugs*	X		01/01/08
56.0 Injectables / Physician Office	56.03 Unused Injectable Drugs*	X		01/01/08
81.0 General Coding Information	81.01 Correct Coding	X		01/01/08

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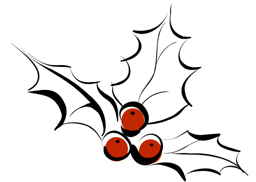
http://msmedicaid.acs-inc.com



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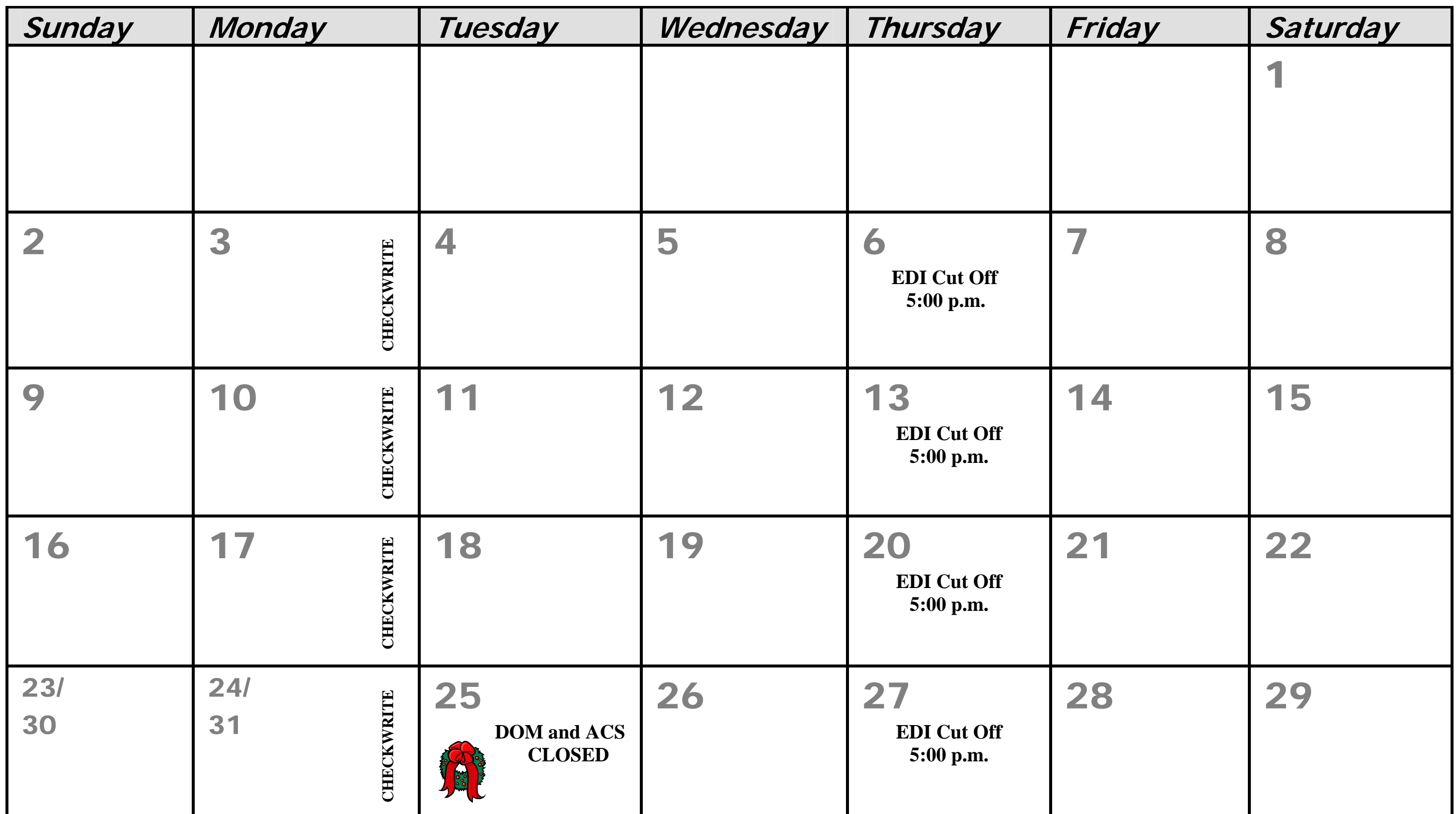

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3 CHECKWRITE	4	5	6 EDI Cut Off 5:00 p.m.	7	8
9	10 CHECKWRITE	11	12	13 EDI Cut Off 5:00 p.m.	14	15
16	17 CHECKWRITE	18	19	20 EDI Cut Off 5:00 p.m.	21	22
23/ 30	24/ 31 CHECKWRITE	25 DOM and ACS CLOSED	26	27 EDI Cut Off 5:00 p.m.	28	29

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.