Mississippi Medicaid Bulletin

Volume 14, Issue 1

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Inside this Issue

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.

Charges for Missed or Cancelled Appointments

All Providers: Please be advised that beneficiaries *cannot* be charged for missed or cancelled appointments. Refer to Division of Medicaid Provider Manual Section 3.09, item #9.

Mississippi Medicaid *Roads to Good Health* Wellness Program

The Division of Medicaid, in its continuing effort to support good health for Mississippians, encourages all beneficiaries to utilize the benefits provided in the *Roads to Good Health* Wellness Program. The Division of Medicaid reimburses for certain wellness services for eligible beneficiaries and encourages health-care providers to utilize current evidence-based guidelines in providing wellness services to their patients.

Wellness services covered by Mississippi Medicaid include

- Annual health screening/physical exam
- Cardiovascular screening
- Diabetes screening
- Cervical and vaginal cancer screening
- Screening mammography
- Colorectal cancer screening
- Prostate cancer screening
- Bone density study
- Glaucoma screening
- Influenza vaccine
- Pneumococcal vaccine
- EPSDT services

Annual Health Screening/Physical Exam

Eligible Mississippi Medicaid beneficiaries are encouraged to have an annual health screening, or physical exam. Appropriate age-related screenings such as those listed below will be reimbursed separately when performed as part of the annual physical exam. The annual physical exam does not count toward the physician visit limit of twelve (12) per fiscal year and is covered after the limit is reached. The physical exam is exempt from copayment. Refer to Section 53.18 in the Mississippi Medicaid Provider Manual for policy concerning physical examinations.

Cardiovascular Screening An annual screening of cholesterol, lipids, and triglyceride levels is covered.

Diabetes Screening An annual screening for diabetes that may include appropriate laboratory studies is covered.

Cervical and Vaginal Cancer Screening A Pap test and a pelvic exam are covered yearly for women.

Screening Mammography Beginning at age 40, an annual mammogram is covered for women.

Colorectal Cancer Screening Beginning at age 50, a yearly screening for occult blood is covered. Additionally, a flexible sigmoidoscopy or barium enema is covered every 5 years, or a colonoscopy is covered every 10 years.

Prostate Cancer Screening A prostate-specific antigen (PSA) blood test and digital rectal examination (DRE) are covered annually for men beginning at age 50. Both screenings are covered annually beginning at age 45 for men of African-American descent.

Bone Density Studies Bone density studies are allowed every 24 months for women age 65 and older.

Vision and Glaucoma Screening Eye exams are covered as specified in section 29 of the Mississippi Medicaid Provider Policy Manual.

Influenza and Pneumonia Vaccines Influenza and pneumonia vaccines are covered services for both children and adults under Mississippi Medicaid. Refer to section 77.04 of the Mississippi Medicaid Provider Manual for policy for adult vaccines and section 77.05 for vaccines for children.

Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) The EPSDT program, a mandatory service under Medicaid, provides preventive and comprehensive health services for Medicaid-eligible children and youth up to age twenty-one (21). Please refer to section 73 of the Mississippi Medicaid Provider Manual for policy concerning EPSDT services.

You will find the complete Wellness policy in Section 53.30 of the Mississippi Medicaid Provider Manual. For billing guidelines, refer to the "Wellness Benefits" link located last in the vertical green banner on the Mississippi Medicaid website, www.dom.state.ms.us

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.

   NOTE: All claims to be processed after January 1, 2008 must have the appropriate NPI number or it will deny. Medicaid Crossover Claim forms have been revised to include this requirement.

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 write across the bottom portion of the claim form **"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 **mus**t 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.

HELP MEDICAID BENEFICIARIES BECOME TOBACCO-FREE

Dear Medicaid Provider,

DO YOU KNOW . . .?

- In Mississippi, 4,700 adults die each year from their own smoking.
- More than 4,400 youth become regular smokers each year, and
- 192,000 children are exposed to secondhand smoke at home.
- Tobacco use results in $719 million in annual healthcare costs in Mississippi.

- Source: Mississippi State Department of Health

The Mississippi Medicaid Program would like to **ENCOURAGE YOU TO HELP YOUR PATIENTS, ESPECIALLY MEDICAID BENEFICIARES, TO BECOME TOBACCO-FREE.** This will be an important step on the road to having better health.

DO YOU ALSO KNOW THAT …?

- the Mississippi Medicaid program will pay for a prescription that covers nicotine replacement gum, patches and other medicines like Chantix to help our beneficiaries to quit using tobacco?

YES, the Division of Medicaid will pay for nicotine replacement therapy and medicines to help beneficiaries become tobacco-free.

Statistics have shown that tobacco users who are encouraged to quit by their healthcare providers are more likely to be motivated than those who were not. The Division of Medicaid also encourages you to refer your patients to an important support service - the **Mississippi Tobacco Quitline** to further assist your patients in becoming tobacco-free. Counselors are available through the Quitline to work with persons, referred by their prescribing physicians, in customizing a plan to aid in their quitting tobacco use.

The Quitline offers a fax referral form that is designed to allow healthcare providers the ease of referring beneficiaries to the counseling service. By having a beneficiary to sign the **Patient Referral/Consent Form, on the following page,** and by providing basic contact information, the Quitline is able to start the quit process by making a pro-active contact with the referral. This form will allow the referring provider to receive updates and progress reports on the referral and allows a dual opportunity for cessation services to be the focus of the telephone counseling and the face to face visits to the healthcare provider.

All information is considered confidential and can only be released by the beneficiaries' signature for consent. The form is HIPAA approved and no identifying information is reported to any outside entity.

If you are interested in utilizing this service, **please contact the Mississippi Tobacco Quitline at 1-800-784-8669.** They will provide you with an electronic copy of the Fax Referral Form for your use.

1-800-QUIT NOW
(1-800-784-8669)
TOBACCO QUITLINE

Patient Referral/Consent Form

FAX TO: **1-601-899-8650**
E-mail: quitline@iqh.org
MAIL TO: IQH, Tobacco Quitline
385B Highland Colony Parkway, Suite 503
Ridgeland, MS 39157
Web Address: www.iqh.org

Patient's Name: _____ **Date:** _____
Address:_____City_____State_____Zip Code_____
Telephone #: _____ **Backup Telephone #:** _____

Best Contact Time: _____ **Morning** _____ **Afternoon** _____ **Evening**

I understand that the Tobacco Quitline will be contacting me to provide quit tobacco information and offer counseling. My participation is voluntary. I understand that any information I provide will be kept confidential. I give permission for my information to be exchanged between the Tobacco Quitline and my healthcare provider.

Patient/Client Signature for Consent: _____

Comments:
_____
_____
_____

I request that the Tobacco Quitline, operated by IQH, contact my patient/client for the provision of tobacco cessation services.

Signature: _____ Date: _____

Print Name: _____

Office Address:_____

Telephone #: _____

Revised 03/12/2007 **Duplication permitted**

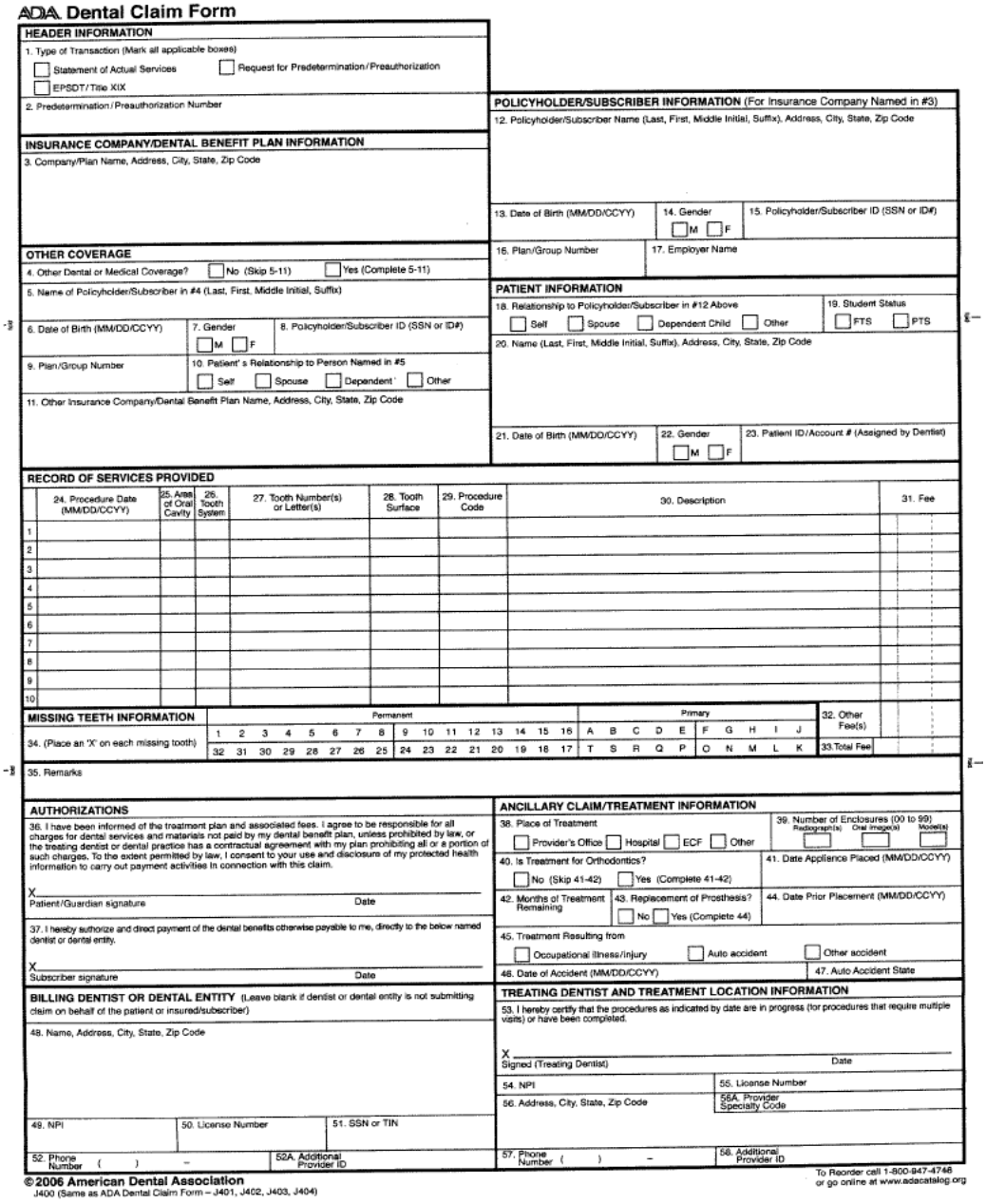
Dental Claim Forms – Paper Billing

Effective January 1, 2008, the Division of Medicaid will accept only the 2006 ADA Dental Claim form when providers bill on paper. No other paper claim forms, including earlier versions of ADA forms, will be accepted. This change was originally effective in May 2007, but the deadline was extended to allow additional time for requiring the provider NPI. The 2006 ADA Dental claim form has fields for the provider NPI, which is required beginning January 1, 2008.

The Division of Medicaid strongly encourages all dental providers to bill electronic claims. Paper claims are more vulnerable to error, and electronic billing is faster and more efficient. If you need information on electronic billing, including the availability of free software, please contact ACS at 1-800-884-3222.

Instructions for completing the paper 2006 ADA Dental Claim form are as follows:

2006 ADA Dental Claim Form



ADA Dental Claim Form

HEADER INFORMATION
1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE
4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION
18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION
34. (Place an 'X' on each missing tooth)
Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
Primary: A B C D E F G H I J / T S R Q P O N M L K
32. Other Fee(s)
33. Total Fee

35. Remarks

AUTHORIZATIONS
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X_____ Patient/Guardian signature Date
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X_____ Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)
48. Name, Address, City, State, Zip Code
49. NPI | 50. License Number | 51. SSN or TIN
52. Phone Number ( ) – | 52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION
38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X_____ Signed (Treating Dentist) Date
54. NPI | 55. License Number
56. Address, City, State, Zip Code | 56A. Provider Specialty Code
57. Phone Number ( ) – | 58. Additional Provider ID

©2006 American Dental Association
J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)
To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

2006 ADA Dental Claim Form Instructions for Mississippi Medicaid

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
1	Not Required	**Type of Transaction**: Not Required.
2	Required if Applicable	**Predetermination/Preauthorization Number**: Enter the prior authorization (PA) number for services that require PA and approval by DOM. Refer to the Medicaid Provider Policy Manual and Dental Fee Schedule at www.dom.state.ms.us for specific instructions about services that require PA.
3	Required	**Company/Plan Name, Address, City, State, Zip Code**: Enter the name and address for the insurance company that is the third party payer receiving the claim. For Mississippi Medicaid, enter Mississippi Medicaid Program, P. O. Box 23076, Ridgeland, MS 39225-3076. If the beneficiary has more than one dental insurance plan and Medicaid is the secondary payer, enter the Medicaid address in this field and complete fields 4 through 11 and field 17.
4	Required	**Other Dental or Medical Coverage?** Check "NO" if the patient does not have dental coverage under any other dental or medical benefit plan and do not complete fields #5-11. Check "YES" if the patient has dental coverage under any other dental or medical plan.
5	Required if applicable	**Name of Policyholder/Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix)**: If "yes" is checked in field #4, enter the name of the policyholder for the other dental or medical plan. If the patient has other coverage through a spouse, domestic partner or, if a child, through a parent, the name of the person who has other coverage is reported here.
6	Required if applicable	**Date of Birth (MM/DD/CCYY):** If "yes" is checked in field #4, enter the date of birth of the person listed in field #5. The date must be entered with two digits for the month and day, and four digits for the year of birth.
7	Required if applicable	**Gender:** If "yes" is checked in field #4, mark the gender of the person who is listed in field #5. Mark "M" for male or "F" for female as applicable.
8	Required if applicable	**Policyholder/Subscriber Identifier (SSN or ID#):** If "yes" is checked in field #4, enter the Social Security Number or the identifier for the person listed in field #5. The identifier number is a number assigned by the payer/insurance company to this individual.
9	Required if applicable	**Plan/Group Number:** If "yes" is checked in field #4, enter the group plan or policy number for the person identified in field #5.
10	Required if applicable	**Patient's Relationship to Person Named in Field #5:** If "yes" is checked in field #4, check the box corresponding to the patient's relationship to the other insured named in field #5.
11	Required if applicable	**Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code**: If "yes" is checked in field #4, enter the complete information of the additional payer, benefit plan or entity for the insured named in field #5.
12	Required	**Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:** Enter the complete name, address and zip code of the Medicaid beneficiary receiving treatment.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
13	Required	**Date of Birth (MM/DD/CCYY)**: Enter the Medicaid beneficiary's date of birth with two digits for the month and day and four digits for the year.
14	Required	**Gender:** Mark "M" for male or "F" for female as applicable for the beneficiary's gender.
15	Required	**Policyholder/Subscriber Identifier (SSN or ID#)**: Enter the full 9-digit Medicaid ID number for the beneficiary as indicated on the beneficiary's Medicaid ID card.
16	Not Required	**Plan/Group Number**: Not required.
17	Required if applicable	**Employer Name:** Required if the beneficiary has other dental insurance in addition to Medicaid. Enter the name of the policyholder/subscriber's employer.
18	Required	**Relationship to Policyholder/Subscriber in #12 Above:** Mark the relationship of the patient to the person identified in field #12 who has the primary insurance coverage. For Medicaid beneficiaries, mark the box titled "Self" and skip to field #24.
19	Not required	**Student Status:** Not required.
20	Not required	**Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:** Not required.
21	Not required	**Date of Birth (MM/DD/CCYY):** Not required.
22	Not Required	**Gender:** Not required.
23	Not Required	**Patient ID/Account# (Assigned by Dentist)**: Not required.
24	Required	**Procedure Date (MM/DD/CCYY)**: Enter the procedure date for actual services performed. The date must have two digits for the month, two for the day, and four for the year.
25	Not Required	**Area of Oral Cavity:** Not required.
26	Not Required	**Tooth System:** Not required.
27	Required if applicable	**Tooth Number(s) or Letter(s):** Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure code and tooth involved on separate lines on the claim form. When a procedure involves a range of teeth, the range is reported in this field. This is done either with a hyphen "-" to separate the first and last tooth in the range (e.g., 1-4; 7-10; 22-27), or by the use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10, 3-5, 22-27). Supernumerary teeth in the permanent dentition are identified by tooth numbers 51 through 82; for primary dentition, supernumerary is identified by placement of the letter "S" following the letter identifying the adjacent primary tooth.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
28	Required if Applicable	**Tooth Surface:** Enter a tooth surface code when the procedure performed by tooth involves one or more tooth surfaces.
29	Required	**Procedure Code:** Enter the appropriate procedure code from the current version of the American Dental Association (ADA) Current Dental Terminology manual.
30	Required	**Description:** Enter a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature).
31	Required	**Fee:** Report the dentist's full fee or usual and customary charge. Do not deduct copayment from your usual and customary charge.
32	Not required	**Other Fee(s):** Not required.
33	Required	**Total Fee:** Enter the sum of all fees from lines in field #31.
34	Required if applicable	**Missing Teeth Information:** Report a missing tooth/teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant procedures.
35	Required if Applicable	**Remarks**: If submitting a claim that was originally submitted within twelve (12) months from the date of service, but is now over twelve (12) months old, enter the 17-digit transaction control number (TCN). If the beneficiary has dental insurance other than Medicaid, and Medicaid is the secondary payer, enter the payment amount received from the primary dental insurance in this field.
36	Required	**Patient Consent:** The beneficiary must sign his/her name indicating he/she has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim. If the beneficiary cannot write his/her name, he/she should sign by a mark and have a witness sign his/her name and indicate by whom the name was entered. If the beneficiary is a minor or is otherwise unable to sign, any responsible person such as a parent or guardian must enter the beneficiary's name and write "By," sign his/her own name in the space, show his/her relationship to the beneficiary, and explain briefly why the beneficiary cannot sign. In lieu of having the beneficiary sign a claim form on each visit, the provider may retain a copy of a statement of release signed by the beneficiary or his/her guardian. Medicaid will allow a beneficiary signature for a lifetime when the provider has a signature authorization on file. On the claim form, the provider would enter "Signature on file" to satisfy the signature guidelines. If the beneficiary is unable to sign, the billing clerk may sign the beneficiary's name and indicate "By: (name of office person signing)." In addition, the reason the beneficiary is not available must be specified.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
37	Not required	**Insured's Signature:** Not required.
38	Required	**Place of Treatment:** Check the appropriate box to indicate the place where services were provided. Provider's Office — Service provided in the dentist office Hospital — Service provided in the inpatient or outpatient hospital ECF — Service provided in an extended care facility, e.g., nursing home, PRTF, ICF/MR Other — Service provided in a location other than those listed.
39	Not Required	**Number of Enclosures (00 to 99)**: Not required.
40	Not Required	**Is Treatment for Orthodontics?:** Not required.
41	Not required	**Date Appliance Placed (MM/DD/CCYY)**: Not required.
42	Not Required	**Months of Treatment Remaining**: Not required.
43	Not Required	**Replacement of Prosthesis?** Not required.
44	Not Required	**Date of Prior Placement (MM/DD/CCYY)**: Not required.
45	Not Required	**Treatment Resulting From:** Not required.
46	Not Required	**Date of Accident (MM/DD/CCYY)**: Not required.
47	Not Required	**Auto Accident State**: Not required.
48	Required	**Billing Dentist Name, Address, City, State Zip Code:** Enter the name and complete address of the billing dentist, dental group, FQHC, or RHC.
49	Required	**Billing Dentist NPI (National Provider Identifier):** Enter the appropriate NPI number for the billing dentist, dental group, FQHC, or RHC. The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. An NPI is required for payment of Medicaid claims.
50	Not Required	**License Number:** Not required.
51	Not Required	**SSN or TIN:** Not required.
52	Not Required	**Phone Number**: Not required.
52A	Required	**Additional Provider ID:** Enter the Medicaid provider number for the billing provider, i.e., dentist, dental group, FQHC, or RHC.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
53	Required	**Certification:** Enter the signature of the treating or rendering dentist and the date the form was signed. The provider must sign and date the claim form; a rubber stamp signature is not acceptable. If anyone other than the provider is designated to sign the provider's name, a power of attorney must be on file and available on request. The provider is certifying that it is understood that payment and satisfaction of the claim will be from federal or state funds, and that any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable federal and state laws.
54	Required	**Treating Dentist NPI:** (National Provider Identifier): Enter the appropriate NPI number for the treating dentist. The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. An NPI is required for payment of Medicaid claims.
55	Not Required	**License Number:** Not required.
56	Not Required	**Address, City, State, Zip Code:** Not required.
56A	Required	**Provider Specialty Code:** Enter the code that indicates the type of dental professional who delivered the treatment. Provider specialty codes, also known as "provider taxonomy" codes, come from the Dental Service Providers section of the Healthcare Providers Taxonomy code list, which is used in HIPAA transactions. The current full list of provider taxonomy codes is posted at www.wpc-edi.com/codes/codes.asp.
57	Not Required	**Phone Number:** Not required.
58	Required	**Additional Provider ID:** Enter the Medicaid provider number for the treating or rendering dentist.

Web Portal Reminder

For easy access to up-to-date information, Providers are encouraged to use the **Mississippi *Envision* Web Portal**. The Web Portal is the electronic approach to rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The **Mississippi *Envision* Web Portal** is available 24 hours a day, 7 days a week, 365 days a year via the Internet at **http://msmedicaid.acs-inc.com**.

Dental Claim Check List for Required Fields	Required	Required if Applicable	Optional	Not Required
1 Type of Transaction				✓
2 Predetermination/ Preauthorization Number		✓		
3 Company/Plan Name, Address, City, State, Zip Code	✓			
4 Other Dental or Medical Coverage?	✓			
5 Name of Policyholder/Subscriber with Other Coverage Indicated in Field #4		✓		
6 Date of Birth		✓		
7 Gender		✓		
8 Policyholder/Subscriber Identifier (SSN or ID#)		✓		
9 Plan/Group Number		✓		
10 Patient's Relationship to Person Named in Field #5		✓		
11 Other Insurance Company/ Dental Benefit Plan Name, Address, City, State, Zip Code		✓		
12 Policyholder/Subscriber Name, Address, City, State, Zip Code	✓			
13 Date of Birth	✓			
14 Gender	✓			
15 Policyholder/Subscriber Identifier (SSN or ID#)	✓			
16 Plan/Group Number				✓
17 Employer Name		✓		
18 Relationship to Policyholder/Subscriber in #12 Above	✓			
19 Student Status				✓
20 Name, Address, City, State, Zip Code				✓
21 Date of Birth				✓
22 Gender				✓
23 Patient ID/Account#				✓
24 Procedure Date	✓			
25 Area of Oral Cavity				✓
26 Tooth System				✓
27 Tooth Number(s) or Letter(s)		✓		
28 Tooth Surface		✓		
29 Procedure Code	✓			
30 Description	✓			
31 Fee	✓			
32 Other Fee(s)				✓
33 Total Fee	✓			
34 Missing Teeth Information		✓		

Dental Claim Check List for Required Fields	Required	Required if Applicable	Optional	Not Required
35 Remarks		✓		
36 Patient Consent	✓			
37 Insured's Signature				✓
38 Place of Treatment	✓			
39 Number of Enclosures				✓
40 Is Treatment for Orthodontics?				✓
41 Date Appliance Placed				✓
42 Months of Treatment Remaining				✓
43 Replacement of Prosthesis?				✓
44 Date of Prior Placement				✓
45 Treatment Resulting From				✓
46 Date of Accident				✓
47 Auto Accident State				✓
48 Billing Dentist Name, Address, City, State, Zip Code	✓			
49 Billing Dentist NPI	✓			
50 License Number				✓
51 SSN or TIN				✓
52 Phone Number				✓
52A Additional Provider ID	✓			
53 Certification	✓			
54 Treating Dentist NPI	✓			
55 License Number				✓
56 Address, City, State, Zip Code				✓
56A Provider Specialty Code	✓			
57 Phone Number				✓
58 Additional Provider ID	✓			

Attention: Dialysis Providers

In response to inquiries and interest being expressed for home dialysis services for Mississippi Medicaid beneficiaries, the Division of Medicaid is providing this reminder to physicians and dialysis facilities. Hemodialysis, Peritoneal Dialysis, Continuous Ambulatory Peritoneal Dialysis (CAPD), and Continuous Cycling Peritoneal Dialysis (CCPD) are covered by Medicaid. These modes of treatment are reimbursed in either the hospital based, freestanding dialysis facility or in the home setting. Facilities and nephrologists may refer to Mississippi Provider Policy Manual, Section 41, at www.dom.state.ms.us, for the dialysis policies.

NPI DEADLINE ON PHARMACY CLAIMS: January 1, 2008

Effective January 1, 2008, pharmacies must use the National Provider Identification (NPI) to identify both the billing pharmacy and the prescriber on prescription claims. Pharmacy providers are responsible for maintaining accurate and current prescriber identification information. Accurate prescriber identification **is** required; non-compliance may result in termination of POS privileges.

The procedure to determine prescriber's NPI:

- Call the prescriber's office for the NPI.
- If the prescriber is a member of the clinic from which the prescription was issued, but the individual physician/nurse practitioner does not have his or her own NPI, the provider may use the clinic's NPI if one is available.
- If the prescription is issued at a hospital or ER for outpatient dispensing and that location has an NPI, the provider may use the facility's NPI or the prescriber's individual NPI.
- A current Prescribing Provider's List is available by accessing the DOM website at www.dom.state.ms.us and clicking on "Pharmacy Services" in the left window or by contacting the fiscal agent.
- CMS has prepared a NPI Registry. The shortcut to the Registry is https://nppes.cms.hhs.gov/NPPES/Welcome.do.
- If for those situations where the prescribing provider does not have a NPI, or you are unable to find their NPI, contact the ACS call center at 1-800-884-3222.

The Division of Medicaid does not require prescribers to be Mississippi Medicaid providers in order to write a prescription for a Mississippi Medicaid beneficiary.

DME Suppliers
2008 HCPCS Code Update

The Division of Medicaid has updated Envision with the 2008 HCPCS Codes according to HIPPA requirements. The following list of codes will be deleted effective January 1, 2008. Any TAN's with these codes which are valid for dates of service January 1, 2008 forward will need to be replaced using a valid 2008 HCPCS code. All claims submitted with the codes listed below, for dates of service January 1, 2008 forward, will be denied for payment due to invalid code.

B4086	L3815	L3916	L3940
E2618	L3820	L3918	L3942
K0553	L3825	L3920	L3944
K0554	L3830	L3922	L3946
L0960	L3835	L3924	L3948
L1855	L3840	L3926	L3950
L1858	L3845	L3928	L3952
L1870	L3850	L3930	L3954
L1880	L3855	L3932	L3985
L3800	L3860	L3934	L3986
L3805	L3907	L3936	
L3810	L3910	L3938	

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	01/01/08
8.0 Ambulance	8.17 Unused Injectable Drugs * 8.18 Drug Rebates (NDC Drug Numbers)**	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
27.0 Nursing Services	27.05 Drug Rebates (NDC Drug Numbers)**	X		01/01/08
29.0 Vision	29.16 Drug Rebates (NDC Drug Numbers)**	X		01/01/08
41.0 Dialysis	41.09 Unused Injectable Drugs* 41.10 Drug Rebates (NDC Drug Numbers)**	X X		01/01/08
42.0 Foot Care	42.27 Drug Rebates (NDC Drug Numbers)**	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
46.0 Radiology	46.08 Drug Rebates (NDC Drug Numbers)**	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* 55.17 Drug Rebates (NDC Drug Numbers)**	X X		01/01/08
56.0 Injectables / Physician Office	56.03 Unused Injectable Drugs* 56.04 Drug Rebates (NDC Drug Numbers) **(Cross-references to section 56.04)	X X		01/01/08
81.0 General Coding Information	81.01 Correct Coding 81.02 Modifiers	X X		01/01/08

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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

January

January 2008

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

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.