Mississippi Medicaid Bulletin

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Coming Soon! Provider Enrollment Reverification
Do Not Hesitate To Respond When Notice Is Received

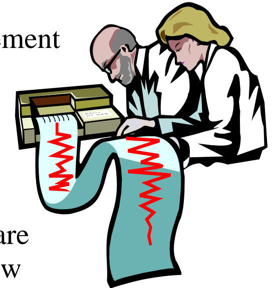
Providers will be required to reverify their enrollment with the Division of Medicaid. Notification for review of the provider file and submission of any revisions may be done through various methods. The providers will be able to review and revise their provider file as follows:

- Through ACS Web Portal;
- By Fax; or
- By Mail.

Providers will be notified by way of ACS web portal message center, blast fax, and/or by letter. Providers are encouraged to register on the web portal at https://msmedicaid.acs-inc.com/msenvision/ to be able to complete the provider enrollment reverification online, including the ability to upload documents necessary to complete the transaction. Upon review and approval of changes by Provider Enrollment, notification will be sent to the providers via the message center, if submission was through the web portal. Otherwise, notification will be provided through regular mail.

If providers do not reverify their provider profile, tax information (1099 form) will be sent using the current information on the provider file. Again, do not hesitate to review, revise, and submit your provider enrollment reverification information as soon as possible, after it is received. If you have any questions, contact Division of Medicaid at 601-359-6133, or ACS at 1-800-884-3222.

NOTICE TO PROVIDERS
Payment Error Rate Measurement (PERM)



The Centers for Medicare & Medicaid Services (CMS) implemented the Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP). PERM is designed to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300).

The PERM program is designed to evaluate the accuracy of Medicaid payments to providers, including medical records documentation. The CMS contractors who will be working in Mississippi are Livanta, LLC (the documentation/database contractor (DDC)), and HealthDataInsights, Inc. (the review contractor (RC)). The process will be conducted using a case sampling plan, in compliance with applicable regulations and instructions developed by CMS.

Understandably, you are concerned with maintaining the privacy of patient information. However, you are required by Section 1902(a) (27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information regarding any payments claimed by the provider for rendering services. The furnishing of information includes medical records. In addition, the collection and review of protected health information contained in individual-level medical records for payment review purposes **is permissible** by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

In order to obtain medical records for a claim sampled for review, the Livanta, LLC (DDC) will be contacting you to obtain the required information. Their specific contact information will be provided at a later date. It is extremely important that Mississippi Medicaid providers cooperate and respond to the requests for documentations in a timely manner.

For information about the federal PERM regulations, contractor oversights, and overall project information, please refer to those items located on the CMS website at www.cms.hhs.gov .

Vaccines for Children Program Update
(Beneficiaries Age 18 and Under)

The Vaccines for Children Program (VFC) has added three new vaccines - Pentacel (CPT code 90698), Kinnrix (CPT code 90696), and Rotavirus (Rotarix) (CPT code 90681). These vaccines are covered for Medicaid beneficiaries 18 years of age and under. The Human Papillomavirus (HPV) vaccine (CPT code 90649) is also reimbursed for Medicaid beneficiaries' 18 years of age and under, through the Vaccines for Children Program. The Division of Medicaid reimburses for administration of the vaccines **ONLY**, when they are obtained through the Mississippi State Department of Health's Vaccines for Children Program.

To bill for administration of the immunizations provided in the Vaccines for Children Program, providers must bill CPT Code 90471, with an EP modifier, and one unit for the single administration of one vaccine. If more than one is administered, providers must also bill 90472, with and EP modifier, and indicate the appropriate number of units, based on the number of additional vaccines administered to the beneficiary. Mississippi Medicaid allows $10 for each vaccine administered.

Following the designation of 90471 and 90472, with an EP modifier, the provider must also bill appropriate vaccine code(s) in the CPT 90476 through 90479, with an EP modifier and show a zero ($00.00) charge. The provider must bill only those codes covered by the VFC Program.

Questions relating to these billing requirements should be directed to the Bureau of Maternal and Child Health at 601-359-6150.

POLICY REVIEW
General Medical Policy: Circumcisions - Section 53.03

Providers are reminded of the Medicaid policy on coverage of circumcisions that has been in effect since August 1, 2000; there are no changes to this policy.

Routine Newborn and Other Not Medically Necessary Circumcisions
No benefits will be provided for the routine circumcision of newborn infants or other circumcisions for whom the medical necessity is not documented according to the criteria listed below.

Medically Necessary Circumcisions
Medically necessary circumcisions will be covered based on documentation of medical necessity. Medically necessary circumcisions may be performed in the inpatient hospital setting (subject to precertification of all inpatient days), the outpatient hospital setting, the ambulatory surgical center, or a physician's office. Each of the following criteria must be met for coverage:

1. Medical necessity for the procedure is fully documented in the medical records,

AND

2. Documentation in the medical records includes:

    - a diagnosis which justifies the medical necessity for circumcision. Examples include, but are not limited to, recurrent balanoposthitis or recurrent urinary tract infections, AND
    - failure of the patient to respond to conservative treatment, AND
    - the recurrent nature of the medical condition,

AND

3. The sole diagnosis is not phimosis. A diagnosis of phimosis alone will not be sufficient documentation of medical necessity, AND
4. There is documentation such as physician progress notes and office records to justify the medical necessity. A pathology report alone will not be sufficient as documentation of medical necessity.

The medical documentation may be included either in the surgeon's report or the beneficiary's attending physician records. Documentation of conservative treatment must include, but is not limited to, teaching about appropriate hygiene and listing of appropriate drug therapy used to treat the condition. Documentation must be legible and available for review if requested.

Reimbursement for hospital inpatient procedures will be included in the per diem rate of the facility and may be included in the cost report. Facility charges for procedures performed in the outpatient department of the hospital will be reimbursed according to established Medicaid rates for outpatient hospital services. Facility charges for procedures performed in an ambulatory surgical center are paid according to the Medicaid Ambulatory Surgical Center procedure schedule. Physician fees are reimbursed based on the Medicaid Physician Fee Schedule.

Appropriate anesthesia, which is considered the standard of care, is covered in accordance with the Division of Medicaid's policies for anesthesia services.

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 Center (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) will be zero paid.

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 aged 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.

Frequently Asked Questions in the Pharmacy about Medicaid

Many of the following questions have been addressed previously in the MS Medicaid Provider Bulletin. However, since the Pharmacy Bureau continues to receive inquiries regarding these subjects, these questions will be answered again.

Question: Why are some drugs not covered by Medicaid?
Response: Drug non-coverage may be due to:

- ***Non-rebated drug***: Prescription drugs for Medicaid beneficiaries are restricted to medically necessary products manufactured by pharmaceutical companies that agree to participate in the CMS rebate program. A drug re-packager is an example of a company who does not participate in the CMS rebate program.
- ***DESI Drug status***: MS Medicaid does not reimburse for DESI 5 and 6 categories. A DESI drug is any drug that lacks substantial evidence of effectiveness, or is 'less than effective' according to the FDA. For a current listing of DESI drugs, go to CMS' DESI drug webpage at http://www.cms.hhs.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp
- ***Excluded drug status***: Some categories of drugs are excluded from coverage in accordance with OBRA '90. Examples include, but are not limited to, drugs for cosmetic purposes, fertility drugs, drugs for cough and cold, and drugs for weight gain or weight loss. For additional information regarding non-covered pharmacy services, refer to DOM's Pharmacy Manual, and Section 31.07.
- ***Other:*** The National Drug Code number is obsolete, that is, the manufacturer has notified CMS and FirstDataBank (FDB) that they are no longer manufacturing the product or using this NDC number.

Question: Does DOM reimburse an administration fee for immunizations given in pharmacies?
Response: No. Reimbursement is limited to the cost of the drug, plus a dispensing fee. Immunizations administered in the pharmacy setting must be provided from a credentialed pharmacist, count against the service limits, and co-payments are applicable. As with other drugs, other insurance carriers must be billed first. These are the only vaccines/immunizations available via the Pharmacy Program. ***All immunizations for children age 18 and younger must be handled through the Vaccines for Children Program (VFC), and are non-covered services in the Pharmacy Program.***

Question: Cough and cold products are not covered by Medicare. What cough products are reimbursed by Mississippi Medicaid?
Response: The following cough products are reimbursed by DOM:

- **Benzonatate** (*compares to Tessalon*) – limited to beneficiaries 10 years of age and older
- **Guaifenesin** *(compares to Robitussin)*
- **guaifenesin with dextromethorphan** *(compares to Robitussin DM)*
- **guaifenesin with codeine** *(compares to Robitussin AC)*
- **guaifenesin, pseudoephrine, and codeine** *(compares to Robitussin DAC)*

Question: Do children have monthly prescription limits?
Response: In cases of medical necessity, requests for more than the monthly benefit limits, i.e., more than five prescriptions monthly or more than two brand name drugs for beneficiaries under the age of 21, are to be submitted via fax to Health Information Designs (HID) at 1-800-459-2135. There is no change in policy regarding drug benefits for children. Medically necessary prior authorization form for beneficiaries less than 21 may be found on DOM's web site at www.dom.state.ms.us, Pharmacy Services, and forms; or call HID at 1-800-355-0486.

Question: Is there a grace period for prescribers to get tamper resistant pads/paper?
Response: The grace period to obtain compliant tamper resistant pads/paper (TRPP) was from October 1, 2007, to March 31, 2008.

Question: Does this prescription blank meet the tamper resistant criteria?
Response: It is the responsibility of prescribers to select documents with tamper resistant features in order to comply with the federal mandate.

Question: Does the pharmacy program ever reimburse for a non-covered drug for children?
Response: While there are many services not covered under the Division of Medicaid's state plan for pharmacy, there are circumstances that may allow coverage through EPSDT (refer to Policy Manual Section 73.09). Pharmacy providers are encouraged to contact the Bureau of Pharmacy at 601-359-5253 or 1-800-421-2408.

Question: After Medicare Part D pays for a pharmacy claim for a dually eligible beneficiary, can MS Medicaid be billed as a secondary insurer or payer?
Response: No**.** MS Medicaid considers Medicare Part D payments as payment in full.

Question: If Medicare Part D denies a pharmacy claim for a dually eligible beneficiary because the drug is non-preferred and requires prior authorization, can I bill MS Medicaid as a secondary insurer or payer?
Response: No**.**

Billing Procedures for Synagis® (palivizumab)

This article should provide clarification in submitting claims to Mississippi Medicaid for Synagis® (palivizumab).

Synagis® (palivizumab), a monoclonal antibody, is used to prevent lower respiratory tract diseases caused by respiratory syncytial virus (RSV) in premature, high-risk infants up to two years of age.

Reimbursement of Synagis® for outpatient beneficiaries is limited to pharmacy point of sale (POS). Claims submitted for Synagis® with HCPCS procedure codes of J3490 C9003, 90378 or 90379 will be denied. Synagis® is available through a limited (pharmacy) distribution network established by the manufacturer. All Mississippi Synagis® pharmacy providers have been contacted by HID regarding guidelines and procedures. Pharmacies must bill Mississippi Medicaid directly for the drug, and ship to the prescriber's office. Prescribers are to bill Mississippi Medicaid for the administration of the drug only.

Mississippi Medicaid requires prior authorization for Synagis®. Prior authorization forms and criteria may be found at www.hidmsmedicaid.com . Synagis® 2008-2009 information may also be found at the Agency's website at www.dom.state.ms.us , Pharmacy Services, and select Synagis® from the menu on right hand of page.

INSTRUCTIONS FOR PAS ACCESS
ENVISION WEB PORTAL & DOM WEBSITE

Envision Web Portal

To access the online Pre-Admission Screening application (PAS) from the Medicaid web portal (https://msmedicaid.acs-inc.com/msenvision/), once you have entered your web portal user ID and password, click the Provider menu at the top of the home page. From the dropdown menu click the 'Long Term Care' menu option, and then click the 'PAS' menu option. You will see the 'PAS' menu options displayed. For informational purposes, a paper version of the 'PAS' is available for download within the 'PAS' menu option by clicking on the 'Hard Copy PAS Application' menu options.

Division of Medicaid Website

To access the online Pre-Admission Screening application from the Division of Medicaid website (http://www.dom.state.ms.us/), scroll to the Provider menu at the top of the home page. From the dropdown menu click the orange icon to link to the Medicaid Envision web portal, and then continue with the instructions for PAS web portal access.

For informational purposes, a paper version of the PAS is available for download from the DOM website. To access this form, from the DOM home page hover mouse over Eligibility & Programs, then Programs, and Long Term Care; click on any LTC link, scroll to the top of page, and click on the Pre-Admission Screening Long Term Care Application link.

To be linked directly to the Long Term Care home page for download of the PAS application: http://www.dom.state.ms.us/LongTermCare.aspx . For assistance, please contact the Bureau of Long Term Care at 601-359-6141.

Completing the Electronic PAS Submission and Physician Certification/Attestation

When entering information into the Mississippi Division of Medicaid's Pre-Admission Screening (PAS) application, providers must log out of the Envision web portal between cases. Failure to log out between cases may cause erroneous information to be transmitted, because it did not save properly.

Physicians are beginning to more frequently utilize the comprehensive web portal functions for the Long Term Care PAS process. This is a welcome and appreciated development. If electronically signing the PAS Summary, and Physician Certification (Electronic PAS) Section X, you must log out between cases if you are going to electronically sign multiple cases.

If you have questions about the PAS process, please see the frequently asked questions posted on the Envision web portal, or call the Medicaid Bureau of Long Term Care at (601) 359-6141.

Bone Marrow and Stem Cell Transplants

As of July 1, 2008, the Mississippi Division of Medicaid **no** longer requires physician review and authorization of the medical necessity for Bone Marrow and Stem Cell transplants. However, the Division of Medicaid's requirement of certification for all inpatient hospitalizations through HealthSystems of MS will still be required for these specific hospital stays. For additional information regarding coverage criteria for bone marrow and stem cell transplants, please refer to Section 28 in the Medicaid Provider Policy Manual.

BILLING FOR ANTEPARTUM SERVICES

Providers must follow policy section 38.05, Billing for Maternity Services, in the Medicaid Provider Policy Manual, when billing for antepartum visits. The following definitions and examples should provide assistance in understanding the billing instructions contained in the policy.

MODIFIER TH

This modifier must be billed with all antepartum, delivery, and postpartum codes, in order to track data and bypass the physician service limits of 12 visits per fiscal year.

NUMBER OF VISITS

This is defined as the number of antepartum visits the beneficiary has made to one group of physicians.

> Beneficiary sees Dr. A for visits 1, 2, & 3 – then sees Dr. B in the same group on the next trip. Dr. B would bill that visit as number 4.
>
> Beneficiary sees Dr. A of Group ABC for visits 1, 2, & 3 – then sees Dr. B of Group XYZ on the next visit. Dr. B would bill the visit as number 1.

NEW PATIENT

A new patient is one who has not received any professional services, within the past three years, from the physician or another physician of the same specialty, who belongs to the same group practice.

VISITS	PROCEDURE CODES
1	99201 – 99205 with modifier TH
2 & 3	99211 – 99215 with modifier TH
4, 5, & 6	59425 with modifier TH for each visit
7 and over	59426 with modifier TH for each visit

ESTABLISHED PATIENT

An established patient is one who has received professional services, within the past three years, from the physician or another physician of the same specialty, who belongs to the same group practice.

VISITS	PROCEDURE CODES
1, 2, & 3	99211 – 99215 with modifier TH
4, 5, & 6	59425 with modifier TH for each visit
7 and over	59426 with modifier TH for each visit

Policy Manual Reminder

This bulletin is a document for the Mississippi Medicaid Provider Policy Manual and must be placed in Section 88 of the manual. All providers are held accountable for all policies in the monthly Mississippi Medicaid Bulletins.

Policy Manual Additions/ Revisions

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

Manual Section	Policy Section	New	Revised	Effective Date
25.0 Hospital Inpatient	25.11 Transplant		X	07/01/08
28.0 Transplants	28.01 Introduction 28.02 Covered Transplant Procedures 28.04 Bone Marrow/Peripheral Stem Cell Transplant Coverage Criteria 28.09 Prior Approval 28.10 Facility Criteria 28.15 Reimbursement		X X X X X X	07/01/08 07/01/08 07/01/08 07/01/08 07/01/08 07/01/08
3.0 Beneficiary Information	3.08 Beneficiary Cost Sharing		X	10/01/08
7.0 General Policy	7.14 False Claims Act	X		10/01/08
13.0 Ambulatory Surgical Center	13.17 Insertion of Retisert (Cross reference to section 53.36) 13.18 Co-Payment (Cross reference to section 3.08)	X X		10/01/08 10/01/08
26.0 Hospital Outpatient	26.30 Insertion of Retisert (Cross reference to section 53.36)	X		10/01/08
30.0 Hearing Services	30.05 Bone Anchored Hearing Aid (Cross reference to section 52.20)	X		10/01/08
52.0 Surgery	52.20 Bone Anchored Hearing Aid 52.21 Otoplasty 52.22 Uvulopalatopharyngoplasty	X X X		10/01/08 10/01/08 10/01/08
53.0 General Medical Policy	53.33 Otoplasty (Cross reference to section 52.21) 53.36 Insertion of Retisert (Fluocinolone acetonide intravitreal implant)	X X		10/01/08 10/01/08
55.0 Physician	55.14 Insertion of Retisert (Cross reference to section 53.36)	X		10/01/08
3.0 Beneficiary Information	3.01 Eligibility Groups		X	11/01/08

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

ACS
P.O. Box 23078
Jackson, MS 39225

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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

October

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

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