Mississippi Medicaid Bulletin

Volume 14, Issue 11

November 2008

Inside this Issue

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

Providers will be required to reverify their information 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 reverification online, including the ability to upload documents necessary to complete the transaction. Upon review and approval of changes, notification will be sent to the providers via the message center, only if submission was through the web portal. Otherwise, notification will be provided through regular mail.

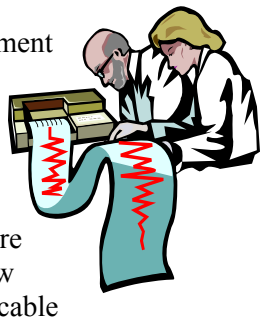
If providers do not update their provider file, tax information (IRS tax form 1099) will be sent using the existing information on the file. Again, do not hesitate to review, revise, and submit your provider reverification information as soon as possible, after it is received. If you have any questions, contact ACS at 1-800-884-3222.

ICD-9-CM Code Update

As a result of the Health Insurance Portability and Accountability Act (HIPAA), providers are required to bill with current code sets. The Division of Medicaid has updated the system to accept new ICD-9-CM codes and deny invalid ICD-9-CM codes, effective October 1, 2008.

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

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 Title 45 of the 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. Failure to respond will result in a non-appealable error.

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 an 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.

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.**

Medicaid Coverage of Chiropractic Services

Chiropractors are reminded to review Medicaid policies on coverage of chiropractic services as detailed in the Provider Policy Manual Section 9. The following CPT procedure codes are the only ones acceptable and covered for chiropractors, under the Mississippi Medicaid program:

98940	72010
98941	72040
98942	72070
	72080
	72100

Additionally, there is a $700.00 limit per fiscal year per beneficiary for chiropractic services. Beneficiaries under age 21 may receive additional chiropractic services with prior authorization.

Cool Kids Lead Reporting Protocol

All Cool Kids (EPSDT) providers who have purchased and/or utilize the ESA Leadcare machine (in-house lead analyzer) must report **ALL** blood lead levels to the Mississippi State Department of Health's (MSDH) Childhood Lead Poisoning Prevention Program (CLPPP). There are standard reporting requirements that must be followed as part of the lead screening and testing process.

Effective May 2008, MSDH and the Division of Medicaid require reporting of all venous blood lead levels ≥10µg/dL to the CLPPP within one week of diagnosis (Class II). Laboratories and clinics utilizing the in-house lead analyzer must report **ALL** blood lead test results to the CLPPP within one week of completion (Class III).

The standard reporting tool must be completed in its entirety for each child tested. If the form is not legible or is incomplete it will be returned to the clinic for completion. A copy of the standard reporting tool is included on the following page for your convenience.

The MSDH CLPPP maintains the blood lead surveillance system, and is the point of contact for any questions regarding testing, follow-up, case management, and education. Educational materials are available upon request. Additional information can be found on the MSDH website at www.msdh.state.ms.us.

Any questions should be directed to the CLPPP at (601) 576-7447.

MISSISSIPPI STATE DEPARTMENT OF HEALTH

Report of Lead Levels

Child's Name _____Date of Birth_____

Sex_____ Race_____ Phone Number_____ Medicaid # _____

Mailing Address _____

Physical Address_____

County _____ Social Security #_____

Parent/Guardian Name_____

Lead Reports:
Date of Tests:_____ Lead Level_____ Venous__ Capillary_____

Date of Tests:_____ Lead Level_____ Venous__ Capillary_____

Date of Tests:_____ Lead Level_____ Venous__ Capillary_____

Follow Up Care:
Next scheduled Testing Date:_____
Is the Child on WIC? Yes_____ No_____
Have the parents received nutritional information? Yes____ No_____
Have the parents received educational information? Yes_____ No_____

Clinic Information:
Name of Clinic_____
Address_____ Phone#_____
Physician_____

** Feel free to use a stamp to fill in the clinic information**

Please print legibly in black ink. The CLPPP will return if unable to read the information.

CLPPP Program: Crystal Veazey (601)-576-7447, Fax **(601)-576-7498**.

Thank You!

Mississippi Medicaid Pharmacy Program Reminders

- **Return to Stock/Claims Reversals:** If a beneficiary does not receive a drug within 15 calendar days from the date that the prescription is filled, the pharmacy must reverse the claim, and refund payment to the Division of Medicaid (DOM). For additional information regarding DOM's policy on Pharmacy Return to Stock/Claims Reversals, refer to the Provider Policy Manual, Pharmacy Section 31.25.

- **72-Hour Emergency Supply:** According to Title XIX of the Social Security Act for Mississippi, in emergency situations, DOM will allow payment for a 72-hour emergency supply of drugs that are to be prior authorized. Emergency supplies should be reserved for situations in which the pharmacist may dispense a *one time only* 72-hour emergency supply without prior authorization (PA), if the beneficiary's monthly prescription benefit limit has not been met.

  A 72-hour emergency supply may be provided to beneficiaries who are awaiting the acknowledgment of PA. The pharmacy will be reimbursed for this product even if the prescription is changed to an alternative medication or the PA is denied. If the drug is approved for PA, the emergency supply should be submitted as part of the original fill. The dispensing fee and beneficiary co-pay may not be collected until the remainder of the drug is dispensed.

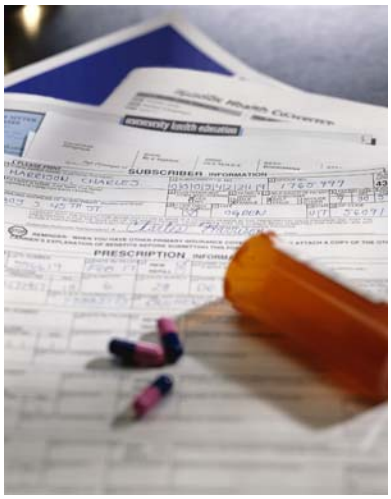
  Claims for a 72-hour emergency supply when the PA is not approved should be billed by hard copy claim to DOM. For additional information regarding DOM's policy on 72-hour emergency supply, refer to the Provider Policy Manual, Pharmacy Section 31.09.

- **Beneficiary signatures:** The beneficiary or his/her representative must sign for the prescription each time it is filled. A signature is required for each medication received by individuals, with the exception of long-term care facilities. Electronic signatures are acceptable for Medicaid beneficiaries. *If multiple prescriptions are dispensed, there must be a signature for each and every prescription dispensed. One signature for multiple entries is not acceptable*. For additional information regarding DOM's policy on Beneficiary Signatures, refer to the Provider Policy Manual, Pharmacy Section 31.21.

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.

Questions about DOM's Pharmacy Program



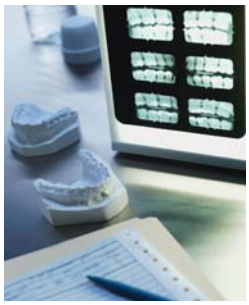
Question: Does DOM have an automatic or electronic prior authorization system? How does it work?
Response: Yes. The electronic prior authorization (PA) system is an automatic prior authorization system operating behind the scenes to approve prescription claims for Medicaid beneficiaries who meet predetermined criteria. The electronic PA system automatically approves claims medications in ***46 different drug classes*** without requiring prescribers to submit PA paperwork.

Question: Tell me more about DOM's electronic prior authorization system.
Response: Operational for over three years, the electronic PA program has successfully reviewed over 700,000 PA requests for DOM providers and beneficiaries. During the first quarter of 2008, *approximately 99% of all prescription claims paid required no prior authorization paperwork by providers*.

Question: What needs to be done if there are problems processing claims for a product with a prior authorization?
Response: If a prior authorization has been issued and there are problems processing the claim, then the PA on file may require modification in order to match the claim. Providers are requested to contact the HID PA Help Desk at 1-800-355-0486.

Question: Why is it important to use the correct Prescriber's Identification Number or NPI?
Response: 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 the 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.

Web Portal Submission of Tooth Quadrant Designation



When filing dental claims through the web portal only the numeric designations will be accepted for submission and not the alpha designations for codes requiring the tooth quadrant.

10 – Upper Right (UR) / 20 – Upper Left (UL) / 30 – Lower Left (LL) / 40 – Lower Right (LR)

Changes in Pre-Certification/Certification Requirements

Effective for dates of services on and after January 1, 2009, the Division of Medicaid (DOM) is announcing changes to pre-certification and/or certification requirements for the following services.

DOM's Utilization Management and Quality Improvement Organization (UM/QIO), HealthSystems of Mississippi (HSM), will manage the changes and conduct statewide provider workshops in December, 2008. Both HSM and DOM strongly encourage providers to participate in the workshops for the purpose of obtaining information and instructions. The dates, locations, times, and description of workshops, scheduled for hospital providers, can be found on page 9 within this Bulletin.

DOM is in the process of updating appropriate policies for the Provider Policy Manual. These updates will be announced in a future Bulletin.

Home Health Visits (Home Health Agency Providers)	Twenty-five home health visits are allowed per Medicaid fiscal year. For adults (beneficiaries age 21 or over), the home health visits may be a combination of skilled nurse or home health aide visits. For children (beneficiaries under age 21), the visits may be a combination of skilled nurse, home health aide, physical therapy, and speech therapy visits. Additional visits are available for children through the Expanded EPSDT Program when approved for medical necessity by the UM/QIO. Effective for dates of service on and after January 1, 2009, home health agency providers will only be required to certify visits beyond the 25th visit for beneficiaries under age 21. Beginning with the 26th visit, the provider must request certification either before or within 30 days after the service, unless Medicaid eligibility is determined after services are rendered, and made retroactive to the date of service. There will be no certification requirement for the 25 visits allowed for adults, and for the initial 25 visits for children. This change does not affect home health services provided to beneficiaries in the Elderly and Disabled Waiver program.
Inpatient Hospital Days	Hospitals will continue to pre-certify all medical/surgical, maternity, and psychiatric admissions and continued stays in an acute care facility and a freestanding psychiatric hospitals. However, the process for obtaining the Treatment Authorization Numbers (TAN) will be expanded to include an automated rule driven system-based review process. Through this process, hospital providers will be able to submit both initial and concurrent requests and clinical information for certain conditions and receive real-time approvals.
Maternity Reporting	Effective for dates of admission on and after January 1, 2009, DOM will allow hospitals to report admissions up to three days for a vaginal delivery and five days for a Cesarean Section delivery. A Treatment Authorization Number (TAN) will be issued for the respective number of days. Hospitals **must** submit a request for a continued stay for admissions exceeding three days for vaginal delivery and five days for a Cesarean Section delivery, in accordance with the UM/QIO's policy and procedures. A TAN will be issued if the continued stay is determined to be medically necessary.

Medical Supplies	Through the Durable Medical Equipment (DME) Program, benefits are provided for medically necessary durable medical equipment, orthotics, prosthetics, and medical supplies. Currently, DOM requires certification for all items supplied through the DME program. Effective for dates of service on and after January 1, 2009, DME providers will no longer be required to certify medical supplies except for underpads and diapers. DOM will continue to require certification for underpads and diapers either before the provider provides the item or within 30 days of delivery unless Medicaid eligibility is determined after services are rendered, and made retroactive to the date of service. DME providers must continue to certify all durable medical equipment, orthotics, and prosthetics.
Outpatient Hospital Mental Health Services	Effective for dates of service on and after January 1, 2009, hospitals must pre-certify all mental health services provided through outpatient hospital departments. The services must be pre-certified prior to the service, unless Medicaid eligibility is determined after services are rendered, and made retroactive to the date of service.
Therapy Services (Outpatient Physical, Occupational, and Speech Therapy)	Effective for dates of service on and after January 1, 2009, the following services will no longer be exempt from pre-certification requirements for outpatient physical, occupational, and speech therapy services: • Therapy services provided to beneficiaries in nursing facilities. • Therapy services covered under regular State Plan benefits and provided to beneficiaries also enrolled in a Home and Community Based (HCBS) waiver program. Pre-certification will be required for the above services when provided by therapists (individual or groups) or therapy clinics and billed directly to Medicaid. Pre-certification is not required, regardless of the CPT codes used, when the services fall into one of the following categories: • Therapy services billed by school providers. • Therapy services provided to beneficiaries in an ICF/MR. • Therapy services provided to beneficiaries enrolled in a hospice program. • Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted.

Questions relating to the following changes should be directed to the Division of Medicaid's Provider Relations Division at telephone 601- 359-6133 or 1-800-421-2408.

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 Groups		X	11/01/08
10.0 Durable Medical Equipment	10.02 Reimbursement		X	11/01/08

HOSPITAL PROVIDERS - Changes to Precertification/Certification Requirements Workshops

The following workshops are designed to help hospital providers become more familiar with several 'new' changes to the Mississippi Medicaid Precertification and/or Certification Requirements. The changes will be effective for dates of services on and after January 1, 2009. All workshops will be conducted by staff from HealthSystems of Mississippi (HSM). More information can be found on the HSM web site at www.hsom.org or by contacting them at 601-360-4961. The dates for the workshops are as follows:

DATE	LOCATION	TIME	WORKSHOP DESCRIPTION
December 1, 2008	Regency Hotel Jackson, MS	9:00 a.m. - 12:00 p.m.	Outpatient Hospital Mental Health
December 1, 2008	Regency Hotel Jackson, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities
December 3, 2008	Vicksburg Convention Center Vicksburg, MS	9:00 a.m. – 12:00 p.m.	Outpatient Hospital Mental Health
December 3, 2008	Vicksburg Convention Center Vicksburg, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities
December 10, 2008	Hattiesburg Lake Terrace Convention Center Hattiesburg, MS	9:00a.m. – 12:00 p.m.	Outpatient Hospital Mental Health
December 10, 2008	Hattiesburg Lake Terrace Convention Center Hattiesburg, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities
December 11, 2008	Marriott Hotel Gulfport, MS	9:00 a.m. – 12:00 p.m.	Outpatient Hospital Mental Health
December 11, 2008	Marriott Hotel Gulfport, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities
December 16, 2008	DeSoto county Civic Center Southaven, MS	9:00 a.m. – 12:00 p.m.	Outpatient Hospital Mental Health
December 16, 2008	DeSoto county Civic Center Southaven, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities
December 17, 2008	Bancorp South Center Tupelo, MS	9:00 a.m. – 12:00 p.m.	Outpatient Hospital Mental Health
December 17, 2008	Bancorp South Center Tupelo, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities

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Jackson, MS 39225

If you have any questions related to the topics in this bulletin, please contact ACS at 1-800 -884 -3222

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

November

November 2008

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 CHECKWRITE	25	26	37 **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.