Mississippi Medicaid Bulletin

Volume 16, Issue 7

December 2010

Inside this Issue

Non-Emergency Transportation: Where's My Ride?

Non-emergency transportation (NET) is covered by Mississippi Medicaid for many beneficiaries. NET services must be medically necessary, the beneficiary has no other means of transportation, and to any Medicaid-reimbursable service for the purpose of receiving treatment, medical evaluation, and/or obtaining prescription drugs or medical equipment. Beneficiaries that are not covered for NET include: Family Planning Waiver, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI).

Here is some important information for providers to know about NET services:

- NET services are arranged through a broker – Logisticare – who contracts with local transportation providers.
- Transport must be requested at least 3 business days before the NET service is needed (there are some exceptions for urgent trips such as hospital discharges).
- NET providers are required to arrive within 15 minutes of the scheduled time.
- When the ending time of a medical appointment is not known ahead of time, the pick-up to return a beneficiary home can be set up as a "Will Call." The beneficiary or office staff should call the appropriate "Where's My Ride?" number for "Will Call" pick-ups. The NET provider has up to one hour to pick up the beneficiary for a "Will Call" ride.
- If a ride is late, call the "Where's My Ride?" number; do NOT call the local driver or NET provider. Logisticare will assist with handling rides that are late, but they can't help if they are not notified.

Contact numbers for NET are:

- Schedule a ride: 1-866-331-6004
- Check on a ride or "Will Call" rides: "Where's My Ride?"
  - North: 1-866-334-3794 (Issaquena, Yazoo, Leake, Neshoba, Lauderdale, and counties north)
  - South: 1-866-331-6006 (Warren, Madison, Scott, Newton, Clarke, and counties south)
- Make a complaint: 1-866-331-6004

For more information, including a brochure with a map of the "Where's My Ride?" counties and phone numbers, go to this link: http://www.medicaid.ms.gov/Pamphlets/NETBrochure.pdf.

New Eligibility Verification and Claim Status Inquiry Options

In order to better serve our provider community, DOM and ACS are pleased to announce two new options for eligibility verification and status inquiries. Effective 10/15/2010, eligibility verification and claim status inquiries may be e-mailed to **msinquiries@acs-inc.com** or faxed to **601-206-3003**. E-mail and fax inquiries will be responded to within **48** hours.

When using the e-mail or fax inquiry options for eligibility verification, please include your NPI, beneficiary ID#, beneficiary name, service codes (if applicable), and a return e-mail or fax number. For claim status, please include your NPI, beneficiary ID#, beneficiary name, dates of service, total charge, and TCN (if applicable).

You may continue to utilize the AVRS, Web Portal or Call Center for eligibility or claim status inquiries. Please note the eligibility inquiries made through the Call Center will be limited to five **(5)** inquiries per call and claim status inquiries will be limited to three **(3)** inquiries per call. Details on how to utilize all inquiry options are provided below.

1. **Automated Voice Response System (AVRS)**
   - 1-800-884-3222
   - Press "1" from the main menu and then select "1" for beneficiary eligibility or "2" for claim status
   - Unlimited inquiries
   - Available 24 X 7
2. **Web Portal**
   - Go to **https://msmedicaid.acs-inc.com/msenvision**
   - Login with your Web Portal user ID and password (Not registered? Go to **https://msmedicaid.acs-inc.com/msenvision/regUserSelection.do**)
   - Go to Provider menu-> Inquiry Options
   - Unlimited inquiries
   - Available 24 X 7
3. **E-mail**
   - Send eligibility or claim status inquiries to **msinquiries@acs-inc.com**
   - Response within **48** hours
   - Unlimited inquiries
4. **Fax**
   - Fax eligibility or claim status inquiries to 601-206-3003
   - Response within **48** hours
   - Unlimited inquiries
5. **Call Center**
   - 1-800-884-3222
   - Limited to five **(5)** eligibility inquiries
   - Limited to three **(3)** claim status inquiries

MISSISSIPPI MEDICAID PROVIDER SURVEY

Provider Name _____ **Medicaid Provider #**_____

The Mississippi Division of Medicaid and ACS are interested in improving services and relationships with the provider community. Effective 10/15/2010, new e-mail and fax inquiry options were implemented for the provider community in an effort to improve the level of service that you experience. We know that your time is valuable and appreciate your willingness to participate in this survey. Please note that your participation is voluntary. The information obtained in this survey will be used to further improve quality standards and services to the provider community. Thank you for taking the time to complete the Mississippi Medicaid Provider Satisfaction Survey. **Please fax your completed Survey to 601-359-4185.** If you have any questions or concerns, you may call **601-359-6133** and ask to speak with a Provider Relations Representative.

CALL CENTER – ACS CUSTOMER SERVICE

How satisfied are you with the accessibility of customer service representatives?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

How satisfied are you with the accuracy and clarity of the responses by the customer service representatives?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

How satisfied are you with the number of eligibility and claim status inquiries per call offered by the call center?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

AUTOMATED VOICE RESPONSE SYSTEM (AVRS)

How satisfied are you with the accessibility of the Automated Voice Response System (AVRS)?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

How satisfied are you with the inquiry and self-service options available on the AVRS?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

How satisfied are you with the accuracy and clarity of the responses to your questions by the AVRS?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

MISSISSIPPI ENVISION WEB PORTAL

How satisfied are you with the accessibility of the web portal?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

How satisfied are you with the inquiry and self-service options available on the web portal?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

How satisfied are you with the accuracy and clarity of the responses to your questions by the web portal?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

E-MAIL (MSINQUIRIES@ACS-INC.COM) & FAX INQUIRY (601-206-3003) OPTIONS

How satisfied are you with the accessibility of the e-mail and fax inquiry options?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

How satisfied are you with the accuracy and clarity of the responses to your e-mail and fax inquiries?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

How satisfied are you with the timeliness of the responses to your e-mail and fax inquiries?

○ Completely Satisfied ○ Somewhat Satisfied ○ Neutral ○ Somewhat Dissatisfied ○ Not at all Satisfied ○ Have Not Used

COMMENTS - Please provide comments on how ACS and DOM may improve provider services in any of the above areas.

_____

_____

_____

_____

Implementation of
Mississippi Coordinated Access Network (MississippiCAN)

The Centers for Medicare and Medicaid Services (CMS) has approved a State Plan Amendment (SPA) giving the Division of Medicaid (DOM) the authority to implement a statewide coordinated care program. DOM has named the program MississippiCAN. Implementation is scheduled for January 1, 2011. The program is designed to:

- improve beneficiary access to needed medical services
- improve the quality of care
- improve program efficiencies as well as cost effectiveness

Who is eligible to participate in MississippiCAN?
The MississippiCAN program is limited to targeted high cost Medicaid beneficiaries. These beneficiaries were identified by claims review to be in a category of eligibility with an above average per member per month cost and more than 1,200 member months in the category. The categories of eligibility are:

- SSI
- Disabled Children Living at Home
- Working Disabled
- Department of Human Services Foster Children
- Breast/Cervical Cancer Group

Certain beneficiaries in these categories are excluded from participation in the program. They are:

- Beneficiaries locked in to any waiver program (HCBS, IL, IDD/D, etc.)
- Beneficiaries who are dually eligible (Medicare/Medicaid)
- Beneficiaries who at the time of application are institutionalized (Nursing Facility, ICF/MR, etc.)

Is enrollment in MississippiCAN mandatory?
Enrollment in the MississippiCAN program is voluntary. Beneficiaries in the targeted population will have the opportunity to enroll in one of the Coordinated Care Organizations (CCOs) or opt out of the program and stay in regular Medicaid.

Beneficiaries enrolled in MississippiCAN will have an annual enrollment period at which time they may change plans or opt out of the program.

Have the CCOs been selected?
DOM has selected two CCOs to provide services to Medicaid beneficiaries:

- Magnolia Health Plan
- United HealthCare

What services are covered by the CCOs?
CCOs will provide, at a minimum, the same comprehensive services as Medicaid, with the exception of:

- Inpatient hospital services
- Mental health services
- Non-emergency transportation

Both CCOs are offering additional benefits, i.e., additional office visits, additional prescriptions, etc.
CCOs will be responsible for providing services to their enrollees on January 1, 2011.

Are there other benefits for beneficiaries?

There are many benefits for beneficiaries enrolled in MississippiCAN. They will be connected to a medical home and will be required to have an annual physical. CCOs will be providing comprehensive care management which includes coordinating services with mental health providers, social service agencies, and other providers to improve care and quality outcomes for these beneficiaries. Additionally, CCOs are required to develop disease management programs which include, but are not limited to:

- Diabetes
- Asthma
- Organ Transplants
- Obesity
- Hemophilia
- Hypertension
- Congestive Heart Disease

What requirements does Medicaid have for the CCO networks?

- All CCO contracted providers must be Mississippi Medicaid providers.
- CCO networks must include all types of Medicaid providers and the full range of medical specialties necessary to provide covered benefits.
- Access standards for network require primary care services availability within 60 minutes or 60 miles in rural regions and 30 minutes or 30 miles in urban regions.
- In accordance with State law, CCOs are required to reimburse all providers in those organizations at rates **no less** than what Medicaid reimburses providers who do not participate.

How will MississippiCAN impact providers who choose not to participate in a CCO network?

- Providers may have current patients who enroll in MississippiCAN. If you are not in the provider network of the CCO in which they enroll, you will be considered an Out-of-Network provider.
- Out-of-Network providers who provide services to MississippiCAN members without authorization from the CCO **may not** receive payment.
- It will become even more important to check beneficiary eligibility **prior** to providing services as information that identifies those beneficiaries enrolled in MississippiCAN and the CCO with which they are enrolled.

Will the CCOs be monitored for contract compliance?

DOM will:

- Complete readiness reviews of CCOs prior to implementation of MississippiCAN
- Audit the performance of the CCOs against contract requirements on an ongoing basis
- Closely monitor the financial performance of the CCOs
- Impose penalties for failure to meet established standards
- Require corrective action plans from CCOs for non-compliance with contract requirements

Please refer to the DOM website at www.medicaid.ms.gov and click on the MississippiCAN link for FAQs, benefit comparisons and other information on MississipiCAN.

ICD-10 TRANSITION

On January 16, 2009, the U.S. Department of Health and Human Services (HHS) released the final rule mandating that everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) must implement ICD-10 for medical coding on **October 1, 2013**.

On this date medical coding in U.S. health care settings will change from ICD-9 to ICD-10. The transition will require business and systems changes throughout the health care industry. Everyone who is covered by HIPAA must make the transition, not just those who submit Medicare or Medicaid claims.

The first ICD-10 related compliance date is less than two years away. **On January 1, 2012**, standards for electronic health transactions will change from Version 4010/4010A1 to Version 5010. Unlike Version 4010, Version 5010 accommodates the ICD-10 code structure. This change occurs before the ICD-10 implementation date to allow adequate testing and implementation time.

The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.

Listed below are links to information concerning this transition:

Centers for Medicare and Medicaid Services	http://www.cms.gov/ICD10/
Centers for Disease Control and Prevention	http://www.cdc.gov/nchs/icd/icd10.htm

2011 CPT & HCPCS CODE UPDATE

The Health Insurance Portability and Accountability Act (HIPAA) requires providers to bill with current code sets. The Division of Medicaid will make every effort to have the annual update of the CPT and HCPCS codes completed by January 1, 2011. In the event that the update is not complete, claim lines billed with new codes will deny for Exception Code 0430. Please do not resubmit the denied claims. There will be an automatic reprocessing of these claims when the codes are updated. Remember to retain your previous CPT and HCPCS code books as they may be needed when reconciling older claims.

Reminder All MS Cool Kids Providers!

All children enrolled in Head Start programs must receive an annual health assessment equivalent to the EPSDT screening assessment offered by MS Medicaid Cool Kids (EPSDT) providers within 45 days of Head Start enrollment. Cool Kids (EPSDT) providers who currently screen Head Start children are encouraged to continue to do so and provide the screening results to the Head Start agency. Cool Kids (EPSDT) providers who currently screen Head Start children are encouraged to continue to do so and provide the screening results to the Head Start agency even if the provider has no prior knowledge of their Head Start status. Screening results should be released to the Head Start agency in a timely manner so that the Head Start can meet the mandatory 45 day deadline.

Also, be reminded that routine physical examinations, such as school, sports, or employment physicals that are not part of the EPSDT well child screening program for beneficiaries under 21 years of age **are not covered through provisions set forth in Section 53.18 or the Wellness Program in Section 53.30 of the Provider Policy Manual.**

Questions relating to the above article should be directed to the Bureau of Maternal and Child Health at 601-359-6150.

"Text 4 Baby" Initiative for Pregnant Women and New Mothers

In an effort to reduce the U.S. infant–mortality rate, which is currently 30th worldwide, public health advocates are using an unlikely resource to make available important and life saving maternal and child health information to pregnant women and new mothers: the cell phone.

The exciting new initiative called ***"Text 4 Baby"*** is a free mobile health service that provides health information through SMS text messages to pregnant women and new mothers during their babies' first year.

By texting BABY to 511411 (BEBE for Spanish) or registering through www.text4baby.org, women receive three free SMS text messages each week timed to their due date or based on baby's date of birth. These messages focus on a variety of topics critical to maternal and child health, including preventive care, immunizations, oral health, birth defects prevention, nutrition, seasonal flu, mental health, and safe sleep. Text4baby messages also connect women to prenatal and infant care services and other resources.

Text4baby is a service of the Healthy Mothers, Healthy Babies Coalition (HMHB), but the Department of Health and Human Services and the White House Office of Science and Technology Policy are partners in the initiative. Due to the support of all major US mobile phone operators, ***the service is free to women who subscribe.***

Since its launch on February 4th, Text4baby has registered over 30,000 pregnant women and new moms from all 50 states. The Division of Medicaid is soliciting your help in making sure that all Medicaid – eligible pregnant women and new moms serviced in your clinics are made aware of this new initiative and its vital health informational benefits.

Mississippi Cool Kids Participation and Screening Ratios by Age Group for 2007, 2008, and 2009

Mississippi Cool Kids, formerly known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), service is Medicaid's comprehensive and preventive child health program for beneficiaries under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA89) legislation and includes periodic screening, vision, hearing and dental services. In addition, section 1905 (r) (5) of the Social Security Act requires that any "medically necessary" health care service discovered through the exam be provided to the Medicaid-eligible beneficiary even if the service is not routinely covered under the regular Medicaid program.

The state of Mississippi is required to report EPSDT performance information annually on the CMS-416 form. The annual EPSDT report provides basic information on participation in the Medicaid child health program which is used to assess the effectiveness of the State's EPSDT program. The chart below shows the State's EPSDT participation and screening ratios by age groups for federal fiscal years 2007 – 2009. Centers for Medicare & Medicaid Services (CMS) standard screening and participation ratios is 80% or greater. As reflected in the results below, the State has an overall average of 66% screening ratio and a 43% participation ratio for the three federal fiscal years respectively. In spite of the State's effort to achieve CMS' 80% overall screening and participation standard requirements, we have only been consistently successful for age groups two and under in the screening ratio standard only. The other age groups are not close to meeting either standard requirement, which show a dismal overall average screening and participation ratios of 33% and 28% respectively.

The Division of Medicaid is requesting that all Medicaid providers (EPSDT screeners or not) assist us in stressing the importance of their five years and older eligible Medicaid beneficiaries taking advantage of this vital preventive health screening service to help us achieve or surpass CMS' 80% universal screening and participation standard requirements.

Results

State FY	2007		2008		2009	
	Screening Ratio	Participation Ratio	Screening Ratio	Participation Ratio	Screening Ratio	Participation Ratio
All Children	67%	42%	72%	41%	60%	41%
< 1	100%	83%	100%	77%	92%	82%
1 – 2	100%	59%	100%	60%	100%	63%
3 – 5	64%	51%	66%	49%	55%	49%
6 – 9	30%	26%	32%	26%	28%	26%
10 – 14	30%	25%	33%	25%	28%	28%
15 – 18	26%	22%	29%	22%	23%	21%
19 - 20	17%	15%	21%	17%	11%	10%

Billing Influenza and Pneumonia Immunizations (including H1N1 Swine Flu)

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.

This notice also includes important information related to Mississippi Medicaid coverage of the H1N1 (swine) flu vaccine and administration.

Seasonal Flu and Pneumonia Immunizations for Adult Beneficiaries Age 19 and Over

Physicians, nurse practitioners and physician assistants will be reimbursed for seasonal 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) for seasonal flu vaccine, and the appropriate vaccine administration code. 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) for seasonal flu vaccine, and the CPT vaccine administration code. 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.

- Providers should bill 90471 and 90472 for administration of the seasonal influenza vaccine.

- Rural Health Clinic (RHC) and Federally Qualified Health Centers (FQHC) providers will be reimbursed according to their encounter payment method. If an encounter visit is provided, one encounter payment is made regardless of other procedures included on the claim. If no encounter visit is provided, the CPT vaccine administration code and the vaccine code(s) will be zero paid.

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

- All seasonal flu and pneumonia 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.

H1N1 Flu (Swine Flu) Vaccine for All Beneficiaries (Children and Adults)

The Center for Disease Control and Prevention has announced that the 2010-2011 seasonal influenza vaccine will include protection against the 2009 H1N1 influenza virus. Based on this information the H1N1 administration code G9141 should no longer be used for billing effective June 30, 2010. Providers should bill using the appropriate CPT code 90471 or 90472.

Seasonal Flu and Pneumonia Vaccine and Administration Fees

Reimbursement rates effective July 1, 2010 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	$12.54	90732	$43.25	90471	$18.52
90658	$11.37			90472	$9.55
90660	$22.32				

Annual Physical Examinations for Beneficiaries Age 21 and Over

During the 2004 Legislative Session, House Bill 1434 authorized the Division of Medicaid to cover annual physical examinations. The Bureau of Medical Services Care Management Division recently performed a review of billed claims for annual physical exams and found many eligible Mississippi Medicaid beneficiaries who had not received this benefit. The Division of Medicaid is asking for your assistance with informing beneficiaries about Medicaid coverage of an annual physical exam to help establish a base-line level of health. Coverage details are listed below:

- The annual physical exam does **not** count toward the limit of 12 physician visits per fiscal year.
- There is **no** co-payment for the physical exam.
- Providers should bill the age-appropriate CPT E&M Preventive Medicine codes (99385, 99386, 99395, 99396 or 99397) for the annual physical exam.
- Routine radiology and laboratory procedures will be covered based on current MS Medicaid policies for the individual procedures.
- For beneficiaries who have both Medicare and Mississippi Medicaid, a routine annual physical examination is covered under Medicaid UNLESS the beneficiary is eligible for or has already received the "Welcome to Medicare" physical examination.

The annual physical exam is not covered for beneficiaries in an institutional setting (locked-in to a nursing home or intermediate care facility for the mentally retarded [ICF/MR] or those covered in Category of Eligibility 029 (Family Planning) or 088 (Pregnant Women – 185%). Using the examination as a physical for school, sports, or employment will not be covered and must not be billed to Medicaid.

For additional information, please refer to the Mississippi Medicaid Provider Policy Manual, Section 53.18 or contact the Bureau of Medical Services at (601) 359-5683. There is a helpful flyer about the Mississippi Medicaid Wellness Benefit and Physical Exams on the Medicaid web site at this link: **http://www.medicaid.ms.gov/Documents/HW_Program_Billing_Suggestions_for_Providers.pdf.**

December 1, 2010

Division of Medicaid Notice Physicians, Mid-Level Practitioners, and Pharmacy Providers

Introducing SmartPA®

Beginning December 15, 2010 Mississippi Medicaid will implement an automated prior authorization (PA) application called SmartPA®. ACS's proprietary electronic PA application should provide immediate adjudication and turnaround for those drugs selected for the initial implementation. SmartPA® will enhance the Division's prior authorization program by electronically processing the majority of prior authorization requests at the pharmacy with fewer phone calls required from prescribers to the Drug PA Unit.

How Does SmartPA® Work?

- The pharmacist submits a beneficiary's prescription to Mississippi Medicaid through the point of sale system. If the medication requires prior authorization and the claim has not denied for any other edit, the claim is electronically transmitted to SmartPA®.
- SmartPA® applies predetermined PA criteria to the pharmacy drug claim utilizing both medical and drug claims history.
- Claims that meet the predetermined criteria are approved and adjudicated in a real time environment without the need for human intervention.
- If the criteria are not met, the pharmacy provider is sent an electronic message at POS that states "PA required" and the drug claim is denied.

How to Obtain Prior Authorization Consideration After Denial for "PA Required" at Pharmacy

If the claim denies for "PA Required" and the prescriber or pharmacist wants to pursue a prior authorization, the prescriber or pharmacist may submit requests by telephone, fax, or Web Portal to:

Division of Medicaid, Pharmacy Bureau
Phone number : 1-877-537-0722
Fax Line : 1-877-537-0720
Webportal: **https://msmedicaid.acs-inc.com/msenvision/**

The Medicaid's Pharmacy Bureau staff members will review and apply the additional information into the POS system to determine if the PA criteria have been met.

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 quarterly Mississippi Medicaid Bulletins.

Reminder to Dental Providers

Sealants

Dental sealants are thin plastic coatings which are applied to the chewing surfaces of the back teeth to prevent decay.

Sealants are covered for beneficiaries under age 21 when applied to newly erupted first and second permanent molars or to first and second pre-molars**.** Prior authorization is required for sealants applied to primary teeth. Sealants are allowed only once every five years. **PRIOR AUTHORIZATION DOES NOT OVERRIDE THE FIVE YEAR LIMITATION.**

Providers may bill Medicaid for sealants only when the sealant is applied to all pits and fissures (grooves) on the occlusal surface and, in some instances, the lingual groove surface of the upper molars.

Documentation must include the tooth number and tooth surface being treated.

Allowable Board of Directors Fees for Nursing Facilities, ICF-MR's and PRTF's 2010 Cost Reports

The allowable Board of Directors fees that will be used in the desk reviews and audits of 2010 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 in the plan 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 meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2010 are as follows:

Category	Maximum Allowable Cost for 2010
0 - 99 Beds	$ 3,667
100 - 199 Beds	$ 5,500
200 - 299 Beds	$ 7,334
300 - 499 Beds	$ 9,167
500 Beds or More	$11,001

2010 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 2010 are based on 150% of the average salaries paid to non-owner administrators in 2009 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 2010 are as follows:

- Small Nursing Facilities (1-60 Beds) $112,430
- Large Nursing Facilities (61 + Beds) $143,183
- Intermediate Care Facilities for the Mentally Retarded (ICF-MR) $101,330
- Psychiatric Residential Treatment Facilities (PRTF) $171,947

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.medicaid.ms.gov and clicking on "Provider Policy Manuals" under "Publications".

Manual Section	Policy Section	New	Revised	Effective Date
2.0 Benefits	* 2.05 Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles		X	01/01/10
14.0 Hospice	* 14.07 Dual Eligibles		X	01/01/10
25.0 Hospital Inpatient	* 25.22 Dual Eligibles		X	01/01/10
36.0 Nursing Facility	* 36.05 Dual Eligibles		X	01/01/10
2.0 Benefits	2.03 Exclusions		X	12/01/10
3.0 Beneficiary Information	3.02 Newborn Child Eligibility 3.04 Eligibility for Medicare and Medicaid 3.08 Beneficiary Cost Sharing		X X X	12/01/10
4.0 Provider Enrollment	4.12 Audiologist/Hearing Aid Dealer		X	12/01//10
8.0 Ambulance	8.08 Mileage 8.09 Codes/Description		X X	12/01/10
11.0 Dental	11.05 Oral Evaluations 11.07 Preventive Services and Sealants		X X	12/01/10
25.0 Hospital Inpatient	25.08 Newborn Child Eligibility 25.25 Prior Authorization of Inpatient Hospital Services		X X	12/01/10
26.0 Hospital Outpatient	26.17 Outpatient Hospital Services 26.23 Outpatient Rates		X X	12/01/10
28.0 Transplants	28.15 Reimbursement		X	12/01/10
47.0 Outpatient Physical Therapy	47.03 Exclusions 47.04 General Coverage Criteria 47.05 Definitions 47.06 Therapist Assistants, Aides, and Students 47.11 Evaluation/ Re-Evaluation 47.12 Plan of Care		X X X X X X	12/01/10
52.0 Surgery	52.13 Modifier -54,-55, and Modifier -56		X	12/01/10
53.0 General Medical Policy	53.26 Hyaluronate Joint Injection		X	12/01/10
55.0 Physician	55.04 Oral Health Assessment and Application of Fluoride Varnish by Medical Providers	X		12/01/10
70.0 Family Planning (Non-Waiver)	70.04 Covered Services 70.05 Program Exclusions		X X	12/01/10
76.0 EPSDT School Health Related Services	76.07 Audiological Services		X	12/01/10
7.0 General Policy	7.02 Access to Public Information 7.03 Maintenance of Records		X X	01/01/11

Manual Section	Policy Section	New	Revised	Effective Date
14.0 Hospice	14.02 Program Overview 14.03 Physician Certification/Re-Certification and Plan of Care 14.04 Beneficiary Election Requirements 14.05 Waiver of Medicaid Services 14.06 Revocation and Change of Hospice 14.08 Covered Services 14.09 Special Coverage Requirements 14.10 Reimbursements 14.12 Documentation Requirements		X X X X X X X X X	01/01/11
16.0 HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver	All Sections (16.01-16.16)	X		01/01/11
55.0 Physician	55.19 Mental Health/ Psychiatry	X		01/01/11
67.0 HCBS Mentally Retarded/Developmentally Disabled (MR/DD) Waiver	**All Sections (67.01- 67.11)			01/01/11

*The effective date for these policy revisions is retroactive to January 1, 2010.
** This manual section is being removed from the Provider Policy Manual.

Correction- The November 2010 Special Bulletin reflected a revision to Section 40.02 Criteria for Coverage. This policy has been delayed. Providers will be notified of any changes to this section in the future.

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.**

Verifying Beneficiary Eligibility

Providers have a variety of resources for verifying the eligibility of a Medicaid beneficiary. Eligibility can be checked by contacting the Provider and Beneficiary Services Call Center at 1-800-884-3222, by calling the AVRS at 1-866-597-2675, by utilizing the Mississippi Envision Web Portal at http://msmedicaid.acs-inc.com, and by using a swipe card verification device.

When verifying eligibility through the call center, please obtain the call record number (CRN) from the Call Center Associate prior to ending the call. When verifying eligibility through the web portal, please print a copy of the documentation which contains the eligibility information. If verifying eligibility through the use of a swipe card verification device, please keep a copy of the receipt. If verifying eligibility though the use of the AVRS, please document the audit reference number.

The Division of Medicaid (DOM) Announces the Provider Incentive Payment Program (PIP)

The nation's healthcare system is undergoing a transformation in an effort to improve quality, safety and efficiency of care for everyone. New programs from the upgrade to ICD-10 to information exchanges to electronic health records (EHR) technology are being implemented to help our providers make the transformation. To help facilitate this vision, DOM is participating in CMS' Medicaid Provider Incentive Payment (MPIP) Program to provide incentive payments to eligible hospitals and providers to offset the cost of implementing certified EHR technology. The MPIP will provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The program will begin in the first quarter of 2011 and DOM plans to begin accepting applications from eligible providers and eligible hospitals at that time. Eligible professionals (EP) can receive up to $63,750 over the 6 years that they choose to participate in the program.

A Medicaid EP is defined as a physician, nurse practitioner, certified nurse-midwife, dentist, or physician assistant. Physician assistants must practice in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician. To qualify for an EHR incentive payment, a Medicaid EP must not be hospital-based and must meet one of the following criteria:

- Have a minimum 30% Medicaid patient volume*
- Have a minimum 20% Medicaid patient volume, and is a pediatrician*
- Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals

NOTE: A Medicaid EP is considered hospital-based if 90% or more of the EP's services are performed in a hospital inpatient or emergency room setting.

* Children's Health Insurance Program (CHIP) patients do not count towards the Medicaid patient volume criteria.

Medicaid excludes podiatrists and chiropractors.

Watch for the Late Breaking News announcements on the Mississippi Envision website. Additional resource information may also be found at the following web sites:

- The DOM website at **www.medicaid.ms.gov** and
- The CMS EHR website at **http://www.cms.gov/EHRIncentivePrograms/.**

Providers may email specific questions to **ehr-pip@medicaid.ms.gov**.

Medicaid Payment Incentive Plan

Got Questions about EHR, Meaningful Use, and Qualifying for an Incentive Payment???
We've Got Answers…

Mississippi Division of Medicaid
Introduces
Medicaid Payment Incentive Plan for Eligible Professionals

Winter Workshop Series
Registration 8:30 AM - 9:00 AM
Workshop 9:00 AM - 12:00 PM

DATES & LOCATIONS

December 13, 2010 — **Tupelo, MS**

Hilton Garden Inn/Bancorp South Conference Center
363 East Main Street

December 14, 2010 — **Raymond, MS**

Eagle Ridge Conference Center
1500 Raymond Lake Road

December 15, 2010 — **Meridian, MS**

MSU Riley Center
2200 Fifth Street

December 16, 2010 — **Gulfport, MS**

Hilton Garden Inn
14108 Airport Road

December 17, 2010 — **Hattiesburg, MS**

Lake Terrace Convention Center
One Convention Center Plaza

Please submit RSVP with date, location, number of attendees, and contact information by December 6, 2010 to:

Attention: DOM Provider Relations
Fax: 601-359-4185
Phone: 601-359-6133
Email: ehr-pip@medicaid.ms.gov

Registration for this first series of workshops is limited to 50 providers with a maximum of 2 attendees per office. There will be other workshops in this series offered in the spring of 2011.

Session Topics

Program Overview

Provider Eligibility Criteria

Application Process

The Meaning of "Meaningful Use"

Shared Health Overview of Medicaid Electronic Health Record System

Assistance from Regional Extension Centers

www.medicaid.ms.gov
http://msmedicaid.acs-inc.com

Medicaid Payment Incentive Plan

Got Questions about EHR, Meaningful Use, and Qualifying for an Incentive Payment???
We've Got Answers…

Mississippi Division of Medicaid
Introduces
Medicaid Payment Incentive Plan for Eligible Hospitals

Winter Workshop Series
Registration 1:00 PM – 1:30 PM
Workshop 1:30 PM – 4:30 PM

Dates & Locations

December 13, 2010 **Tupelo, MS**
Hilton Garden Inn/Bancorp South Conference Center
363 East Main Street

December 14, 2010 **Raymond, MS**
Eagle Ridge Conference Center
1500 Raymond Lake Road

December 15, 2010 **Meridian, MS**
MSU Riley Center
2200 Fifth Street

December 16, 2010 **Gulfport, MS**
Hilton Garden Inn
14108 Airport Road

December 17, 2010 **Hattiesburg, MS**
Lake Terrace Convention Center
One Convention Center Plaza

Please submit RSVP with date, location, number of attendees, and contact information by December 6, 2010 to:

Attention: DOM Provider Relations
Fax: 601-359-4185
Phone: 601-359-6133
Email: ehr-pip@medicaid.ms.gov

Registration for this first series of workshops is limited to 50 providers with a maximum of 2 attendees per facility. There will be other workshops in this series offered in the spring of 2011.

Session Topics

Program Overview

Provider Eligibility Criteria

Application Process

The Meaning of "Meaningful Use"

Assistance from Regional Extension Centers

Question & Answer Session

www.medicaid.ms.gov
http://msmedicaid.acs-inc.com

Billing Medicaid Beneficiaries

All Mississippi Medicaid providers are reminded of the following conditions for participation in the Mississippi Medicaid program, as stated in the Medicaid Provider Policy Manual, Section 4.01, items 5 and 6:

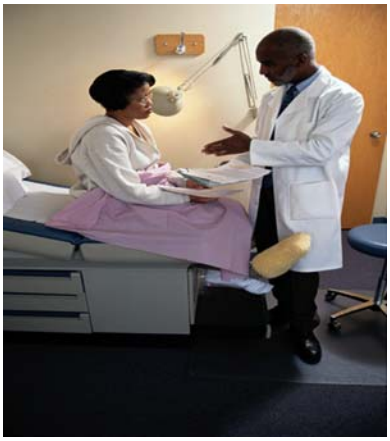
5. The provider must agree to accept payment for Medicaid covered services in accordance with the rules and regulations for reimbursement, as declared by the Secretary of Health and Human Services and by the state of Mississippi, and established under the Mississippi Medicaid program.
6. The provider must agree to accept as payment in full the amount paid by the Medicaid program for all services covered under the Medicaid program within the beneficiary's service limits with the exception of authorized deductibles, co-insurance, and co-payments. All services covered under the Medicaid program will be made available to the beneficiary. Beneficiaries will not be required to make deposits or payments on charges for services covered by Medicaid. A provider cannot pick and choose procedures for which the provider will accept Medicaid. At no time shall the provider be authorized to split services and require the beneficiary to pay for one type of service and Medicaid to pay for another. All services provided to Medicaid beneficiaries will be billed to Medicaid only where Medicaid covers said services, unless some other resources, other than the beneficiary, or the beneficiary's family will pay for the service.

Providers who bill Medicaid beneficiaries for covered services or charges outside of the required copayments are not in compliance with this policy and are subject to penalty.

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.

Hospital Emergency Room Visit Limit – Six Visits per Fiscal Year



Hospital providers are reminded that beneficiaries age 21 and over are limited to six emergency room visits per fiscal year (July – June). Emergency room visits billed with revenue codes 450 through 459 are counted toward the six-visit limit. Hospital outpatient charges related to services outside of the emergency room are not counted toward the six-visit limit. For example, beneficiary visits to the outpatient department of a hospital for non-emergency services, such as outpatient surgery, outpatient chemotherapy, outpatient radiation treatment, or outpatient laboratory or radiology services would not count toward the six-visit emergency room visit limit. For more details, please refer to the Mississippi Medicaid Provider Policy Manual, Section 26.16.

Medicaid Identification Card

It is the responsibility of the Medicaid provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service. The provider is also responsible for confirming that the person presenting the card is the person to whom the card is issued. This can be done by requesting a picture ID, such as a driver's license, school ID card, or verifying the Social Security number and/or birth date. It is preferred that providers verify the identity of the person presenting for service with a picture ID when possible. If it is found that the person presenting for services is not the Medicaid beneficiary to whom the card was issued, the provider is responsible for refunding any monies paid by Medicaid to the provider for those services provided.

Additional information regarding the Division of Medicaid's policy regarding the Medicaid identification card is in Section 3.05 of the Provider Policy Manual. Providers are reminded that they should review this policy periodically with their office staff.

Suspended Claims – What Do They Mean?

When claims process they either pay, deny, or suspend and are reflected on the Remittance Advice (RA) as such. Claims that deny should be researched, corrected, and resubmitted immediately. Claims that suspend should **NOT** be resubmitted.

Claims suspend for various reasons and will eventually pay or deny. If a second claim is submitted while the initial claim is in a suspended status, both claims will suspend. Providers should allow the suspended claim to be fully processed and reported on the RA as paid or denied before additional action is taken.

Claims commonly suspend when:

- beneficiary eligibility updates are required
- manual pricing from an invoice is required
- a prior authorization is required and the authorization is not in the Medicaid system
- a consent form is required
- generic codes are billed

Completing the Adjustment/Void Request Form

In order for provider requests for adjustments and voids of claims to be processed appropriately, it is extremely important that the Adjustment/Void Request Form is completed fully. The Adjustment/Void Request Form is a one-page document used by the provider community to give direction regarding requests to adjust or void claims already submitted and processed. There are several sections on the form that identify the type of request and additional fields which supply the necessary details required to adjust or void the indicated claim(s). All fields must be completed in order to process the request of the provider. Additionally, there is an "other explanation" field that is made available to allow for further details regarding the request.

If an Adjustment/Void Request Form (AVR) is received by ACS and it is not completed fully, then it will be returned to the provider for clarification. If you need assistance completing the Adjustment/Void Request Form, please contact Provider Services at 800-884-3222 and ask a Service Associate for assistance, or contact your assigned Provider Field Representative.

PRSRT STD
U.S. Postage Paid
Jackson, MS
Permit No. 53

ACS
P.O. Box 23078
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.medicaid.ms.gov
And
Medicaid Bulletins are on the Web Portal
http://msmedicaid.acs-inc.com

December

December 2010

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 **DOM and ACS closed**	25
26	27 **DOM and ACS closed** CHECKWRITE	28	29	30 **EDI Cut Off 5:00 p.m**	31 **DOM and ACS closed**	

Checkwrites and Remittance Advices are dated every Monday. The Remittance Advice is available for download each Monday morning at while funds are not transferred until the following Thursday.