Mississippi Medicaid Bulletin

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Anti-Fraud Provisions for Enrolling and Currently Active Medicaid Providers

The Centers for Medicare and Medicaid Services (CMS) published a final rule in the February 2, 2011 Federal Register. This Rule set forth new guidelines in accordance with the provision of the Affordable Care Act (ACA) to implement screening procedures of Health care providers and suppliers in an effort to prevent fraud, waste and abuse. The specific screenings to be conducted include but are not limited to:

- Fingerprinting
- Criminal background checks
- Unscheduled on-site visits
- Integrated database checks with state and federal agencies

Additionally, this Rule allows that:

- An application fee be imposed on institutional providers and suppliers at initial enrollment and during the provider revalidation process (to be conducted every three (3) to five (5) years),
- A temporary moratoria be imposed if necessary, on high risk provider types,
- A provider maybe terminated from the Medicaid program if the provider has been terminated by Medicare, another Medicaid State program or the Children Health Insurance Program (CHIP), and
- A Provider's payments may be suspended during an investigation of pending credible allegations of fraud in the Medicare and/or Medicaid programs.

The Division of Medicaid's Provider Enrollment Division is working diligently to implement the required guidelines of this Final Rule. Please watch for upcoming communications on the DOM website and the Envision Web Portal concerning implementation of processes and policies relating to these guidelines. For in-depth details on this CMS Final Rule, please refer to the CMS website at www.cms.hhs.gov.

How to Proceed When You Receive Edit 0280: Requires Fiscal Agent Review

Edit 0280 posts on claims when the CPT or HCPCS procedure code billed requires additional supporting documentation in order to process the claim. This documentation could include information from the beneficiary's medical records to support the medical necessity or to support the procedure performed. Some codes billed may require that you submit an invoice in order to price the claim for payment (i.e. a physician administered drugs).

Providers receiving edit 0280 on their Remittance Advice must provide the requested supporting documentation for the claim to be processed. The supporting documentation should be mailed to ACS, Medicaid's fiscal agent and addressed to the attention of the Medical Review Department.

ACS
Attn: Medical Review
P.O. Box 23080
Jackson, MS 39225

Recovery Audit Contractors (RACs)

Section 6411 of the Patient Protection and Affordable Care Act (PPACA), enacted on March 23, 2010 requires States to contract with Recovery Audit Contractors (RACs). The RACs will review Medicaid claims submitted by providers of services for which payment may be made under section 1902 (a) of the Act. RACs will review the accuracy of the claims payments.

PRGX Global was awarded the contract to provide these audit services to Mississippi Medicaid. PRGX will begin performing audit functions within the next few months.

As a provider, you may receive medical record requests or other correspondence from PRGX Global, Inc. indicating that you are the subject of an audit. In the event you receive a letter, specific instructions on how to respond and who to contact will be contained in the body of the letter. We encourage providers to communicate the existence of this overpayment recovery program to affected staff to provide a better understanding of responding to requests and other correspondence in a timely manner.

This recovery program is considered to be crucial in promoting the continuance of a cost effective and efficient Medicaid program. The State of Mississippi, Division of Medicaid and PRGX Global, Inc. are dedicated to ensuring the success of this program; therefore, it is important that providers are informed of this recovery audit initiative and the potential impact. We encourage the provider community to monitor the Mississippi Division of Medicaid's website for updates and announcements regarding the Mississippi Overpayment Audit Recovery program. Additional opportunities for provider education and training will be forthcoming and we encourage your full participation in the program.

ATTENTION. . .

PROVIDER RE-VALIDATION

The Division of Medicaid – Provider Enrollment Division is in the planning stage for **Provider Re-validation** (formerly known as Provider Re-enrollment). In accordance with 42 CFR 455.414 the state Medicaid agency *must* revalidate enrollment of **ALL** providers at least every 5 years. The revalidation process allows providers the opportunity to verify and update their provider information. Stay tuned for additional details.

Compliance with Title VI of the Civil Rights Act of 1964

The Division of Medicaid (DOM) will be conducting Title VI Civil Rights compliance Reviews beginning September 2011 for Medicaid enrolled hospital providers. A Civil Rights compliance packet will be mailed to these providers during the month of August 2011. This packet should be completed and forwarded back to the DOM by the indicated date of reply. These reviews are being conducted in accordance with and by the authority of the Department of Health and Human Services, Office of Civil Rights (OCR), which is charged with monitoring Title XIX service providers to insure compliance with federal nondiscriminatory regulations. Pursuant to Title VI of the Civil Rights Acts of 1964, *"No person in the United States shall, on the grounds of race, color, or national origin (including persons with limited English Proficiency) be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies."*

Providers who have completed their Civil Rights compliance review with the Medicare Program will be allowed to submit a copy of their current Medicare Civil Rights Compliance approval letter in lieu of completing the Medicaid compliance review forms. Medicaid's compliance review process mirrors the Medicare requirements, as both programs are recipients of federal financial assistance and are monitored by the Office of Civil Rights for compliance with the statute.

The Division of Medicaid will make available all respective implementing regulations, relevant data and the required information necessary to determine compliance with the Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. These requirements may be viewed at http://www.medicaid.ms.gov/ (click on the publications tab, scroll down and select the State plan link, select section 7.2 – Non-Discrimination).

Once you have completed the required documentation, mail your completed packet to:

Attention: Sabrina Hogue
Office of the Governor - Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201-1399

or send it electronically via e-mail as an attachment to CRC-PBR@medicaid.ms.gov

If you need additional information, please contact Sabrina Hogue at 601-359-3696.

The 5010 Compliance Date is Less Than Five Months 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

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 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 (not just those who submit Medicare or Medicaid claims) must make the transition.

International Classification of Diseases, 9th Revision, Clinical Modification Code Update

Effective October 1, 2011, the Division of Medicaid will update the claims payment system to accept the new ICD-9-CM codes and deny invalid ICD-9-CM codes. As a result of the Health Insurance Portability and Accountability Act providers are required to bill with current code sets. ICD-9-CM code sets are three, four, or five digits in length. A code is invalid if it has not been coded to the full number of digits required for that code. In order to ensure accurate coding and sequencing when assigning ICD-9-CM diagnosis and procedure codes, you must use the current version of ICD-9-CM. The ICD-9-CM is updated October 1st of each year. Be sure to keep your previous books as they may be needed when reconciling older claims.

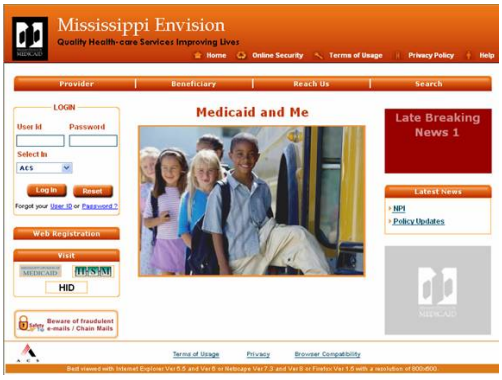
2011 New Bed Values for Nursing Facilities, ICF-MR's and PRTF's

The new bed values for 2011 for nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR's) and psychiatric residential treatment facilities (PRTF's) have been determined by using the R.S. Means Construction Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

Facility Class	2011 New Bed Value
Nursing Facility	$50,700
ICF-MR	$60,840
PRTF	$60,840

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.**



Notice to Providers - August 15, 2011

Payment Error Rate Measurement (PERM)

PERM was developed by CMS to measure improper payments in the Medicaid program and the Children's Health Insurance Program (CHIP). PERM reviews will be conducted in three areas:

- Beneficiary Eligibility for both the Medicaid and CHIP programs,
- Managed Care payments, and
- Fee-for-service claims payments.

  The fee-for-service claims review includes medical record collection, medical reviews, and data processing reviews. Please refer to CMS website http://www.cms.gov/PERM.

PERM Reviewers include:

The Lewin Group – Statistical Contractor (SC) - sampling and calculation of error rate

A+ Government Solutions – Review Contractor (RC) – fee for service reviews

A+ Government Solutions will contact providers directly, via telephone, fax, and mail from a sample of providers to collect medical documentation for review to substantiate claims paid in federal fiscal year 2011 (October 1, 2010 to September 30, 2011).

Health Data Insights (HDI) – subcontractor for A+ Government Solutions

HDI will be responsible for medical reviews but will not contact providers.

The first requests for documentation by **A+** should be mailed to the providers in September 2011. Providers must respond as soon as possible.

- **75 Days** – Provider must submit medical records to A+ within 75 days of date of letter.
- **14 Days** – Provider must submit additional medical records to A+ within 14 days of date of letter when the contractor makes a request for additional information.
- **Failure to comply will result is an automatic error and recoupment of paid claim.** Therefore, DOM requests that providers also send a copy of the supplemental documentation to the attention of DOM PERM to confirm that documentation is complete. This is to eliminate the problem of incomplete documentation from provider, and allows DOM to secure the additional documentation from the provider to avoid error assignment and subsequent claims recoupment or repayment.

For assistance from DOM, please call PERM representative Sharon Jones at 601-359-6134 or 1-800-421-2408, or email Sharon.Jones@medicaid.ms.gov

Notice to Providers - August 15, 2011

Payment Error Rate Measurement (PERM)

PERM reviewers/contractors examine claims to determine whether the provider:

- Responded to the request for documentation within the required time frame;
- Submitted documentation, but the documentation did not support the procedure code that was reimbursed;
- Submitted insufficient documentation;
- Submitted a procedure code that was an error (such as, the provider performed a procedure but billed using an incorrect procedure code);
- Billed with an incorrect diagnosis;
- Billed for the separate components of a procedure code when only one inclusive procedure code should have been billed;
- Billed for an incorrect number of units for a particular procedure or revenue code;
- Billed for a service determined to have been medically unnecessary based on the information in the medical/service record about the patient's condition;
- Billed and was paid for a service that was not in agreement with a documented policy, regulation or other requirement;
- Met all DOM, CMS, and other applicable policies, procedures and regulations.

For further information regarding PERM, please refer to CMS website http://www.cms.gov/PERM.

For assistance in faxing information to A+, please call 301-987-1100.
The toll free number for records to be faxed to A+ is 1-877-619-7850.

For assistance from DOM, please call PERM representative Sharon Jones at 601-359-6134 or 1-800-421-2408, or email Sharon.Jones@medicaid.ms.gov

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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. Additionally, DOM and ACS implemented two new options for eligibility verification and status inquiries in October 2010. Eligibility verification and claim status inquiries can 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 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.

HCBS Intellectual Disabilities/Developmental Disabilities Waiver Providers

Effective July 1, 2011, a new Intellectual Disabilities/Developmental Disabilities Waiver service, "Home and Community Supports" replaced "Attendant Care" and "Supported Residential Habilitation". Due to this change, the procedure code T2017 (Supported Residential Habilitation) is no longer billable to the Division of Medicaid. Home and Community Supports has been assigned the procedure code S5125.

Another ID/DD Waiver change effective July 1, 2011, was the addition of a second modifier if Home and Community Supports (S5125) or Supported Employment (H2023) is provided to more than one individual at the same location. The modifier U3 is still required as the first modifier when billing for any ID/DD Waiver procedure codes. The modifier UN should be used as the second modifier when two individuals are served. The modifier UP should be used if three individuals are served. The rates for these services were also changed. Please refer your billing staff to the procedure codes, modifiers, and rate changes in the chart below to avoid claim denials. The ID/DD Waiver Procedure Code Fee Schedule Effective July 1, 2011, is available at the following link http://www.medicaid.ms.gov/Fees/IDDDWaiverFeeSchedule.pdf on the Mississippi Division of Medicaid's website.

SERVICE	PROCEDURE CODE	FIRST MODIFIER	SECOND MODIFIER	RATE
Supported Employment	H2023	U3	None	**$25.00/hr.÷ 4 = $6.25/ 15 min. unit**
Supported Employment 2 people same location	H2023	U3	UN	**$32.00/hr.÷ 4 = $4.00/ 15 min. unit**
Supported Employment 3 people same location	H2023	U3	UP	**$36.00/hr.÷ 4 = $3.00/ 15 min. unit**
Home and Community Supports	S5125	U3	None	**$16.00/hr.÷ 4 = $4.00/ 15 min. unit**
Home and Community Supports 2 people same location	S5125	U3	UN	**$24.00/hr.÷ 4 = $3.00/ 15 min. unit**
Home and Community Supports 3 people same location	S5125	U3	UP	**$27.00/hr.÷ 4 = $2.25/ 15 min. unit**

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.

Bridge to Independence

The pathway to supported community living for the elderly, persons with intellectual and developmental disabilities, and mental illness.

The Division of Medicaid, with the help of its many stakeholders, will begin implementation this fall of a new federal demonstration grant, Bridge to Independence. The program is designed to empower consumers and remove barriers to community living for eligible persons with disabilities currently residing in qualified facilities and nursing homes.

Bridge to Independence is not a new waiver. Rather, it works to enhance existing waivers and State Plan options by providing specific services for up to one year and is meant to ease transition out of a facility. Those services include help with security and utility deposits, home adaptation, life skills training, extended pharmacy, and caregiver support.

In February 2011, the federal Centers for Medicare and Medicaid Services awarded Mississippi the nearly $38 million federal Money Follows the Person grant, which the state branded Bridge to Independence.

Objectives of the $42 million grant (counting state match) include:

- Assisting 595 people living in nursing homes and other facilities with their transition into the community by 2017. The target populations are persons with intellectual and developmental disabilities, serious mental illness, and the elderly and/or disabled. To participate in Bridge to Independence, individuals must have resided in a nursing home or intermediate care facility for the mentally retarded for at least 90 days. A patient-driven discovery process and Medicaid polices will determine whether a transition to the community is a viable, safe alternative to living in a facility. Patient safety will always trump grant benchmarks.

- Increasing the ratio of community-based service spending compared to institutional spending over the course of the six-year grant. Cost savings achieved by transitioning people out of institutions will be directed into community-based services, which are less costly on average. The state's goal is to increase community-based services' expenditures by at least $50 million through 2016. This ongoing rebalancing effort will allow Mississippi to increase its capacity to serve people in the community and make effective use of taxpayer dollars.

- Building new and improving old relationships with key state agencies, nonprofits, community providers, beneficiaries, policymakers, and other interested parties. Creating a long-term care system that is sustainable, equitable, and serves people in the least restrictive environment possible requires across-the-board cooperation and a willingness to consider new ideas. The Bridge to Independence program through its stakeholder group and outreach efforts already has sparked encouraging conversations about sustainable housing, supportive employment, direct workforce development and other initiatives vital to ensuring the goals of the Bridge to Independence demonstration grant translate into positive, permanent changes for the state.

  - For questions or to contribute ideas to the program, contact Molly Parker, research analyst and outreach coordinator, at 601-359-9524 or e-mail molly.parker@medicaid.ms.gov. You may also contact Jennifer Fulcher, assistant project director, at 601-359-4101 or email jennifer.fulcher@medicaid.ms.gov.

Mississippi Division of Medicaid

Family Planning Waiver Program Application Instructions

The information below is being sent to you to share with potential beneficiaries:

If you are applying for the first time or were not in the program in the past year, you must send in:

- A complete application
- Copy of your State issued ID (i.e. copy of a driver's license or school ID)
- Copy of your Birth Certificate
- Copy of your Social Security Card
- Copy of the most recent paystubs for one month's pay (If married, send in spouse's paystubs too)

If you were in the program last year and need to re-apply to keep receiving services, you must send in:

- A complete application
- Copy of the most recent paystubs for one month's pay (If married, send in spouse's paystubs too).

TIPS

- If married, paystubs must be sent in for both you and your spouse. If you or your spouse is getting unemployment, social security, child support or alimony, etc., you must send proof of this income.
- If you are unemployed and claim "zero" income, please send a letter saying you are unemployed and why.
- If you are a student and claim "zero" income, please send a copy of your school ID or a letter saying you are enrolled in school.
- If you are legally separated, divorced or widowed, please send proof (divorce decree, death certificate or court papers).

Family Planning Waiver Program Quick Tips

Did you know…?

- Policy Section 72 – Family Planning Waiver, of the Provider Policy manual, can be found online at: www.medicaid.ms.gov.
  - Click Publications
  - Select Provider Policy Manuals
- A downloadable copy of the FPW Program application and the approved list of FPW Program procedure and diagnosis codes can be found online at: www.medicaid.ms.gov.
  - Click Programs
  - Select the Family Planning Waiver Demonstration Program Link
- Family Planning Waiver (FPW) applications can be ordered by calling ACS at 1-800-884-3222. Quantities limited to a maximum of 250 per request.
- Beneficiary eligibility can be verified
  - Via the Envision Web Portal at https://msmedicaid.acs-inc.com/msenvision/ or
  - By calling the ACS Call Center at 1-800-884-3222 or
  - By calling the Automated Voice Response System (AVRS) at 1-866-597-2675

Help for Hospice Providers

On January 1, 2011, the Mississippi Division of Medicaid (DOM) began requiring prior approval (PA) for certification for all hospice admissions and certification periods before payment can be made. Health Systems Management (HSM) is the Utilization Management and Quality Improvement Organization responsible for prior approvals of hospice services for qualified Medicaid beneficiaries.

Before submitting the required information to HSM, hospice providers must first verify that a beneficiary is eligible. Providers who participate with Mississippi Medicaid are required by law to determine if a beneficiary is covered by a third party source, including Medicare, which is the primary payor for dual eligibles; with Medicare as primary, HSM prior approval is not required for Medicaid payment.

After verifying eligibility and before submitting information to HSM for obtaining prior approval, providers must discuss with the beneficiary or his/her legal representative the services that can be provided by the hospice. This discussion must include any limitations for the provision of care. The beneficiary or legal representative must formally elect hospice services by completing the election form (DOM 1165A) and the enrollment form (DOM 1165B). The provider must obtain a written certification statement (DOM Form 1165C) signed by the beneficiary's attending physician ***and*** the hospice's medical director (the physician member of the hospice interdisciplinary team may sign in the place of the medical director). The physicians' signatures on DOM Form 1165C certify the beneficiary as being terminally ill with a life expectancy of six-months or less. The physician must include a brief narrative explanation of the clinical findings that support a life expectancy of six-months or less, as an addendum to the certification and recertification form. Additionally, a patient History and Physical (H&P), completed no more than 30 days from the start of care date, is a requirement for certification.

After verifying beneficiary eligibility, completing the election/enrollment forms with the beneficiary or legal representative, and obtaining the physician certification accompanied by an H&P and clinical explanation as noted above, the provider is ready to submit the information to HSM via the web portal.

For additional information regarding the DOM hospice requirement, go to http://www.medicaid.ms.gov, >Provider, >Policy Manual, >Section 14.

The HSM provider manual is currently under revision and the updated version will be available soon at http://www.hsom.org.

Preadmission Screening (PAS) Application Process for Long Term Care Eligibility in a Nursing Facility

IMPORTANT REMINDER

When completing the Preadmission Screening (PAS) application electronically via the ACS Web Portal, it is necessary that the submission process be finalized and a **case number** obtained for the application. This "case number" should not be confused with the PAS **reference number**, which is used to recall an incomplete PAS application. The case number is obtained *only after* the PAS submission process is completed in all of its components.

Continued on the next page

Submission of the PAS is a two (2) step process:

Step 1 Submit the completed PAS application (Section I through Section IX) to obtain the scored Section X Summary.

Step 2 (and these are **required** components of the submission process):

- Attach the completed and signed informed choice document (scanned)
- Attach the PAS Section X Summary which has been signed by the physician (scanned) **or** the physician may choose to complete the electronic attestation.
- Submit these to obtain a case number

Once the second step of the submission process is completed, a *case number* should be noted at the top of the Section X Summary. It is only ***after*** a **case number** is obtained that the Level II, Pre-Admission Screening and Resident Review (PASRR), referral is made and/or a secondary review can be completed for individuals with a PAS score between 45 and 49.5.

ACS Web Portal address: https://msmedicaid.acs-inc.com/msenvision

For more information regarding the PAS process or providers in need of PAS training may contact Gay Gipson at 601-359-9529 or Cherlyn Carter a 601-359-5251.

AMBULATORY SURGICAL CENTER CODE CROSSWALK

The Division of Medicaid developed a crosswalk based on CPT coding guidelines for the following discontinued procedure codes. These codes were previously allowed for reimbursement to the Ambulatory Surgical Center (ASC). The new codes have been opened for reimbursement effective for dates of service on or after January 1, 2010. Resubmitted claims must follow all timely filing requirements.

Discontinued		**New Codes**	
Code	Group	Code	Group
14300	04	14301	04
		14302	04
24350	03	24357	03
24351	03	24358	03
24352	03	24359	03
24354	03		
24356	03		
32000	01	32421	01
45170	02	45171	02
		45172	02

Discontinued		**New Codes**	
Code	Group	Code	Group
51010	01	51102	01
51772	01	51727	01
		51729	01
64470	01	64490	01
64472	01	64491	01
		64492	01
64475	01	64493	01
64476	01	64494	01
		64495	01

The following crosswalk is for discontinued codes that have new codes which are already open for reimbursement to the ASC. There have been no changes to these codes, so no resubmission of claims is required.

Discontinued		Open Code	
36834	03	36832	04
43750	02	43246	02
46937	02	45190	09
46938	02		
49420	01	49421	01
		49080	01
		49081	01

Discontinued		Open Code	
52606	01	52214	01
52612	02	52601	02
52614	01		
52620	01	52630	02

The following procedure codes have been reinstated for reimbursement to the ASC for dates of service on or after January 1, 2010, at their previous group rates. These claims will require resubmission based on timely filing requirements.

Code	Group Rate
50590	08

Code	Group Rate
58600	04

Providers will need to resubmit their denied claims in accordance to multiple and bilateral surgery policy sections 13.10 Ambulatory Surgical Center – Payment for Multiple Procedures, 52.04 Surgery – Bilateral Procedures, and 52.05 Surgery – Endoscopy. Please review any claims submitted for correct billing according to these policies.

NOTE: Page 2 of Policy Section 13.10 states that add-on codes will be reimbursed at 50% of the Medicaid allowable for the ASC. Providers must bill the 51 modifier with the add-on code to be correctly reimbursed for these services. A list of the add-on codes can be located in the current CPT book. Not all add-on codes listed there are allowed for reimbursement to the ASC so providers should review the current DOM ASC rate schedule. Both the policy manual and schedules are located at www.medicaid.ms.gov under Publications.

Additional information and examples for the correct billing of multiple and bilateral surgeries are located in the March, June, and December 2008 bulletins which can be found at www.msmedicaid.acs-inc.com.

Pharmacy Prior Authorization Manual Form

The Division of Medicaid has noted an influx in the submission of prior authorization requests without the prescriber's physical signature. In the case of pediatric beneficiaries where the requested drug is outside of FDA approved age, dose, and/or indications, accepted options for prior authorization submission are:

- prescriber's actual signature on the form; or
- prescriber's signature by surrogate on the form *and* prescriber's initials by age, dose or indication waiver; or
- waiver written in prescriber's handwriting; or
- prior authorization submitted through the Web Portal.

Submission of forms without the prescriber's signature and/or initials will automatically result in a denial of the Prior Authorization or Appeal.

Prescribers are strongly encouraged to submit prior authorization requests via the Web Portal. A Prescriber can designate office personnel as their surrogate to submit prior authorization requests through the Web Portal. Web Portal instructions may be found at this link:
https://msmedicaid.acs-inc.com/msenvision/pharmacyPriorAuthInstructionAction.do

If you require assistance using the ACS Envision Web Portal, please contact ACS at 1-800-884-3222, select option 2 for Provider, then option 2 for Pharmacy.

SYNAGIS SEASON, 2011-2012

The Mississippi Division of Medicaid supports the administration of Synagis® for children meeting the American Academy of Pediatrics Redbook 2009 criteria for RSV immunoprophylaxis. Beginning October 24, 2011, prior authorizations may be submitted to DOM's Pharmacy PA unit for administration starting on October 31, 2011. Up to a total of five doses will be allowed per beneficiary. In accordance with AAP revised guidelines, some beneficiaries may be approved for a maximum of three doses, depending upon gestational and/or chronological age. Synagis® prior authorization criteria and forms may be found at http://www.hidmsmedicaid.com/ www.medicaid.ms.gov/Pharmacy , go to Prior Authorization, and select Synagis® 2011-2012 prior authorization form and criteria. Be advised that these procedures are the same as in the 2010-2011 season. PA requests for beneficiaries enrolled in MississippiCAN are to be submitted to the respective PBM and not to Medicaid.

Medicaid and MississippiCAN Pharmacy Contact Information

Payer	Provider Phone number	Beneficiary contact information
MS Medicaid Pharmacy PA	**1-877-537-0722; 601-359-6685; Fax 1-877-537-0720**	**1-800-421-2408; 601-359-6050**
MississippiCAN: Magnolia Health Plan Pharmacy Help Desk	PBM is US Script, Inc. **1-800-460-8988**	**1-866-912-6285 or 601-863-0700**
MississippiCAN: UnitedHealthcare Pharmacy Help Desk	PBM is Prescription Solutions **1-877-305-8952**	**1-877-743-8731**

Remember that MississippiCAN claims and PA requests must be submitted to the respective PBM. Submitting claims and/or prior authorization requests to MS Medicaid rather than to the respective plan delays the process for Medicaid, providers, and beneficiaries.

FDA Prompts Removal From Market of Unapproved Prescription Products

The FDA continues to remove unapproved prescription products from the U.S. market. According to the FDA's March 2, 2011, news release, "*This is the 17th action on a drug class as part of FDA's Unapproved Drugs Initiative*[1]*, which began in June 2006. The initiative is the agency's risk-based enforcement approach to efficiently and rationally bring all unapproved new drugs into the approval process. One of the goals of the initiative is to reduce consumer exposure to drugs that are not proven safe, effective, and of high quality."*

For additional information on this FDA initiative, go to *http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/EnforcementActivitiesbyFDA/SelectedEnforcementActionsonUnapprovedDrugs/ucm118990.htm*.

OVER THE COUNTER (OTC) FORMULARY ADDITIONS EFFECTIVE SEPT. 1, 2011

The Division of Medicaid has revised the OTC formulary. The following items have been added for coverage as of Sept. 1, 2011:

- *Oxymetazoline Nasal Solution 0.05% spray; compares to Afrin, Sinex 12 Hr Decongestant*
- *Phenylephrine Nasal Solution drops/spray, 0.5%, 1%; compares to 4 Way, Sinex 12-Hr Decongestant Ultrafine Mist*
- *Sodium Chloride Nasal Solution drops/spray, 0.2%, 0.65%,0.9%; compares to Ayr, Ocean*

Some former preferred legend prescription products have moved from legend to OTC status. **If an OTC product is not listed on DOM's OTC formulary, it is not covered.** For a comprehensive listing of the OTC formulary, go to www.medicaid.ms.gov/Pharmacy and select OTC formulary list from the menu on right hand side of the page.

Pharmacy Billing for Influenza and Pneumonia

Influenza and pneumonia immunizations are covered services under the MS Medicaid Pharmacy program. In order to be eligible the beneficiary must be age 19 or older and not a resident of a long-term care facility. These are the only vaccines/immunizations available via the Pharmacy program. As with other pharmacy services, a hard copy prescription must be on file. Immunizations provided from a credentialed pharmacist will count against the service limits and co-payments are applicable. MS Medicaid reimburses for the drug's ingredient cost and a dispensing fee for immunizations administered in the pharmacy venue. *No administration fee is paid for immunizations administered in the pharmacy venue.*

All immunizations for children age 18 and younger must be handled through the Vaccines for Children Program (VFC). Influenza and pneumococcal vaccines will be reimbursed by MS Medicaid for residents with a payment source of Medicaid only in nursing facilities. The facilities may have the provider come to the facility and administer the injections or may send a resident to the provider's office for the injection. The provider may bill and be reimbursed by Medicaid, or the facility may purchase the vaccine, administer the injection, and claim the cost of the vaccine in the Medicaid cost report for Medicaid only residents. *Facilities cannot claim the cost of the vaccine in the Medicaid cost report for Medicare patients.*

Continued on the next page

Be advised that Medicare provides coverage for the flu vaccine and its administration. Influenza vaccination is covered as a Medicare Part B benefit, and *NOT* as a Part D drug. For additional information regarding immunizations and Medicaid policies, refer to Medicaid's Provider Manual, Section 77, Immunization. This may be directly accessed at: http://www.medicaid.ms.gov/ProviderManualSection.aspx?Section 77 – Immunization.

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 vaccinesadministered 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. Providers should bill using the appropriate CPT code 90471 or 90472.

Seasonal Flu and Pneumonia Vaccine and Administration Fees

Reimbursement rates effective July 1, 2011for 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	$12.38	90732	$57.19	90471	$19.64
90658	$11.37			90472	$9.94
90660	$22.32				

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.

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.

Fall 2011 Hospital Provider Workshops

The Division of Medicaid and ACS Government Healthcare Solutions are planning the Fall 2011 Hospital Provider Workshops. The workshops will be designed to address issues and topics that are of most importance to the Medicaid provider community.

More specific information, including dates and locations, will be posted on the Mississippi Medicaid web portal at http://msmedicaid.acs-inc.com when it becomes available.

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

September

September 2011

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**		

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.