

## MISSISSIPPI MEDICAID

### Invalid Taxonomy Number Edit 1347 Disposition Change. Late Breaking News - Mississippi Medicaid. July 23, 2023

“Beginning Aug. 1, 2023, claims that have historically been placed in a PENDING status with Explanation of Benefit (EOB) Code 1347 (Billing Provider Number is not found or is not valid for Dates of Service) with corresponding Claim Adjustment Reason Code 208 (NPI not matched) and Remark Code N257 (Missing/incomplete/invalid billing provider/supplier primary identifier) will now be DENIED with the same EOB, Claim Adjustment Reason Code, and Remark Code combination.

The above listed code combination is set to post on a claim when the system cannot find a unique billing provider Medicaid ID to utilize when processing the claim. The system is coded to utilize the NPI, Taxonomy, Zip Code, and the 4-digit postal code to reconcile the billing provider to the appropriate Medicaid ID. In the instance that a billing provider has more than one Medicaid ID with the same NPI, Taxonomy, Zip Code, and 4-digit postal code, the claims system may be unable to reconcile the billing provider to a unique Medicaid ID, thus resulting in the claim denying and posting the above reference code combination. For more details, please see: <https://medicaid.ms.gov/wp-content/uploads/2023/07/Explanation-of-Benefit-Code-1347.pdf>.

Should you experience this issue and need assistance, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or use the Provider Field Representative list on Medicaid’s website to identify your designated representative. The Provider Field Representative list includes email addresses and phone numbers for each representative. This resource document is located at <https://medicaid.ms.gov/wp-content/uploads/2022/12/Provider-Field-Representatives.pdf>.”

### Notice of Claims Appeal Process Change. Magnolia Health. July 21, 2023

“Magnolia Health is updating our Claim Appeal timeframe to align with the Division of Medicaid’s timeframe of 30 days that went into effect July 1, 2017. MississippiCAN claim appeals must be received within 30 days from the date of notification of payment or denial, rather than 90 days.

**The First Time Claim submission timeframe will not change. First-time clean claims must be submitted within 180 days of the member's service date.**

**The Reconsiderations process and time frame will not change. Reconsiderations are optional in the claim dispute process. Reconsiderations must be submitted within 90 days of the Explanation of Payment or Denial.**

**Corrected Claims timeframe will not change: Corrected claims must be received within 90 calendar days from the notification of payment or denial.**

**UPDATE\* The Claim Appeal must be received within 30 days from the date of notification of payment or denial.**

Corrected Claims and Reconsiderations can be submitted through the Magnolia Secure Provider Portal, through your preferred clearinghouse, or by mail to Magnolia Health Attn: Corrected Claim PO Box 3090 Farmington, MO 63640-3800.

The claim should include the appropriate resubmission code, and the original claim number or EOP must be included with the resubmission.

Failure to include the appropriate resubmission code and original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit

**Request for Claim Reconsideration** can be submitted by logging into your Magnolia Secure Provider Portal or by mail to Magnolia Health Attn: Reconsideration PO Box 3090 Farmington, MO 63640-3800. Magnolia encourages providers to utilize the Secure Web portal or the [Reconsideration Dispute form](#) when submitting a reconsideration request.

A request for reconsideration is a written communication from the provider about a disagreement of a processed claim.

Request must include sufficient identifying information which includes, at minimum, the patient's name, ID number, date of service, total charges, and provider name.

Documentation must also include a detailed description of the reason for the request.

**\*Important: Please note that a request for reconsideration cannot be filed after a request for a claim appeal or exhausting the claim dispute process.**

If the corrected claim or the request for reconsideration results in an adjusted claim, you will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and the next step in the claim dispute process.

**Request for Claim Appeal must be submitted by mail to Magnolia Health Attn: Dispute PO Box 3090 Farmington, MO 63640-3800.**

**To ensure timely processing, please utilize the NEW! [Claim Appeal form](#)** or the request must be marked as "Claim Appeal" at the top of your documentation. Request must include detailed and sufficient information, which includes the reason for the claims appeal request, the patient's name, patient ID number, date of service, total charges, and provider name.

If the request for a claim appeal is upheld or overturned, you will receive a letter detailing the decision. Please note that reconsideration cannot be filed after an appeal.

If you have questions about this process or want to receive education related to the changes, don't hesitate to contact Provider Services at 1.866.912.6285 or your Provider Engagement Representative.

### **“Balance Due” Letters to be Mailed. Mississippi Medicaid Late Breaking News. July 25, 2023**

“Providers with an outstanding balance owed to the Mississippi Division of Medicaid (DOM) will start receiving balance due letters. The first letter is sent at 30 days past the original balance set-up date. Additional letters are sent at 60 and 90 days past due. The letter contains a detailed listing of the amount(s) due associated with liabilities that were previously assessed against the provider or created by claims adjustments. Providers should refer to their Remittance Advice (RA) in the [MESA provider portal](#) for more information.

Current payments of claims may be used to offset this balance or providers may pay the balance by check. Checks should be made payable to the MS Division of Medicaid. A copy of the letter and the payment should be mailed to Gainwell Technologies, P.O. Box 6014, Ridgeland, MS 39158.

Questions can be directed to (800) 884-3222 – Option 2, Option 7, Option 0 to speak to a representative – or by sending an email to [ms\\_financial@gainwelltechnologies.com](mailto:ms_financial@gainwelltechnologies.com).”

<https://medicaid.ms.gov/late-breaking-news/>

## **CMS, NOVITAS SOLUTIONS, RAILROAD MEDICARE**

### **CMS Physician Payment Rule Advances Health Equity. CMS. July 13, 2023**

RHW: CMS has released the Proposed Final Rules for the Physician Fee Schedule (PFS) and the news is not great. Among the proposals is a significant decrease in the PFS payments to providers. However, CMS has also proposed reinstating the G2211 code (proposed previously) that would be applicable to certain types of patient office visits as an additional payment with the goal of

recognizing the inherent costs providers might have when longitudinally treating a patient's single, serious, or complex chronic condition. It is unclear at this time, how or if this code would be applicable to Optometry. The AOA will carefully review the 2024 PFS and provide feedback to CMS. Typically the Final Rule for PFS is not finalized until late approximately November.

“Proposed Payment Rate: The CY 2024 PFS proposed rule includes updates to PFS payments for clinicians as required by law. Overall proposed payment amounts under the PFS would be reduced by 1.25% compared to CY 2023, in accordance with factors specified by law. CMS is also proposing increases in payment for many visit services, such as primary care, and these proposed increases require offsetting and budget neutrality adjustments to all other services paid under the PFS, by law. The proposed CY 2024 PFS conversion factor is \$32.75, a decrease of \$1.14, or 3.34%, from CY 2023.”

**Announcement:** <https://www.cms.gov/newsroom/press-releases/cms-physician-payment-rule-advances-health-equity>

**FAQ for PFS:** <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-proposed-rule>

### **ABN Alert: Renewed Advance Beneficiary Notice of Noncoverage Became Mandatory on June 30, 2023. Novitas Solutions. July 21, 2023**

RHW: Please remember that you can only use the CMS version of the ABN verbatim.

“The ABN, Form CMS-R-131, and form instructions have been approved by the Office of Management and Budget (OMB) for renewal. The use of the renewed form with the expiration date of January 31, 2026, became mandatory on June 30, 2023.

Any ABN signed on or after June 30, 2023, with a prior expiration date, will not be considered valid.

The ABN is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service - FFS) beneficiaries in situations where Medicare payment is expected to be denied. The ABN is issued to transfer potential financial liability to the Medicare beneficiary in certain instances. Guidelines for issuing the ABN can be found beginning in Section 50 in the CMS IOM Pub. 100-04 Medicare Claims Processing Manual, Chapter 30, [Section 50 Advance Beneficiary Notice of Non-coverage \(ABN\)](#).

Note: Skilled nursing facilities (SNFs) issue the ABN to transfer potential financial liability for items/services expected to be denied under Medicare Part B only.

Additional Resources:

MLN Connects [2023-04-06-MLNC](#)

[CMS Beneficiary Notices Initiative \(BNI\)](#)

[Advance beneficiary notice of non-coverage”](#)

### **The Medicare Enrollment System Is Changing—What You Need To Know. AOA Week in Focus. July 13, 2023 and**

### **Provider Enrollment, Chain and Ownership System (PECO) is Modernizing. CMS.**

AOA: “Centers for Medicare & Medicaid Services (CMS) announced a redesign to the Provider Enrollment, Chain, and Ownership System (PECOS). The new, modernized PECOS will make the Medicare enrollment and revalidation processes faster and more efficient. The new experience is expected to launch this summer.”

CMS: “PECOS 2.0 will make the Medicare enrollment and revalidation processes faster and more efficient. The new experience is expected to launch in Summer of 2023.

Explore the [educational videos and resources](#) to learn about some of the enhancements you can look forward to in PECOS 2.0.”

<https://www.cms.gov/medicare/provider-enrollment-and-certification/introducing-pecos-20>

FAQ: <https://www.cms.gov/files/document/pecos-20-faqs.pdf>

### **Keep Your Railroad Medicare Enrollment Record Up to Date. Railroad Medicare Bulletin. August 2023**

“As a Medicare provider, you are responsible for notifying Medicare of changes to the information in your Medicare enrollment record, including provider name and address changes. Incorrect information in your enrollment file could lead to claim rejections or correspondence being delivered to an incorrect address. Railroad Medicare does not automatically receive updates you make to your enrollment record with your Part B Medicare Administrative Contractor (MAC). Please notify Railroad Medicare promptly of any enrollment changes once those changes have been made by your Part B MAC. Types of Enrollment Changes to Report to Railroad Medicare include: • Provider name changes • Practice name changes • Billing address changes • Practice address changes • Practice location added (only if the additional practice location is in a different contractor locality, or you have been assigned a new NPI for the location) • Provider has retired • Provider has left group Railroad Medicare cannot accept enrollment changes by telephone. You can find instructions for faxing or mailing enrollment changes to Railroad Medicare on our Provider Enrollment Update an Enrollment Record webpage at <https://www.palmettogba.com/palmetto/rr.nsf/DID/H4AZXTC6NU>.”

### **Novitasphere: Annual Certification-Monthly Reminder and Education. Novitas Solutions. July 17, 2023**

“The initial CMS Identity Management (IDM) annual certification requirements were implemented in July 2021. Roles are due for the annual certification one year after the previous certification, or one year after the role was established. Due to the initial requirements start date, many recertifications are due in the month of July.

Novitas EDI staff handle the certifications for the office approver (OA) and office back-up approver (OBA) role accesses. However, OAs and OBAs are responsible for routinely certifying the Novitasphere End User role accesses before the annual certification due dates. Failure to certify end users timely will result in the End User’s role being removed. Instructions are also available on the IDM annual certification ([JH](#)) ([JL](#)) web page.

MONTHLY REMINDER: All users must access Novitasphere at least once every 30 days to maintain access. Log in to Novitasphere TODAY at <https://www.novitasphere.com> to preserve your role. Any user IDs that do not sign in monthly will be considered inactive and the Novitasphere role will be removed. If you can no longer access Novitasphere due to the role removal, follow these steps to regain access ([JH](#)) ([JL](#)).”

### **NEW Novitas Smart Edits. Novitas Solutions Medicare News. July 18, 2023**

“Reminder - The payer ID Smart Edit was implemented on July 15. Have you reviewed the 277CA reports for all electronic claim files submitted since then?

One of the new edits is verifying that the Payer ID reported in your electronic file is accurate. This field has been required but not previously reviewed for accuracy. With the implementation of this edit, the correct payer ID will need to be provided or the claim will reject.

Several other Smart Edit messages were also effective on July 15. Make sure your electronic billing staff is familiar with the [Smart Edit List](#) page. These edits are very technical and intended for health care electronic billing professionals. We strongly encourage you discuss these changes with the person who handles electronic billing for your office today.

For additional information regarding the Novitas Smart Edits, visit the [Smart Edits](#) web page. Thank you for reading this full message and taking the necessary actions to ensure your Medicare payments will not be negatively impacted.

**Smart Edits List:** <https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00276106>

**Smart Edits Webpage:** <https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00275505>

### **Novitas: Additional Smart Edits effective July 29. Novitas Solutions. July 27, 2023**

“The Payer ID edit and several other Smart Edits were implemented on July 15. With the initial implementation results being positive, we are preparing to implement additional Smart Edits on July 29. The Smart Edit List pages linked below have been updated to show July 29 effective dates for all impacted edits. These edits are very technical and intended for health care electronic billing professionals. We strongly encourage you discuss these changes with the person who handles electronic billing for your office today.

JH Novitas Smart Edit List ([Part B](#))

For details on the Smart Edit project, visit the Smart Edits ([JH](#)) web page. Thank you for reading this full message and taking the necessary actions to ensure your Medicare payments will not be negatively impacted”

**Smart Edits List:** <https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00276106>

**Smart Edits Webpage:** <https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00275505>

### **Novitas: Micro-Invasive Glaucoma Surgery (MIGS) (JH, JL) (A56633) – A56633 Local Coverage Article (LCA). July 15, 2023**

Added a new version of the document.

<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56633>

### **Medicare Telehealth Services MedLearn Article. CMS. July 20, 2023**

“Updated information on:

- End of the COVID-19 public health emergency
- CY 2023 and telehealth policies

Added information on:

- G-codes
- Consent for care management and virtual communication services

CMS changed this link. If you previously bookmarked it, update your link.”

<https://www.cms.gov/files/document/mln901705-telehealth-services.pdf>

### **Railroad Medicare Quick Reference Guide for Claims Submission. Palmetto GBA. June 21, 2023**

“The Railroad Medicare Quick Reference Guide is a publication to assist providers with submitting claims to Railroad Medicare. In this guide you can find information about many Railroad Medicare topics including Provider Enrollment, submitting electronic and paper claims, using the eServices portal and the Interactive Voice Response (IVR) system, Appeals, Medical Review, Medicare Secondary Payer, Overpayments and Recoupments, and more. Please share with appropriate staff.”

**Palmetto Site:** <https://www.palmettogba.com/palmetto/rr.nsf/DID/7JYQ282514#ls>

**Guide:** [https://www.palmettogba.com/Palmetto/Providers.Nsf/files/Quick Reference Guide for Railroad Medicare.pdf/\\$File/Quick Reference Guide for Railroad Medicare.pdf](https://www.palmettogba.com/Palmetto/Providers.Nsf/files/Quick Reference Guide for Railroad Medicare.pdf/$File/Quick Reference Guide for Railroad Medicare.pdf)

## **OTHER**

### **Aetna: Ozurdex and Dextenza (Dexamethasone Ophthalmic Implants) (Commercial) - Medical Policy No 0795. Reviewed 06/29/2023**

Reviewed with changes to policy statement and supplementary information.

Added autoimmune retinopathy and diabetic retinopathy as experimental/investigational indications for Ozurdex;

Updated supporting information.

[https://www.aetna.com/cpb/medical/data/700\\_799/0795.html](https://www.aetna.com/cpb/medical/data/700_799/0795.html)

**Aetna: Graves' Ophthalmopathy Treatments - Medical Policy Number: 0419. Reviewed July 11, 2023**

Reviewed with changes to criteria and supplementary information.

Removed thyroid eye disease (TED) clinical activity score initial approval criterion (see policy for complete changes);

Updated TED recertification requirement criteria statement;

Updated TED disease severity initial approval criterion;

Updated supporting and administrative information.

[https://www.aetna.com/cpb/medical/data/400\\_499/0419.html](https://www.aetna.com/cpb/medical/data/400_499/0419.html)

**BCBS Federal Employee Plan: Xiidra - Prior Authorization (PA) Rationale. June 1, 2020**

“Issued a new version of the document.”

[https://www.caremark.com/content/dam/enterprise/caremark/microsites/dig/pdfs/pa-fep/fep-rationale/FEP\\_Rationale\\_Xiidra.pdf](https://www.caremark.com/content/dam/enterprise/caremark/microsites/dig/pdfs/pa-fep/fep-rationale/FEP_Rationale_Xiidra.pdf)

**BCBS Mississippi: Orthoptic Training for the Treatment of Vision or Learning Disabilities (Commercial) - Medical Policy**

No changes to criteria.

<https://www.bcbsms.com/medical-policy-search#/policy-detail?id=47f69beb-9708-40ec-80a5-17085a9806f5>

**Humana Code Compendium (Ophthalmology). Medical Policy HUM-0571-008. Reviewed June 22, 2023**

**0469T** Retinal Polarization Scan - Not Covered

**0506T** Heterochromatic Flicker Photometry Measurement of Macular Pigment Density - Not Covered

**0509T** Pattern Electroretinography (PERG) - Not Covered

**0514T** Intraoperative Visual Axis Identification - Not Covered and Deleted Code

**0604T, 0605T, 0606T** Remote Optical Coherence Tomography (OCT) - Not Covered

**0616T, 0617T, 0618T, C1839** Iris Prosthesis and Insertion - Not Covered

**0687T, 0688T, 0704T, 0705T, 0706T** Digital Amblyopia Therapy - Not Covered

<https://dctm.humana.com/Mentor/Web/v.aspx?objectID=0900092987067f2b>

**Molina Healthcare: Ozurdex (dexamethasone intravitreal implant) - Medical Policy #282. Reviewed June 14, 2023**

High Importance Update.

Reviewed with changes to coding and supplementary information.

Added CPT code 67027;

Updated supporting information.

No changes to criteria.

[https://www.molinahealthcare.com/~media/Molina/PublicWebsite/PDF/Common/Molina%20Clinical%20Policy/Ozurdex\\_dexamethasone%20intravitreal%20implant\\_R.pdf](https://www.molinahealthcare.com/~media/Molina/PublicWebsite/PDF/Common/Molina%20Clinical%20Policy/Ozurdex_dexamethasone%20intravitreal%20implant_R.pdf)

**Molina Healthcare: Ophthalmic Agents Presbyopia - Prior Authorization (PA) Form. Reviewed May 8, 2023.**

“Reviewed PA form.

This form applies to requests for prior authorization of Ophthalmic Agents Presbyopia.”

<https://www.molinahealthcare.com/providers/ia/medicaid/resources/->

**UHC Macular Degeneration Treatment Procedures Policy Number: 2023T0404Y. Commercial and Individual Exchanges. Effective Date: August 1, 2023**

“Home visual field monitoring (e.g., ForeseeHome) for detection of age-related macular degeneration (AMD)-associated choroidal neovascularization (CNV) is proven and medically necessary when all of the following criteria are met:

1. The individual is at risk for developing CNV with one of the following: Bilateral large drusen; or Large drusen in one eye and advanced AMD in the fellow eye
2. Best corrected visual acuity of 20/60 or better in the affected eye(s)
3. The individual is able to operate the device
4. The individual does not have any of the following:
  - a) Medial opacities that prevent quality fundus photographs
  - b) Other retinal disorders (e.g., diabetic retinopathy)

Home visual field monitoring is unproven and not medically necessary due to insufficient evidence of efficacy for all other indications not listed as proven

Applicable Codes:CPT codes 0378T and 0379T”

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/commercial/macular-degeneration-treatment-procedures-08012023.pdf>

Entire Bulletin: <https://www.uhcprovider.com/content/dam/provider/docs/public/policies/mpub-archives/commercial/medical-policy-update-bulletin-july-2023.pdf>

**UHC Community Plan Corneal Hysteresis and Intraocular Pressure Measurement Policy Number: CS026.O Effective Date: July 1, 2023**

“The following are unproven and not medically necessary due to insufficient evidence of efficacy:

Measurement of corneal hysteresis

Measurement of ocular blood flow using a tonometer

Monitoring of intraocular pressure during vitrectomy

Continuous monitoring of intraocular pressure for  $\geq 24$  hours in persons with glaucoma”

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan/corneal-hysteresis-intraocular-pressure-measurement-cs.pdf>

Commercial Policy (same) : <https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/corneal-hysteresis-intraocular-pressure-measurement.pdf>

**UnitedHealthcare Provider Portal updates are LIVE. UHC Surest. July 27, 2023.**

“New updates have been added to the UnitedHealthcare Provider Portal to help you more effectively work with Surest members. Features include:

Variable copays at your fingertips

Convenient electronic prior authorizations

Network status for Behavioral Health and National Ancillary providers

Visible member ID cards and more

See how these new features work using the [Surest interactive guide.](#)”

<https://www.surest.com/>

“Surest hosted a quarterly provider webinar on June 29. Check out the on-demand version to learn about important topics like setting up billing and registration systems for Surest members and learn about tips and other resources available to you! “

<https://www.youtube.com/watch?v=WV0wqM0wpbM>

**CFPB, U.S. Department of Health and Human Services, and U.S. Department of Treasury Launch Inquiry into Costly Credit Cards and Loans Pushed on Patients for Health Care Costs. Consumer Financial Protection Bureau. July 7, 2023**

“...Consumer Financial Protection Bureau (CFPB), U.S. Department of Health and Human Services (HHS), and U.S. Department of Treasury (Treasury) launched an inquiry into high-cost specialty financial products, such as medical credit cards and installment loans, that are pushed on patients as a way to pay for routine medical care and which drive up health care costs and medical debt. ...

Medical payment products were once used primarily to pay for care not traditionally covered by health insurance plans, such as dental and vision care, fertility services, and cosmetic surgery. However, medical payment products are now also used to pay for a broader set of services, including emergency room visits and primary and specialty care. Even when medical care may otherwise be covered by insurance or financial assistance, patients may be pitched these products by their health care providers who then pass the administration of patient billing and collections over to financial service companies.”

<https://www.consumerfinance.gov/about-us/newsroom/inquiry-into-costly-credit-cards-and-loans-pushed-on-patients-for-health-care-costs/>