



MISSISSIPPI DIVISION OF
MEDICAID

Mississippi Medicaid
Provider Reference Guide
For Part 202
Hospital Services

*This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.*

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INPATIENT SERVICES INTRODUCTION

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Medicaid provides financial assistance for inpatient hospital services. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he/she will remain at least overnight and occupy a bed even though it later develops that he/she can be discharged or is transferred to another hospital and does not actually use a hospital bed overnight.

A hospital provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, he/she must accept the Medicaid payment as payment in full for those services covered by Medicaid. He/she cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid Policy as it relates to these factors is initiated by DOM.

DISCHARGE AGAINST MEDICAL ADVICE (AMA)

Discharge Against Medical Advice (AMA) occurs when a beneficiary leaves a hospital against the advice or consent of a physician. Mississippi Medicaid will reimburse covered inpatient or outpatient hospital services rendered to the beneficiary even though the beneficiary leaves against medical advice.

ANCILLARY SERVICES

Medically necessary ancillary services that are routinely furnished according to medically accepted standards of practice to inpatients by the hospital or by others under arrangements made by the hospital and in accordance with and subject to exclusions of this manual are covered service.

DISPROPORTIONATE SHARE HOSPITAL (DSH)

The Mississippi Medicaid State Plan defines the Disproportionate Share Hospital (DSH) program and the qualifications for participation in the DSH program. Publicly owned and operated hospitals that qualify as DSH hospitals are considered to be High DSH hospitals. High DSH hospitals must participate in an intergovernmental transfer program to participate in the DSH program. Hospitals other than publicly owned and operated hospitals that qualify for the DSH program are considered to be Low DSH hospitals.

HOSPITAL RESPONSIBILITIES FOR PHYSICIAN SERVICES

Physicians employed by or contracted with the hospital may not bill individually for services rendered to Medicaid beneficiaries. The hospital must bill for services provided by physicians employed by or contracted with the hospital (ex: hospitalists, lab directors, etc.). These services must be billed on the HCFA-1500 with the physician's individual Medicaid provider number as the servicing provider and the hospital's Medicaid provider number as the billing provider. This includes services provided in the emergency room by physicians employed on a full-time or part-time basis by the hospital and other physicians employed by or with a contractual arrangement with the hospital.

A hospital that accepts a Medicaid beneficiary for treatment accepts the responsibility for making sure that the beneficiary receives all medically necessary services that are covered by Medicaid. The conditions of participation that govern hospitals providing care to Medicare and Medicaid beneficiaries require that the governing body of the hospital assures accountability of the medical staff for the quality of care provided to beneficiaries. Accordingly, if a particular physician with whom the hospital contract does not accept Medicaid, the hospital has the responsibility of assuring the delivery of these medically necessary services to a Medicaid beneficiary.

BLOOD AND BLOOD COMPONENTS

During each fiscal year, Medicaid will cover the first six (6) pints of whole blood and/or equivalent quantities of packed red blood cells for each eligible beneficiary, when they are not available from other sources (ex: family, autologous precollection, donor-directed precollection, etc.). The term "whole blood" means human blood from which none of the liquid or cellular components have been removed. Where packed red blood cells are furnished, a unit of packed red blood cells is considered equivalent to a pint of whole blood. Other components of blood such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin are not subject to the quantity limits. However, these components of blood are covered and should be billed as biologicals.

Hospitals are encouraged to make every effort to have the blood that is used by a Medicaid beneficiary replaced. If it is the hospital's usual practice to require replacement of more blood than is actually used, the practice can be continued with Medicaid beneficiaries. However, if full replacement is not received, then pint-for-pint credit must be given.

NEWBORN CHILD ELIGIBILITY

Newborn children may become Medicaid beneficiaries effective on his/her date of birth.

NEWBORN TO A MEDICAID-ELIGIBLE MOTHER

A child born to a Medicaid-eligible mother may automatically be eligible for Medicaid coverage for one year. Following the birth of a child of a Medicaid beneficiary and before the mother is discharged from the birthing facility; hospitals must complete the Application for Newborn Health Benefits Identification Number form. This form authorizes the hospital to release information to the Division of Medicaid (DOM). The completed form should be faxed to the appropriate Medicaid Regional Office that serves the county where the mother and baby will reside. The Medicaid Regional Office will process the newborn information and assign a permanent Medicaid ID number within 7-10 days of receipt and fax the form back to the birthing facility initiating the form.

NOTE: Newborns adopted at birth or released for adoption at birth are automatically entitled to the one-year eligibility period. However, if parental rights are terminated, the form must indicate this fact and the form should be faxed to the regional Medicaid office serving the county where the baby will reside; not the mother. The address of the newborn is needed on the form so that DOM will be able to issue a notice of approval and a Medicaid ID card to a correct address.

A hospital can verify eligibility through the AVRS line at 1-800-884-3222 for any Medicaid beneficiary.

NEWBORN WHO IS NOT MEDICAID-ELIGIBLE AT THE TIME OF BIRTH

Eligibility is established by submitting an application to the appropriate Medicaid Regional Office. Application forms are available at Medicaid regional offices and on the DOM website. If eligibility criteria are met and there are unpaid bills, eligibility may be established for as much as three (3) months prior to the date of application.

MATERNITY EPIDURALS

A maternity epidural is a covered procedure under Mississippi Medicaid for all pregnant Medicaid beneficiaries. All pregnant Medicaid beneficiaries must have access to this anesthesia service. Mississippi Medicaid considers maternity epidurals as a medically necessary service for treatment of labor pain. A maternity epidural is not considered an elective procedure.

PHYSICIAN RESPONSIBILITIES

Physician who is participating in the Mississippi Medicaid program must take all reasonable measures to ensure that maternity patients are instructed and offered an epidural as an available and covered service under Mississippi Medicaid as part of the patient's prenatal counseling. The patient's options for pain relief medication during childbirth must be explained to her. If she requests an epidural, she should be instructed that this is a covered service under the Mississippi Medicaid program. Beneficiary problems with access to epidurals should be reported to the Program Integrity Unit hotline number at 1-800-880-5920 or 601-987-3962.

ANESTHESIOLOGIST AND CRNA RESPONSIBILITIES

Anesthesiologists/CRNAs may not refuse to provide a maternity epidural to a Medicaid beneficiary except when medically contraindicated. An anesthesiologist/CRNA who is participating in the Mississippi Medicaid program must make available and offer maternity epidural services to pregnant Medicaid beneficiaries and cannot require a pregnant Medicaid beneficiary to pay for an epidural. He/she must accept the Medicaid payment as payment in full and cannot require a co-payment for his/her services. Under federal Medicaid law, deductions, cost sharing, or similar charges are not permitted for Medicaid services furnished to pregnant women. Thus, a participating provider's demand for these additional payments would be in violation of the law.

The decision to have an epidural is to be decided between the beneficiary and her anesthesiologist/CRNA in consultation with the obstetrician. No means of coercion, dissuasion, or refusal by an anesthesiologist/CRNA to provide an epidural to a beneficiary in labor shall be utilized in determining this decision.

HOSPITAL RESPONSIBILITIES

Hospital that accepts a pregnant Medicaid beneficiary for treatment accepts the responsibility for making sure that the beneficiary has access to an epidural. If an anesthesiologist does not accept a Medicaid patient for treatment, the hospital has the responsibility of assuring the delivery of this service. A pregnant beneficiary is entitled to receive the service from a provider who has accepted her as a patient without the imposition of deductibles, cost sharing, or similar charges.

The conditions of participation that govern hospitals providing care to Medicaid beneficiaries require that the governing body of the hospital assures accountability of the medical staff for the quality of care provided to patients. There must be an effective hospital-wide quality assurance program to evaluate the provision of patient care, and all organized services related to patient care, including services furnished by a contractor must be evaluated, and where deficiencies are identified, remedial action must be taken (42 CFR 482.12, 21 & 22).

As referenced in Part 200 Chapter 4 Rule 4.2, Conditions of Participation, of the Administrative Code: "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 service, unless some other resources, other than the beneficiary or the beneficiary's family, will pay for the service.

TAKE HOME DRUGS, SUPPLIES, AND EQUIPMENT

DRUGS

Drugs for use in a hospital that are ordinarily furnished by the hospital for the care and treatment of the beneficiary are covered. Take home drugs are NOT covered. A beneficiary may, upon discharge from the hospital, take home remaining amounts of drugs that have been supplied for him/her either on prescription or doctor's order, if continued administration is necessary, since they already would have been charged to his/her account by the hospital.

SUPPLIES

Supplies ordinarily furnished by the hospital for the care and treatments of the beneficiary solely during his/her stay in the hospital are covered beneficiary hospital services. Under certain circumstances, supplies during the hospital stay are covered even though the beneficiary is discharged from the hospital with them. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the beneficiary's use of the item to the periods during which the beneficiary is an inpatient. Examples of items covered under this rule are cardiac valves, cardiac pacemakers, and such items as tracheotomy or drainage tubes which are temporarily installed in or attached to the patient's body while he/she is receiving treatment and which are also necessary to permit or facilitate the beneficiary's release from the hospital. Supplies and appliances furnished to a beneficiary for use solely outside the hospital are NOT covered.

OXYGEN

The reasonable cost of oxygen furnished for the care and treatment of the beneficiary solely during his/her stay in the hospital is covered. Oxygen furnished to a beneficiary for use solely outside the hospital is not covered.

DURABLE MEDICAL EQUIPMENT

Equipment ordinarily furnished by the hospital for the care and treatment of the beneficiary solely during his/her stay in the hospital is covered. Equipment furnished to a beneficiary for use solely outside the hospital is not covered.

TRANSPLANTS

Mississippi Medicaid benefits are provided for the following transplants if the transplant facility obtains prior approval (PA), when required, and satisfies all criteria:

Procedure	Covered	PA Required
Cornea	Yes	No
Heart	Yes	Yes
Heart/Lung	Yes	Yes
Kidney	Yes	No

Liver	Yes	Yes
Lung-Single	Yes	Yes
Lung-Bilateral	Yes	Yes
Marrow or Peripheral Hematopoietic Stem Cell	Yes	Yes
Autologous, Syngeneic, or Allogeneic Small Bowel	Yes	yes

Note: Pancreas transplants are not covered by the DOM. When a pancreas transplant is done in conjunction with another covered transplant procedure (example: pancreas transplant in conjunction with the kidney), DOM will only consider reimbursement for those charges related to the covered transplant procedure.

Requests for prior approval should be sent to the Division of Medicaid’s Utilization Management/Quality Improvement Organization (UM/QIO). Physicians are urged to submit their requests as soon as it is determined that the patient may be a potential candidate for transplant.

All transplant benefits are contingent upon:

1. The beneficiary’s continued eligibility for Mississippi Medicaid,
2. The beneficiary’s application for the transplant being approved by DOM’s UM/QIO,
3. All inpatient days being certified by DOM’s UM/QIO,
4. All conditions of third party liability procedures being satisfied,
5. All providers of services completing requirements for participation in the Mississippi Medicaid program; all claims being completed according to the requirements of the Mississippi Medicaid program,
6. All charges, both facility and physician, relating to procurement/storage must be billed by the transplant facility on the appropriate UB claim form under the appropriate revenue code,
7. The transplant facility providing appropriate medical records, progress or outcome reports as requested by DOM, the UM/QIO or the fiscal agent, and
8. The transplant procedure being performed at the requesting facility.

All terms of the Mississippi Medicaid program, including timely filing requirements, are applicable. Approval will not be given for:

- Transplant procedures for which medical necessity has not been proven,

- Transplant procedures which are still investigative, experimental, or still in clinical trial,
- Transplant procedures performed in a facility not approved by DOM,
- Inpatient or outpatient admissions for transplant procedures/services not certified/re- certified by the UM/QIO.

TRANSPORTATION OF PATIENTS

NURSING FACILITY RESIDENTS

If a nursing facility resident is transferred from a nursing facility to a hospital, remains hospitalized for longer than fifteen (15) days, and are discharged from the nursing facility; transportation for these residents should be arranged by the hospital.

If there has not been a final discharge from the nursing facility and the resident had a hospital stay of less than fifteen (15) days, transportation back to the nursing facility must be arranged by the nursing facility staff.

CHANGE OF OWNERSHIP

Refer to Administrative Code Part 200 Chapter 4 Rule 4.3.

CO-PAYMENT

Refer to Administrative Code Part 200 Chapter 3 Rule 3.7.

NON-COVERED PROCEDURES

In keeping with the Mississippi Medicaid policy for not providing reimbursement for services that are non-covered, any non-covered procedure performed in an inpatient or outpatient setting will result in this portion, or possibly the entire claim, being disallowed. Certification of a procedure by the UM/QIO for Mississippi Medicaid does not guarantee payment or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

DUAL ELIGIBLES

Benefits for inpatient hospital services under the Mississippi Medicaid program are limited to thirty

(30) inpatient days per fiscal year. This limitation is applicable to inpatient crossover claims. Each day of inpatient services will count toward the service limit. The deductible period is not exempt from the limit of 30 inpatient days per fiscal year.

All paper crossover claims billed for an inpatient hospital deductible must be billed with a bill type 111 (Hospital Inpatient Admit thru Discharge Claim) or 112 (Inpatient Hospital Interim-First Claim). If a claim is billed for an inpatient deductible and the type of bill is not 111 or 112, the claim will be denied with error code 024. The deductible must be billed with type of bill 111 or 112.

For Medicare Part A crossover claims from hospitals (inpatient) and all Part B crossover claims, Medicaid reimburses the full deductible and coinsurance amount for dual eligibles.

CANCELED PROCEDURES

ELECTIVE CANCELLATION OF PROCEDURES NOT RELATED TO THE BENEFICIARY'S MEDICAL CONDITION

When a surgical or other procedure is canceled due to scheduling conflicts of the operating suite or physician, beneficiary request, or other reason not related to medical necessity, the procedure may not be billed to Medicaid and no payment will be made for the procedure. Services provided prior to the procedure may be billed and will be covered subject to usual Medicaid policies for those services. If the cancellation causes the beneficiary to stay in the hospital for additional time until the procedure is rescheduled, those additional days will not be covered.

CANCELED OR INCOMPLETE PROCEDURES RELATED TO THE BENEFICIARY'S MEDICAL CONDITION

When a surgical or other procedure is canceled or terminated before completion due to changes in the beneficiary's medical condition that threaten his/her well-being, the services that were actually performed may be billed and will be covered subject to usual Medicaid policies for those services. There must be clear documentation regarding the medical necessity for cancellation or termination of the procedure.

PSYCHIATRIC SERVICES/GEROPSYCHIATRIC UNIT

GEROPSYCHIATRIC UNIT

Mississippi Medicaid does not cover services provided in a geropsychiatric unit of a hospital.

INPATIENT PSYCHIATRIC SERVICES

DOM covers inpatient acute psychiatric services in acute freestanding psychiatric facilities and in a psychiatric unit of a medical-surgical facility. Limitations apply to these services and are outlined below by facility type:

ACUTE FREESTANDING PSYCHIATRIC FACILITY

- The services are available for children up to age 21
- The service must be medically necessary, as determined by the PRO

PSYCHIATRIC UNIT AT A MEDICAL SURGICAL FACILITY

- The services are available to children or adults
- The service must be medically necessary, as determined by the PRO
- Services are applied to the limit of thirty (30) inpatient hospital days per fiscal year (services for children may be extended if medically necessary, as determined by the PRO)

PRIOR AUTHORIZATION OF INPATIENT HOSPITAL SERVICES

Prior authorization serves as a utilization review measure and quality assurance mechanism for the Mississippi Medicaid program. Federal regulations permit the Division of Medicaid (DOM) to require prior authorization for any service where it is anticipated or known that the service could either be abused by providers or beneficiaries, or easily result in excessive, uncontrollable Medicaid costs.

As a condition for reimbursement, DOM requires that all inpatient hospital admissions require prior authorization. Failure to obtain the prior authorization will result in denial of payment to all providers billing for services, including the hospital and the attending physician.

Note:

- When a beneficiary has third party insurance and Medicaid, prior authorization must be obtained from Medicaid.
- Prior authorizations are not required for Medicaid beneficiaries who are also covered by both Medicare Part A & B unless inpatient Medicare benefits are exhausted. Prior authorizations are required for Medicaid beneficiaries who are also covered by Medicare Part A only or Medicare Part B only.

SUBMITTING A PRIOR AUTHORIZATION REQUEST

Prior authorization is required for all inpatient hospital admissions except obstetrical deliveries. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he/she will remain at least overnight and occupy a bed even though it later develops that he/she can be discharged or is transferred to another hospital and does not actually use a hospital bed overnight. Emergent and urgent admissions must be authorized on the next working day after admission.

Certification acknowledges only the medical necessity and appropriateness of the setting and does not guarantee payment.

To receive authorization for an inpatient request, the hospital must contact the UM/QIO.

RECEIVING APPROVAL OR DENIAL OF A REQUEST

Letters of approval will be sent to the provider indicating the approved treatment authorization number (TAN) and dates of service. This information should be used when filing the claim form. Letters of denial will be sent to the provider and beneficiary. Letters to the provider will indicate the reason for denial.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s) to the UM/QIO.

Requests for administrative review by DOM must be made within 30 days from the final UM/QIO reconsideration decision letter.

BILLING FOR NON-APPROVED SERVICES

Medicaid beneficiaries in hospitals may be billed for inpatient care occurring after they have received written notification of Medicaid non-approval of hospital services. If the notice is issued prior to the beneficiary's admission, the beneficiary is liable for full payment if he/she enters the hospital. If the notice is issued at or after admission, the beneficiary is responsible for payment for all services provided after receipt of the notice.

In the event that the Utilization Management and Quality Improvement Organization's retrospective review determines that the admission did not meet the inpatient care criteria, Medicaid beneficiaries may not be billed for inpatient stay.

Medicaid beneficiaries may not be billed for inpatient care because the hospital failed to obtain the required admission and continued stay authorization.

This does not apply to Medicaid non-covered services such as geropsychiatric services.

NEWBORNS

If a newborn requires hospitalization beyond the mother's hospital stay, usually three (3) days for a vaginal delivery and five (5) days for a Cesarean delivery, the hospital must obtain a Treatment Authorization Number (TAN) from the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO) for the sick baby's hospital stay. When the mother is discharged and the newborn remains hospitalized, the mother's discharge date becomes the newborn's beginning date for certification purposes.

In addition to newborns remaining after the mother is discharged, newborns delivered outside the hospital and those admitted to accommodations other than well-baby must be authorized by the UM/QIO separately from the mother.

The hospital must provide the baby's name and Medicaid ID number to the UM/QIO in order to obtain a TAN; "Baby Boy" or "Baby Girl" is not acceptable for the baby's name. Upon receipt of the newborn's own Medicaid ID number, it is the responsibility of the hospital to provide that number to the UM/QIO. Once the UM/QIO has received the newborn's Medicaid ID number, the TAN will be released to the hospital and the fiscal agent, and the hospital can then submit claim(s). Newborns delivered to mothers eligible for Medicare are covered under the mother's Medicare claims and do not require certification unless they meet the requirements as noted above.

COSTREPORTS

All cost reports must be filed using the appropriate Medicare/Medicaid forms and instructions. The cost reports and the related information should be mailed to:

Division of Medicaid
Attn: Bureau of Reimbursement
239 North Lamar Street
Robert E. Lee Building, Suite 801
Jackson, MS 39201-1399

STERILIZATION

The Division of Medicaid will require the appropriate medical documentation to justify any emergency abdominal procedures or premature deliveries. For premature deliveries, the physician must document the expected date of delivery.

When submitting the claim for sterilization services, the provider **MUST** attach a copy of the Sterilization Consent Form if one is not already on file with the fiscal agent. The form may be obtained from the fiscal agent. This form is required of all providers (i.e., primary and assistant surgeon, anesthesiologist, and hospital) involved in the sterilization procedure. The Sterilization Consent Form has four (4) parts and should be completed fully and accurately.

The Sterilization Consent Form should be completed as follows:

1. CONSENT TO STERILIZATION

- Name of doctor or clinic **MUST** be entered
- Name of operation **MUST** be entered.
- Patient's date of birth **MUST** be entered.
- Patient's name **MUST** be entered.
- Name of doctor **MUST** be entered.

- Name of operation MUST be entered.
- Form MUST be signed and dated by the beneficiary.

2. INTERPRETER'S STATEMENT

- If an interpreter is necessary, that individual MUST complete this section, sign, and date the form on the same date as the beneficiary.

3. STATEMENT OF PERSON OBTAINING CONSENT

- Patient's name MUST be entered.
- Name of operation MUST be entered.
- Person obtaining the consent MUST sign and date the form on the same day it was signed and dated by the beneficiary.
- Name and address of the facility where the consent is obtained MUST be entered.

4. PHYSICIAN'S STATEMENT

- Name of individual MUST be entered.
- Date of sterilization MUST be entered.
- Type of operation MUST be entered.
- If paragraph (2) is true, the appropriate "block" MUST be checked.
- The physician performing the surgery MUST sign and date the form AFTER completing the operation.

Some general guidelines for filing sterilization claims:

1. The beneficiary must be 21 years old when the consent form is signed,
2. The consent form is valid for 180 days from the date it was signed by the patient, and
3. There must be at least a 30-day waiting period between the date the beneficiary signs the form and the date of the surgery. If emergency abdominal surgery is performed, the sterilization may be performed if 72 hours have elapsed from the time the beneficiary signed the form. Sterilizations performed before the 30-day waiting period or the 72-hour limit will not be reimbursed.

HYSTERECTOMY

Federal law (42 C.F.R. § 441.255) requires that a beneficiary requiring a hysterectomy sign a written acknowledgement, prior to the surgery, that certain information about hysterectomies was received.

A completed Hysterectomy Acknowledgment Form must accompany claims submitted for this service. This form may be obtained from the fiscal agent.

NEWBORN HEARING SCREENS

Hearing screens should be conducted on all newborns to detect hearing impairment and to alleviate the adverse effects of hearing loss on speech and language development, cognitive and social development, and academic performance. Screening consists of a test or battery of tests administered to determine the need for in-depth diagnostic evaluation. Screens may be performed using auditory brainstem response, evoked otoacoustic emissions, or other appropriate technology approved by the United States Food and Drug Administration.

Newborn hearing screens should be administered as follows:

- The initial screen should be conducted during the same hospital admission as the infant's birth.
- If the infant fails the initial screen, a second screen should be administered prior to hospital discharge.
- If the infant fails the second screen, a third screen should be scheduled in a setting other than inpatient hospital.
- If the infant fails the third screen, the infant should be referred to a physician or audiologist for diagnostic testing.

Hearing screens are a covered service for all Medicaid eligible infants. No prior authorization is required.

BILLING REQUIREMENTS FOR NEWBORN SCREENS

INPATIENT HOSPITAL

Hearing screens performed during the same hospital admission as the infant's birth must be billed on the UB-04 claim form using revenue code 470. Reimbursement is included in the hospital's per diem rate.

OUTPATIENT HOSPITAL

Hearing screens performed after discharge in the outpatient department of a hospital must be billed on the UB-04 claim form using revenue code 470. The hospital receives an outpatient reimbursement rate.

NON-HOSPITAL BASED PROVIDERS

Hearing screens performed in the office of a physician or audiologist must be billed on the CMS-1500 claim form using HCPCS V5008. Physicians and audiologists receive fee for service reimbursement.

BILLING REQUIREMENTS FOR DIAGNOSTIC TESTING

Infants failing three (3) hearing screens should be referred to a physician or audiologist for in-depth diagnostic testing.

INPATIENT/OUTPATIENT HOSPITAL

Diagnostic testing performed in the hospital (inpatient or outpatient) must be billed on the UB-04 claim form using revenue code 471. Reimbursement for inpatient services is included in the hospital's per diem rate. Reimbursement for outpatient services is made according to the hospital's outpatient reimbursement rate.

NON-HOSPITAL BASED PROVIDERS

Diagnostic testing performed in the office of a physician or audiologist must be billed on the CMS-1500 claim form using the appropriate code(s). Physicians and audiologists receive fee for service reimbursement.

DOCUMENTATION

In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and paid for by Medicaid, the provider must maintain legible and auditable records that will substantiate the claim submitted to Medicaid. At a minimum, medical record documentation must contain the following on each beneficiary:

- Date(s) of service;
- Demographic information (Example: name, Medicaid number, date of birth, etc.);
- Reason for testing (i.e., universal or hearing loss risk factors);
- Interpretation/Results of testing;
- Recommendations;

- Follow-up, if applicable;
- Parent’s or guardian’s refusal of services, if applicable
- Provider’s signature or initials.

Records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws. DOM, the UM/QIO, and/or the fiscal agent have the authority to request patient records at any time to conduct a random review and/or documentation of services billed by the provider.

TRAUMA TEAM ACTIVATION/RESPONSE

A trauma team activation/response is defined as a “Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient’s arrival” to a trauma center.

Pre-hospital caregivers are Emergency Medical Technicians (basic, intermediate, and paramedic levels) and first responders as recognized by Mississippi Emergency Medical Services or the responsible governing body of the state in which the beneficiary received services.

Trauma team activation/response fees are covered under the Mississippi Medicaid Program according to the following criteria:

- The billing hospital must have a complete designation as a Level I, II, III, or IV trauma center through the Mississippi State Board of Health, Office of Emergency Planning and Response, or if out of state, through the responsible governing body of the state in which the beneficiary received services. Complete designation means the hospital has completed all the requirements for designation at their application level.

LEVEL 1

Level I Trauma Centers must have a full range of trauma capabilities, including an emergency department, a full-service surgical suite, intensive care unit, and diagnostic imaging. Level I Centers must have a residency program, ongoing trauma research, and provide 24-hour trauma service in their facility. These hospitals provide a variety of other services to comprehensively care for both trauma patients, as well as medical patients. Level I Trauma Centers act as referral facilities for Level II, III, and IV Trauma Centers.

LEVEL II

Level II Trauma Centers must be able to provide initial care to the severely injured patient. These facilities must have a full range of trauma capabilities, including emergency department, a full service surgical suite, intensive care unit, and diagnostic imaging. Level II Trauma Centers act as referral facilities for Level III and IV Trauma Centers. For specialty care a patient may be transferred to a Level I Trauma Center.

LEVEL III

Level III Trauma Centers must offer continuous general surgical coverage and can manage the initial care of many injured patients. Level III Trauma Centers must also provide continuous orthopedic coverage. Transfer agreements must be in place with Level I and II Trauma Centers for patients that exceed the Level III Trauma Center's resources. Level III may act as a referral facility for Level IV Trauma Centers.

LEVEL IV

Level IV Trauma Centers provide initial evaluation and assessment of injured patients. Most patients will require transfer to facilities with more resources dedicated to providing optimal care for the injured patients. Level IV Trauma Centers must have transfer agreements in place with Level I, II, and III Trauma Centers.

Payment will be made in accordance with the reimbursement methodology of the Division of Medicaid's inpatient or outpatient hospital services.

Providers may not bill trauma activation fees for beneficiaries who are "drive by" or arrive by private vehicle without notification from pre-hospital caregivers. The patient must arrive by ambulance and the hospital must be pre-notified by pre-hospital caregivers.

Providers must bill the fees for trauma team/activation response with the appropriate revenue code in the 068X range.

Documentation must be maintained in the patient's medical record that supports provision of an organized trauma team response that meets the criteria for the Level I, II, III, or IV service. A facility must not bill and cannot be paid for a level of care above the one which they have been designated by the Mississippi State Department of Health.

All patients must have a primary diagnosis that falls within the ICD-9 diagnosis code range 800-959.9 plus documentation in the medical record of one of the following situations:

1. TRANSFERAL BETWEEN ACUTE CARE FACILITIES (IN OR OUT)

If a trauma center receives a patient that has sustained an injury that the center is unable to treat and transfers the patient to a higher or more appropriate level of care, this patient must be included in the trauma registry at both the transferring and receiving hospital. This will allow regions to identify over and under triage that is occurring.

2. ADMISSION TO CRITICAL CARE UNIT (NO MINIMUM)

Any injury sustained that warrants admission to ICU must be included.

3. HOSPITALIZATION FOR THREE OR MORE CALENDAR DAYS

Any patient hospitalized for three or more calendar days must be included. In some situations, patients may be hospitalized for reasons other than the injury, i.e. medical, social, etc. It is

recommended that hospitals include all of these for evaluation in their own facility, but only those hospitalized due to the injury should be submitted to the state.

4. DEATH AFTER RECEIVING ANY EVALUATION OR TREATMENT

All trauma deaths that receive any evaluation or treatment in the Emergency Department must be entered in the trauma registry and evaluated for preventability at all levels: prehospital, transferring hospital, and receiving hospital.

5. ADMISSION DIRECTLY FROM EMERGENCY DEPARTMENT TO OPERATING ROOM FOR MAJOR PROCEDURE, EXCLUDING PLASTICS OR ORTHOPEDICS PROCEDURES ON PATIENTS THAT DO NOT MEET THE THREE DAY HOSPITALIZATION CRITERIA

All patients that are admitted directly from the ED to the operating room for a major procedure must be included. Any plastic and/or orthopedic procedures that do not meet one of the other criteria for inclusion must not be entered into the trauma registry.

6. TRIAGED (PER REGIONAL TRAUMA PROTOCOLS) TO A TRAUMA HOSPITAL BY PRE-HOSPITAL CARE REGARDLESS OF SEVERITY

If any patient is triaged to a trauma center by pre-hospital care providers (per regional trauma protocols), the patient must be included in the trauma registry. This is how medical direction for pre-hospital care at the local and regional levels will monitor appropriateness of triage protocols.

7. TREATED IN THE EMERGENCY DEPARTMENT BY THE TRAUMA TEAM REGARDLESS OF SEVERITY OF INJURY

Any trauma patient triaged or transferred into a trauma center that results in the activation of the trauma team must be entered into the trauma registry. This will allow a hospital's trauma program manager to monitor appropriateness of trauma team activation protocols.

Note: The term trauma registry that is referenced in items 1-7 above is a system of timely data collection that aids in the evaluation of trauma care. All acute care health facilities that receive injured patients should participate in a trauma registry.

The designation levels have specific criteria and standards of care that guide hospital and emergency personnel in determining the level of care a trauma victim needs and whether that hospital can care for the patient or transfer the patient to a trauma center that can administer more definitive care. The makeup of the trauma team varies according to the designated level and size of the trauma center.

STERILIZATION AND DELIVERIES IN THE SAME ADMISSION

When a Medicaid beneficiary has a delivery and sterilization procedure during the same admission to the hospital, the hospital provider bills all charges and reports both the delivery and sterilization procedures when billing their claim.

In some instances, the sterilization procedure is not covered by Medicaid because the physician failed to get the sterilization consent form requirements completed or the sterilization federal requirements, such as age appropriate, were not satisfied. In such cases, the hospital is entitled to benefits for covered delivery services. To ensure that the fiscal agent can process the claim to pay benefits for the delivery, the Division of Medicaid is authorizing the hospital to carve out all charges relating to the sterilization and submit the claim without reporting the procedure codes for the sterilization. The business office must document the carved out charges and maintain the document in the beneficiary's file for audit purposes.

If the physician failed to get the sterilization consent form requirements completed, the beneficiary cannot be billed. Refer to Part 200 Chapter 3 Rule 3.9, Charges Not Beneficiary's Responsibility, which states that "the beneficiary may not be billed for services denied because a provider failed to request required authorization for a service or failed to meet procedural requirements".

If the federal requirements for sterilization procedures were not satisfied, the beneficiary may be billed as the procedure is non-covered under Medicaid. For example, if the beneficiary is less than 21 years of age or the form was not signed 30 days prior to the procedure. In some instances, the consent form may be forwarded to Medicaid after the hospital claim has been processed; therefore, hospital providers must thoroughly check each case before billing beneficiaries.

The purpose of the policy is to provide a process through which hospitals can receive benefits for covered deliveries in a more expedient manner. If complaints are received from beneficiaries which indicate beneficiaries are being billed for covered instead of non-covered sterilizations, the cases will be investigated by the Division of Medicaid.

INDEPENDENT LABORATORY SERVICES

Independent laboratories may not bill Mississippi Medicaid for lab procedures performed for beneficiaries during a hospital inpatient stay. The per diem rate that the hospital receives is considered to cover all services provided during the inpatient stay. Independent lab reimbursement must be obtained from the hospital.

FORMS

MISSISSIPPI MEDICAID
ABORTION NECESSITY FORM

Beneficiary Name: _____ Medicaid #: _____
(Please Print)

CERTIFICATION REQUIRED:

I, _____ (name of physician),
certify that on the basis of my professional judgment that this procedure should

be performed on _____
(name of patient), of

(address)

because:

1. ___ it is necessary to save the life of the mother.
2. ___ pregnancy is result of alleged rape.
3. ___ pregnancy is result of alleged incest.

Date of Procedure: _____

(Signature of Physician)

MA-1034

Revised 03/06

Hysterectomy Acknowledgement Form

Beneficiary Name: _____ Medicaid ID #: _____

Date of Hysterectomy Procedure: _____

Complete Part I if the beneficiary is not sterile and the hysterectomy procedure is not an emergency.

Complete Part II if the beneficiary is sterile, if the hysterectomy procedure is an emergency, or for retroactive eligibility.

PART I:

Beneficiary or Guardian/Legal Representative Acknowledgement Statement

I acknowledge that I have been advised orally and in writing that a hysterectomy will render me permanently incapable of reproducing and that I have agreed to this operation. I received this oral and written explanation that the hysterectomy would make me sterile before the hysterectomy procedure.

Signature of Beneficiary or Guardian/Legal Representative

Date of Signature

Signature of Person Securing Authorization for Procedure

Date of Signature

Physician Certification Regarding Hysterectomy

I certify the hysterectomy procedure is medically necessary due to the diagnosis _____ diagnosis code _____, and is not performed solely for the purpose of sterilization. Prior to the hysterectomy procedure, the beneficiary and her guardian/legal representative, if any, were informed both orally and in writing that the beneficiary would be permanently incapable of reproducing as a result of this hysterectomy procedure.

Signature of Physician

Date of Signature

PART II:

PHYSICIAN - Waiver of Acknowledgement and Physician Certification

The hysterectomy performed on the above named beneficiary was solely for medical indications and was not for the purpose of sterilization. Check the appropriate box(es) below.

1. The patient was sterile prior to the hysterectomy.

Cause of sterility _____

2. The hysterectomy was performed in a life threatening emergency in which prior acknowledgement was not possible. Describe the nature of the emergency _____

3. For retroactive Medicaid eligible beneficiaries: The patient was not a Medicaid beneficiary at the time the hysterectomy was performed but was informed prior to the hysterectomy procedure that the procedure would make her permanently incapable of reproducing.

Signature of Physician

Date of Signature

SWING BED INTRODUCTION

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of

Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Medicaid covers inpatient hospital swing bed services. Swing bed services are extended care services provided in a hospital bed that has been designated as such, and the services consist of one or more of the following:

- Skilled nursing care and related services for patients requiring medical or nursing care.
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- On a regular basis, health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which can be made available to them only through institutional facilities.

A swing bed provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then rebate Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM staff, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

EXCHANGE OF INFORMATION/DOM-317

The Swing Bed facility receiving the individual for admission must complete a form DOM-317 to determine Medicaid eligibility for individuals in long term care. The Medicaid Regional Office of the individual's county of residence is responsible for authorizing Medicaid reimbursement

payments via Form DOM-317 for each Medicaid beneficiary, including SSI beneficiaries. This form can be obtained from any Medicaid regional office.

The DOM-317 form documents the most recent date of Medicaid eligibility and the amount of Medicaid income due from the beneficiary each month. Medicaid income is the amount of money the beneficiary in a swing bed must pay toward the cost of his/her care.

Form DOM-317 is to be initiated by the swing bed facility only when Medicaid reimbursement for long-term care will be billed by the facility. Form DOM-317 is not needed if Medicare is the primary payer for the swing bed stay.

The completed DOM-317 is used by the swing bed facility and the Medicaid regional office as an exchange of information form regarding applicants for and beneficiaries of Medicaid. It must be completed as follows:

1. The form is initiated by the swing bed facility at the time a Medicaid applicant/beneficiary enters, transfers in or out, is discharged, or expires in the facility.

Note: The DOM-317 Form is initiated only when the facility will bill Medicaid as the primary payer for reimbursement.

2. The Medicaid regional office completes the form at the time an application has been approved for Medicaid and will notify the facility and the fiscal agent of the effective date of Medicaid eligibility, and the amount of the individual's Medicaid income.

The DOM- 317 Form is used to notify the swing bed facility and the fiscal agent of any change in Medicaid income and to report when Medicaid eligibility is denied or terminated.

3. The form is also used to notify the fiscal agent of the date a vendor payment is to begin and the amount the beneficiary must pay toward the cost of care (Medicaid income).

The swing bed facility originating the form will prepare an original and one (1) copy. The original is to be mailed to the appropriate Medicaid regional office while the copy is retained by the facility.

When the Medicaid regional office receives a DOM-317 form from the nursing home or hospital that will be the swing bed provider, the information is entered into their computer, and it generates a DOM-317A form. This form is sent back to the nursing home or hospital by the fiscal agent to inform them of the Medicaid eligibility status, Medicaid income, and other optional information necessary to complete the exchange of information from the regional office. This form should be kept in the beneficiary's file.

DOM-317 forms completed by the regional office to report rejected applications, approvals of yearly reviews with no change in previously reported Medicaid income amounts, or closures with no change in Medicaid income will not be submitted to the fiscal agent for billing purposes. In these

instances, the original is returned to the swing bed or hospital and one (1) copy is retained in the case record.

MEDICAID INSTRUCTIONS FOR COMPLETING THE DOM-317

Items 1-16 are identifying information about the Medicaid beneficiary and are completed by the facility originating the form.

1. Name of Nursing Facility/Hospital
 - Enter the name of the medical facility in which the beneficiary resides.
2. Provider Number
 - Enter the provider's Medicaid ID number.
3. Address
 - Enter the complete street address or post office box of the medical facility.
4. City
 - Enter the city of the medical facility.
5. State
 - Enter the state of the medical facility.
6. ZIP
 - Enter the zip code of the medical facility
7. Client's Name
 - Enter the name of the beneficiary.
8. Medicaid ID
 - Enter the beneficiary's Medicaid ID number, if known.
9. Social Security Number
 - Enter the beneficiary's Social Security number.
10. Name of Responsible Relative
 - Enter the name of the relative(s) authorized to act in the beneficiary's behalf.
11. Address of Relative
 - Enter the responsible relative's address
12. Client's County of Residence Before Entering Facility
 - Enter the name of the county where the beneficiary lived or maintained a home before entering the medical facility.
13. Does This Beneficiary Receive SSI?
 - Mark whether or not the beneficiary is a recipient of SSI. If the beneficiary receives an SSI check, enter the amount of the SSI check, if known.

14. Notice of Action Taken-This portion of the form is completed by the nursing facility or hospital at the time the following occur:
- A. Client entered facility.
 - Enter the month, day, and year the beneficiary entered the facility.
 - Family or Beneficiary has been given an application form. Enter “X” in appropriate place.
 - B. Client has been discharged to another medical facility as of –
 - Enter the date the beneficiary was discharged to another medical facility.
 - C. Name/Address of new facility is –
 - Enter complete name and address of new facility.
 - D. Client has been transferred to another medical facility as of –
 - Enter the date the beneficiary was transferred to another medical facility. Name/Address of new facility is –
 - Enter complete name and address of new facility.
 - E. Client has been discharged to hospice care within same facility effective –
 - Enter the date the beneficiary was enrolled into hospice care provided the beneficiary remains in the same nursing facility.
 - F. Client has been discharged to a private living arrangement
 - Enter date beneficiary was discharged.
 - G. Client is deceased. Date of Death
 - Enter beneficiary’s date of death.
15. Signature
- The nursing facility/swing bed administrator should sign the form.
16. Date
- Enter the date the form is completed.

REIMBURSEMENT

Individuals who are placed in swing beds in a hospital may have Medicare only, Medicare and Medicaid, or Medicaid only. Claims must be filed as follows:

- Medicare only eligibles: no involvement with Medicaid; file claims with Medicare according to Medicare requirements.

- Medicare and Medicaid dual eligibles: file claims directly with Medicare; Medicaid payment of coinsurance is made through the automatic crossover payment system.
- Medicaid only eligibles: file claims directly with the Medicaid fiscal agent.

In all instances where a Medicaid beneficiary is covered by Medicare, Medicare is the primary payer for a swing bed stay. The Medicare claim will cross over to Medicaid for payment of coinsurance charges. There is no Medicare deductible on a swing bed admission.

The UB-04 claim form is used for all swing bed billing. Refer to the Division of Medicaid Billing Manual for specific instructions on filing a UB-04 claim form and coding structures.

DOCUMENTATION REQUIREMENTS

All professional and institutional providers participating in the Medicaid program are required to maintain records that will disclose services rendered and billed under the program and, upon request, make such records available to representatives of DOM or the Office of the Attorney General in substantiation of any or all claims. These records should be retained a minimum of five (5) years in order to comply with all state and federal regulations and laws.

Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

DOM and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the swing bed facility.

If a swing bed provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to the Mississippi Medicaid program any money received from the program for such non-substantiated services. If a refund is not received within 60 days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the swing bed provider.

A swing bed provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws and can be subject to civil monetary penalties or fines, and/or be disqualified as a provider of Medicaid services.

CONTACT INFORMATION

Provider Enrollment
1-800-884-3240

Medicaid Regional Offices

Go to www.medicaid.ms.gov
Click on the Contact Us Tab
Click on the Medicaid Regional Offices Tab

CARDIAC REHABILITATION

PRIOR AUTHORIZATION

Prior authorization acknowledges the medical necessity and appropriateness of services. It does not guarantee payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

Providers must use the standardized Pre-certification Review Request forms provided by the UM/QIO.

REVIEW OUTCOMES

The UM/QIO will issue a Notice of Review Outcome to the provider at the completion of the review process. Once medical necessity is determined, a Treatment Authorization Number (TAN) will be assigned for billing purposes. If the review outcome results in a denial, written notification will be sent to the beneficiary/representative and provider.

RECONSIDERATION PROCESS

The beneficiary or provider may appeal a utilization review denial to the UM/QIO through the reconsideration process outlined in the UM/QIO manual.

ADMINISTRATIVE APPEAL

Disagreement with the UM/QIO reconsideration determination may be appealed by the beneficiary/legal representative. The beneficiary/legal representative must submit a written request for administrative appeal within thirty (30) calendar days of the UM/QIO reconsideration review determination notice. The process for requesting an administrative appeal is included in the denial notice that is sent to the beneficiary/representative.

CARDIAC REHABILITATION PROVIDER RESPONSIBILITIES

The following four factors precipitate discontinuing the cardiac rehabilitation program. These include:

Evidence that the beneficiary is clinically unstable

Achievement of the goals set at program entry

Determination that the beneficiary has received optimal or near-optimal benefits

Beneficiary is non-compliant with treatment plan

PHASE II CARDIAC REHABILITATION REQUIREMENTS

Phase II cardiac rehabilitation will be considered for beneficiaries with the following cardiovascular disease diagnoses (qualifying episodes):

Acute Myocardial Infarction within the preceding 12 months	
Anterolateral AMI	410.02
Anterior AMI	410.12
Inferior Lateral AMI	410.22
Inferior AMI	410.42
Lateral AMI	410.52
Unspecified AMI Site	410.92
Non ST Elevation	410.71
Subendocardial (Non Q-Wave)	410.72
Other Specified Sites	410.82
Coronary artery bypass graft	V45.81
Percutaneous transluminal coronary angioplasty, cardiac stent, atherectomy (DCA)	V45.82
Heart valve repair/replacement(AVR and MVR)	V43.
Heart transplant	V42.1
Stable Angina	413.9

DOCUMENTATION

All professional and institutional providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program and, upon request, make these records available to representatives of DOM in substantiation of any and all claims. These records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws or until a resolution of any pending investigations, audits or litigation.

In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and those paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. DOM, the UM/QIO, and/or the fiscal agent have the authority to request patient records at any time to conduct a random review and/or documentation of services billed by the provider.

The Division of Medicaid, the UM/QIO, and/or the fiscal agent have the authority to request any beneficiary's records at any time to conduct a random sampling review and/or document any services billed by the service provider. If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to DOM any money received from the Medicaid program for any such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties, as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

DUAL ELIGIBLE

Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid (dual) eligible.

Providers may submit a pre-certification request to the UM/QIO for therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The six (6) month timely limitation for filing crossover claims is applicable with no exceptions.

CONTACT INFORMATION

Name	Phone	Fax
Fallon Brewster, Program Administrator	(601) 359-9136	(601) 359-6147
Christy Lyle, Program Nurse	(601) 359-5570	(601) 359-6147
EQ Health Solutions, UM/QIO	(601) 353-6353	(601) 352-6358
Appeals	(601) 359-6039	(601) 359 -6294

REIMBURSEMENT

Reimbursement for services are made from a statewide uniform fee schedule and paid at the lesser of the provider charge or the Medicaid allowable fee. Medicaid allowable fees are set in accordance with the Mississippi Medicaid State Plan.

SLEEP DISORDER STUDIES

SLEEP STUDY SERVICE

Sleep disorder studies are performed to diagnose certain conditions through the study of sleep. The studies are commonly performed in an outpatient setting such as a physician's clinic, a freestanding facility, an Independent Diagnostic Treatment Facility (IDTF), or through an outpatient hospital department.

The Mississippi Medicaid Program reimburses covered and medically necessary sleep study services performed in a physician's office or in the outpatient department of a hospital. Sleep study services are not reimbursed when performed in an IDTF or freestanding facility.

Providers billing sleep disorder studies must maintain proper certification / accreditation by either the American Academy of Sleep Medicine (AASM) or the Joint Commission on Accreditation of

Healthcare Organizations (JCAHO). Space, equipment, and staffing must be consistent with the AASM or JCAHO standards.